GOSPORT

FILE CONTENTS

File 1

Code A working notes (handwritten)

Liz McAnulty (Director FTP) letter to CHI 11.2.02 enclosing correspondence with DS James of Hampshire Constabulary re: Code A and Code A and the police reports into the death of Gladys Richards (Ford and Livesley reports) - police to take NFA.

Liz McAnulty correspondence May 2001 – September 2002 with NHS Directorate of Health and Social Care, NHS South Regional Office

Professional Conduct Report to the PCC 18.9.01 re: Code A (Gladys Richards)

Feb 02 – internal email re: possible re-opening of police case into death of Richards

21.2.02 – letter to DS James to Liz McAnulty re: Ford/Livesley reports - NFA by police, but may raise professional issues – 5 cases now examined

26.2.02 – Liz McAnulty acknowledgement of DS James – passed to case manager as may be new allegations

12.12.01 – Ford report into Richards, Cunningham, Wilkie, Wilson, Page

Jul 01 – Livesley report into Richards

8.3.02 – letter from DR Reid, Portsmouth Healthcare NHS Trust, to DS James re: inaccuracies in Ford report

Internal emails/filenotes March/April 2002

5.2.02 – email from Code A to Code A asking her to telephone Gillian McKenzie re: complaint

29.4.02 – letter from Code A case manager) to Dr Eileen Thomas, acting nursing director at Fareham and Gosport PCT, requesting information in response to Ford and Livesley reports

15.5.02 – response from Dr Eileen Thomas enclosing:

- Notes of PCT meetings to discuss actions of nurses referred to NMC (NB: although this document talks about "three nurses" it does not name them
- Nursing notes Alice Wilkie
- Medical notes Alice Wilkie
- Prescription record Alice Wilkie
- Nursing notes Robert Wilson
- Medical notes Robert Wilson

- Prescription record Robert Wilson
- Nursing notes Arthur Cunningham
- Medical notes Arthur Cunningham
- Prescription record Arthur Cunningham

May 2002 – email correspondence re: NMC and CHI re: factual statement to be included in CHI report (*"The police raised concerns about the registered nurses with the UKCC (now NMC) and the Council is considering whether there are issues of professional misconduct in relation to any of the registered nurses involved"*)

Page complaint letter 17.5.02 re: death of Mrs E Page – names Code A others

NMC acknowledgement of Page complaint 22.5.02

NMC request for further information from Page 12.6.02

NMC filenote (prepared by Code A) summarising Ford report conclusions

July 2002 – internal emails re: case files in respect of Code A and Code A alone (complaint from Jackson and her daughter Yeats)

Code A executive summary of CHI report 11.7.02

Code A filenote re: status of complaints 12.6.02 (only complaint received from Page, Mrs Richard's daughter had telephoned and was told to write in but nothing had been received)

Code A filenote 11.7.02 summarising issues (further complaints received from Jackson against Code A re: Devine. Noted Code A were no longer working for the Trust)

NMC filenote 11.7.02 – internal agreement to put the cases into PPC part 1 end August 2002

CHI report and executive summary July 2002

Masters for PPC meeting 24.9.02 – case ref nos 11978, 12012, 12011, 12012, 12013 re: registrants Code A

PPC marked up agenda 24.9.02 – all adjourned

File 2

Jackson (pp Yeats) complaint re: Wilkie naming Code A d 1.6.02

Duplicate CHI report and executive summary

Duplicate Ford report

Duplicate Livesley report

Page complaint re: Page naming Code A and others" 17.5.02

Code A complaint re: Devine naming Code A 6.6.02
NMC letter of acknowledgement to Jackson 13.6.02

NMC letter informing Jackson that PPC will consider complaint on 27.8.02

Handwritten note re: "further complainants" Mrs Gillian McKenzie (plus address) and Ms Lesley Richards (plus address) – patient not named, but it would appear to be Gladys Richards

File 3

PPC masters 18.9.01

PPC masters 27.8.02

Clare Strickland memo and attachments 20.4.07

Filenote of telephone call from Mrs Bulbeck 26.1.04 re: a patient death at Gosport

Correspondence from Hampshire Constabulary 19.1.05 forwarding letter 26.11.04 and attachments from Wilson re: Code A – no nurses named. Includes report by the Health Service Ombudsman into complaint by Mr Wilson

Duplicate of Code A complaint 6.6.02 re: Devine naming Code A and Code A

NMC letter of acknowledgement to Code A 14.6.02

NMC letter 2.7.02 requesting further information from Code A

NMC letter 12.8.02 to Page informing him PPC would consider allegation on 27.8.02

NMC letter to Code A informing her that PPC would consider allegation on 27.8.02

Fareham and Gosport NHS Trust letter to NMC 16.9.02 asking to be notified of outcome of PPC meeting 24.9.02

Internal email Code A 16.9.02

Fareham PCT press release 13.9.02 announcing CMO's clinical audit

Press cutting 10.7.02 re: CHI findings

Fareham PCT letter 10.9.02 to NMC acknowledging unnamed additional complaint

Jackson letter of authority to NMC 13.9.02

Bulbeck letter of complaint re: Middleton 19.6.02 – no nurses named

NMC acknowledgement letter to Bulbeck 26.6.02

NMC request for further information from Bulbeck 3.7.02

NMC letter 3.7.02 to Gosport WMH re: Bulbeck complaint

Fareham PCT letter to NMC 8.7.02 re: commissioning investigation into Bulbeck complaint

NMC acknowledgement to Fareham PCT 22.7.02

Fareham PCT letter to Mrs Bulbeck 18.7.02

Bulbeck letter 12.8.02 to NMC - can't name individual nurses

NMC letter 5.9.02 to Mrs Conley (sic) re Code A

Carby letter 22.8.02 to NMC re: Carby naming Code A

NMC letter to Fareham PCT 5.9.02 re: Carby complaint

Bulbeck letter to NMC 2.9.02 naming Code A as nurse responsible for care

Hampshire Health Authority letter to NMC 19.9.02 enclosing correspondence provided to PCT management by "a member of staff" on 16.9.02 – enclosures are the 1991 correspondence involving the RCN re: concerns about use of diamorphine - named nurses include Code A, Anita Tubritt, Code A correspondence acknowledged by Liz McAnulty 24.9.02

Dec letters 27.9.02 to Lesley Richards, Mrs Jackson, Mr Page, Ms Yeats, Jan Peach (service manager, community hospitals), Code A Mrs Bulbeck, Mrs McKenzie – adjourned to await outcome of CPS investigations

Dec letter 3.10.02 to Ms Rowles, director of public health, Fareham PCT naming Code A

Letter Hampshire Health Authority to Liz McAnulty 27.9.02 informing NMC that Hampshire Constabulary have referred case back to CPS in light of new information, including documents from 1991

Letter from Fareham PCT to NMC 11.10.02:

- Aware of allegations re Code A
- Not previously aware of allegations re: Code A
- Unsure as to status of cases against Neville, Joice and Couchman

Letter from Fareham PCT to NMC 14.10.02 enclosing PCT investigation report into Bulbeck complaint (prepared by Jane Williams)

5.11.02 BBC news printout of report on GWMH

Letter from Fareham PCT to NMC 15.11.02 enclosing Hooper report 22.10.02 to Fareham PCT re: Carby complaint

Code A PPC report July 2002

Dear all

Thank you very much for meeting this afternoon. Here is a summary of what we have agreed:

- Code A will be the Code A and will take case decisions with the assistance of me and in consultation with Code A where necessary. This will include a decision about whether to put the case into PPC part 2 or part 4. This issue will be resolved at the end of the GMC proceedings.
- At that stage, I will update my full report to the panel and finalise the panel bundle, the whole of which will also be disclosed to the registrants.
- We need to start getting a PPC scheduled to follow the GMC proceedings, which are due to finish on 21 August 2009. To allow enough time to serve the registrants, we are looking at a date at the end of September/beginning of October. Code A will ask the schedulers to list a PPC meeting.
- The PPC will have a legal assessor to assist them.
- Code A will start to arrange a meeting with the Trust to take place prior to the PPC meeting, and immediately after the GMC proceedings (late August/early September). This will enable us to get up to date references and information about the registrants.
- Investigation markers will not be put against the names of the registrants until they are sent formal notification of the PPC meeting. It was noted that Code A s registration is due to lapse in August 2009. It has been reported to us that she is suffering from a terminal illness and so is unlikely to renew.
- When notification is sent to the registrants, letters will also be sent to complainants, including the Richards complainants, whose case was closed in 2001.
- We agreed that it would be inappropriate to give any sort of statement to Comms at present. Code A will reply to Code A request for a statement.
- I will email Sarah Ellson at FFW to ask what sort of contribution the GMC wants re: the transcripts of the inquest.
- Code A will ask admin to ensure that anybody who calls FTP with a query about Gosport is put through to him.

Please let me know if I have missed anything, or if there is anything I have got wrong.

Regards

Clare
Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code C

First Floor
Centrium
61 Aldwych
London
WC2B 4AE

12/06/2009 Sent to Ian Tadd Code A Code A

Code A

Meeting to discuss the Gosport case

12.6.09 2.30pm

Agenda

To: Ian Todd (Director FTP) J Code A Code A
Code A , C Code A Code A
Code A

1. Introduction and update (Code A)
2. Executive decision making arrangements - Code A
3. PPC arrangements: - On outcome PPC.
   a. Rule 8(1) or Part 4?
   b. Timing
   c. Legal assessor?
   d. Shorthand writer?
   ] End Sep / Mid Oct PPC. - Code A
4. Consequential arrangements:
   a. Notice to registrants (to note special circumstances re: Hamblin) - Meet with Trust before sending end Aug / beg Sep
   b. Notice to the Trust ✓
   c. Notice to complainants ✓
   d. The Richards complaint ✓
5. Communications - Nothing to present - aware of cues, ongoing GMC, consid posit - Code A
6. Transcripts:
   a. Coroner's inquest – see email from GMC ✓ - Code A to email SE, ask for GMC to liaise with Code A
   b. GMC proceedings ✓

- Decisions - Code A [illegible] to take Code A & make decis, in discuss with Code A / Code A

Matters [illegible] to go on when formal notif. given.

Code A to instruct admin to put any calls through to him.

Code A

From: Code A
Sent: 12 June 2009 14:10
To: Ian Todd; Code A Code A
Subject: Gosport agenda meeting Code A 20090612
Attachments: Gosport agenda meeting Code A 20090612.DOC

Dear all

Thank you for agreeing to attend the meeting this afternoon. I thought it might assist if we all have a list of the points that we need to discuss, so I have prepared an agenda, a copy of which I attach. Hopefully drop in room 4 is available; otherwise we can use one of the hearing rooms.

See you in 20 minutes!

Regards

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

First Floor
Centrium
61 Aldwych
London
WC2B 4AE

Clare Strickland

From: Clare Strickland
Sent: 03 June 2009 17:02
To: Code A
Subject: Gosport

Hello Code A

Please could you arrange a meeting to discuss this case? I really need to see Ian and Code A and Code A has also kindly offered to come along. Ideally, if Code A as c Code A nd Code A as Code A could come along as well, that would be great.

As soon as possible would be good, but please let me know if any particular person's availability presents any problems.

Many thanks

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code C

First Floor
Centrium
61 Aldwych
London
WC2B 4AE

NMC File Note

Subject: Gosport

Date: 3.6.09

Author: Clare Strickland

Discussion with Code A re: letters to registrant in advance on any PPC:

- Agreed that generally, registrants should be informed whenever a case is being considered by any of the NMC's Committees, and given a full opportunity to comment.
- If we are putting the case in part 4 (i.e. not to proceed), there is no need to send the PRE16A letter (as per Rule 8(1) of the 1993 Rules).
- If the PRE16A letter is not to be sent, there is no need to draft specific allegations – it will be sufficient to inform the registrant that a complaint has been received in which they are named, and ask them to make any comment they like.
- Re Code A who is reported to be terminally ill, we need to agree a sensitive and careful approach. Possibilities include meeting with the Trust to discuss the complaints, not sending her any material at all, or sending her material with a carefully written, sensitive, personal letter suggesting that it should all be forwarded to her representative.
- Code A agrees we need a meeting with Ian Todd (FTP director) and Code A Code A she is also happy to attend.
- Agreed I will get Code A o arrange a meeting asap.

Clare Strickland

From: Clare Strickland
Sent: 03 June 2009 12:09
To: Code A
Subject: Gosport

Hi Code A as you may know I have been doing some work on this case, which we are planning to put back to the PPC after the close of the GMC's proceedings against the doctor. One of the things I am trying to do is draft letters to the registrants to inform them about what is happening. I would be very grateful if we could discuss when you are free, as you are the expert on all things old rules.

Many thanks

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

First Floor
Centrium
61 Aldwych
London
WC2B 4AE

Clare Strickland

From: Ian Todd
Sent: 06 May 2009 20:04
To: Code A
Subject: RE: Last day of Gosport Inquests

Hi Code A

Yes, happy to cover costs on transcript.

I'm away for a few days, we can discuss next steps on my return.

Regards
Ian

From: Clare Strickland
Sent: 01 May 2009 13:21
To: Ian Todd
Cc: Code A
Subject: FW: Last day of Gosport Inquests

Dear Ian

Attached is the verdict from the Gosport inquests.

The only patient in respect of whom we have an existing complaint is Elsie Devine. In her case, the jury found that medication contributed more than minimally to her death, that it was given for therapeutic reasons, but that it was not appropriate for the condition and symptoms.

I would like to accept Sarah Elson's offer of a copy of the full transcript, subject to us covering their administrative costs. Please could you confirm that you are content for us to cover the cost, and I will go ahead and request it.

The GMC case against Dr Barton is due to start on 8 June and to run for 10 weeks. This information is not in the public domain yet.

Also, one of the nurses against whom we have received a complaint is suffering from a terminal illness. She was due to be a witness in the GMC proceedings, but is unlikely to be well enough to attend.

I have reflected on our position in this case following the McNicholas decision, and am of the view that I will need to do significant further work before the case can be put before the PPC. However, I am concerned about my availability to do that work, given my other hearings commitments over the next 3 months. I will discuss this with Sarah in the first instance.

Please do not hesitate to contact me if you need further information.

Regards

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team

Code A

From: Ellson, Sarah [mailto:Sarah.Ellson@ffw.com]
Sent: 29 April 2009 17:39
To: Clare Strickland
Subject: Last day of Gosport Inquests

Dear Clare

It is not the easiest to read but here is the transcript of the last day of the Inquests which contains the verdicts.

If you think you might like the whole transcript can you let me know - I may be asked to make a small charge for this - the GMC would appreciate it if we could at least cover our administrative costs on this.

Sarah Ellson | Partner
for Field Fisher Waterhouse LLP
dd: Code A m: + Code A

Consider the environment, think before you print!

Field Fisher Waterhouse LLP 27th Floor City Tower Piccadilly Plaza Manchester M1 4BD
Tel+44 0161 200 1770 Fax+44 0161 200 1777
E-mail info@ffw.com Web www.ffw.com CDE823

Clare Strickland

From: Ian Todd
Sent: 16 March 2009 09:08
To: Code A
Subject: RE: Gosport War Memorial Inquest

I agree
Ian

From: Clare Strickland
Sent: 16 March 2009 09:09
To: Ian Todd; Code A Code A
Cc: Code A
Subject: FW: Gosport War Memorial Inquest

Dear all

Attached below is an email from the transcribing service which is covering the Gosport inquest (which starts on Wednesday). I have telephoned the company, and explained that we are unlikely to need the daily updates, but that we may want to buy transcripts for all/part of the inquest after the event. They have confirmed that with permission of the coroner, we would be able to do this, and that the rate would be in the region of Code A

Unless anyone disagrees, I would recommend that we take that approach, rather than get daily transcripts at the expense of Code A We do not need them on a daily basis, and we probably would not need all of the evidence in any event.

Finally, I attach a further copy of my memo dated 24 February, to which I have not yet received any acknowledgement or response. If there is anything anyone wishes to discuss before responding , please let me know.

Regards

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

From: Maxwell, James [mailto Code A
Sent: 12 March 2009 10:41
To: Clare Strickland
Subject: Gosport War Memorial Inquest

Dear Clare,

Further to my call earlier today with Adele Watson at FFW, I am currently trying to gauge interest in providing our daily stenography service for the Inquest and have had initial enquiries from FFW and now also the Coroner.

If I may bring a couple of points to your attention with regards to our daily transcript service:

- The transcript that we will produce at the end of each day will be emailed to each party within 2-3 hours

of the inquest ending. It does not form part of a disclosure process and is used by each legal team to reflect on the days proceedings and allow them to review notes in preparation for the following day. Research has shown that by using our daily service, inquest sitting time can be reduced by upto 20%.

- If each party were to agree on receiving the transcript, then I can split the costs accordingly by 7, which would amount to £160 + vat per day, based on a 30 day period.

I am contacting the other parties to also relay this information and I hope to hear from you soon. Hopefully if all parties agree, then I can send a quotation booking form to you, so that we can confirm the service.

Kind Regards,

James

James Maxwell
Merrill Legal Solutions | Account Manager - Public Sector
5th Floor | 190 Fleet Street | London | EC4A 2AG | UK
Code A | **Main: +44 (0) 207 404 1400 | Mob** Code A
Email: james.maxwell@merrillcorp.com Web: www.merrillcorp.com

Winner: Private Equity News Software Provider of the Year 2008
Winner: "Best In VDR Technology 2008", World Finance Magazine
Winner: "Best EDD/Litigation Support Provider", Legal Technology Awards 2009

Clare Strickland

From: Clare Strickland
Sent: 16 March 2009 09:09
To: Ian Todd; Code A Code A
Cc: Code A
Subject: TRIM: FW: Gosport War Memorial Inquest
Attachments: Gosport memo Code A 20090224.DOC
TRIM Dataset: TL
TRIM Record Number: 335310
TRIM Record URI: 349775

Dear all

Attached below is an email from the transcribing service which is covering the Gosport inquest (which starts on Wednesday). I have telephoned the company, and explained that we are unlikely to need the daily updates, but that we may want to buy transcripts for all/part of the inquest after the event. They have confirmed that with permission of the coroner, we would be able to do this, and that the rate would be in the region of £32 per day.

Unless anyone disagrees, I would recommend that we take that approach, rather than get daily transcripts at the expense of £160+ per day. We do not need them on a daily basis, and we probably would not need all of the evidence in any event.

Finally, I attach a further copy of my memo dated 24 February, to which I have not yet received any acknowledgement or response. If there is anything anyone wishes to discuss before responding , please let me know.

Regards

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

From: Maxwell, James [mailto Code A
Sent: 12 March 2009 10:41
To: Clare Strickland
Subject: Gosport War Memorial Inquest

Dear Clare,

Further to my call earlier today with Adele Watson at FFW, I am currently trying to gauge interest in providing our daily stenography service for the Inquest and have had initial enquiries from FFW and now also the Coroner.

If I may bring a couple of points to your attention with regards to our daily transcript service:

- The transcript that we will produce at the end of each day will be emailed to each party within 2-3 hours of the inquest ending. It does not form part of a disclosure process and is used by each legal team to reflect on the days proceedings and allow them to review notes in preparation for the following day. Research has shown that by using our daily service, inquest sitting time can be reduced by upto 20%.

- If each party were to agree on receiving the transcript, then I can split the costs accordingly by 7, which would amount to £160 + vat per day, based on a 30 day period.

I am contacting the other parties to also relay this information and I hope to hear from you soon. Hopefully if all parties agree, then I can send a quotation booking form to you, so that we can confirm the service.

Kind Regards,

James

James Maxwell
Merrill Legal Solutions | Account Manager - Public Sector
5th Floor | 190 Fleet Street | London | EC4A 2AG | UK
Code A | **Main: +44 (0) 207 404 1400 | M** Code A
Email: james.maxwell@merrillcorp.com Web: www.merrillcorp.com/mls

NMC INTERNAL MEMORANDUM

To: Ian Todd

Code A

From: Clare Strickland

Code A

Date: 24 February 2009

CC:

Re: Gosport War Memorial Hospital

---

1. As you will recall, further to my memo of 16 May 2008 (attached), in August 2008 it was agreed that we would instruct leading counsel for advice on how to proceed in this case.

2. In August 2008, we instructed Johannah Cutts QC to advise us and to produce a guidance note for use by the PPC.

3. In September 2008, we established contact with the coroner conducting the inquest, and obtained some further information and documents requested by leading counsel.

4. In October 2008, I completed my report to the PPC, which contains a full summary of the case.

5. In January 2009, we received further information from the coroner following a pre-inquest hearing on 19 January 2009:

    - The inquest will start on 18 March 2009, and is scheduled to run into April 2009;
    - A number of nurses will be called as witnesses, but none of the nurses is to be separately represented.
    - Of the nurses who are subject to existing complaints before the PPC, only Gill Hamblin is to give live evidence at the inquest (although the coroner has witness statements from Freda Shaw as well).

6. In February 2009, we received the opinion and guidance note from Miss Cutts QC. Copies are attached to this memo.

7. You will note that Ms Cutts agrees with our view that matters should be placed before the PPC as soon as possible.

8. However, I am conscious that we have taken longer than expected to reach this point, and as a result, we would be unable to arrange a PPC meeting before the inquest starts on 18 March 2009. I consider that it would be undesirable to arrange for the PPC meeting to take place whilst the inquest is ongoing:

- It will not achieve what was our original aim, i.e. to clarify the position for as many nurses as possible (and the complainants) in advance of the inquest;

- The PPC is unlikely to adopt any course other than adjourn pending the outcome of the inquest.

9. At this stage, it would appear that the inquest is not likely to run beyond the end of April 2009, but there can be no guarantees of this. However, it is unlikely that waiting until the outcome of the inquest is known will delay the case by any more than three months.

10. If this is agreed, we must be ready to proceed quickly once the outcome of the inquest is known. To some extent, the course to be followed will depend upon the outcome of the inquest. However, there are some things we can do to be ready:

    a. Establish the registration status of nurses Code A Code A (all of whom are the subject of the cases currently before the PPC);

    b. Establish the identity and registration status of Staff Nurse Code A Code A (named by Mrs Carby in her complaint, which has never been put before the PPC);

    c. Make a decision on how to proceed in the Richards case, and be ready to explain this decision to the complainant. As you may recall, this case was closed by the PPC in 2001. However, in 2002, the complainant was sent a letter in error saying that the case had been adjourned. This case is one that is being considered by the coroner, but not the GMC. Therefore, at the close of the inquest, we should have everything we need to make this decision and communicate it to the complainant.

    d. Decide which documents should be served on the practitioners and draft letters to be sent to them prior to the referral to the PPC.

11. I would suggest that Code A as Code A is best placed to deal with points a) and b) above, and I would invite him to email me with the results as soon as he can. I can deal with point d). I consider that point c) is a decision to be made by Ian and/or Code A It would be helpful to have your preliminary view, which can be reviewed once we have the outcome of the inquest.

12. Please let me know if you would like to discuss further and/or need any further information.

Clare Strickland

From:	Clare Strickland
Sent:	24 February 2009 16:57
To:	Ian Todd; Code A Code A
Cc:	Code A
Subject:	TRIM: Gosport
Attachments:	Gosport memo Code A 20090224.DOC; Gosport memo Code A 20080516.DOC; Gosport Cutts QC opinion 20090209.DOC; Gosport Cutts QC guidance note to ppc 20090209.DOC
&Catalog On Send:	-1
Container URI:	35474
Delete After:	0
Show Dialog:	-1
TRIM Dataset:	TL
TRIM Record Number:	320132
TRIM Record Type URI:	7
TRIM Record URI:	333558

Dear All

Attached is my memo of today's date which gives you an update on this case. I have also attached my previous memo of 16.5.08 for information, and the advice and draft guidance note we have received from Johannah Cutts QC.

Please let me know if you have any questions or would like any further information from me.

Finally, Code A please could you let me know if you have received any invoices from Miss Cutts? We have received one that is marked "reminder", but have not got the original.

Regards

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

First Floor
Centrium
61 Aldwych
London
WC2B 6LH

NMC INTERNAL MEMORANDUM

To: Ian Todd
Code A

From: Clare Strickland
Code A

Date: 24 February 2009

CC:

Re: Gosport War Memorial Hospital

Nursing & Midwifery Council

1. As you will recall, further to my memo of 16 May 2008 (attached), in August 2008 it was agreed that we would instruct leading counsel for advice on how to proceed in this case.

2. In August 2008, we instructed Johannah Cutts QC to advise us and to produce a guidance note for use by the PPC.

3. In September 2008, we established contact with the coroner conducting the inquest, and obtained some further information and documents requested by leading counsel.

4. In October 2008, I completed my report to the PPC, which contains a full summary of the case.

5. In January 2009, we received further information from the coroner following a pre-inquest hearing on 19 January 2009:

   - The inquest will start on 18 March 2009, and is scheduled to run into April 2009;
   - A number of nurses will be called as witnesses, but none of the nurses is to be separately represented.
   - Of the nurses who are subject to existing complaints before the PPC, only Code A is to give live evidence at the inquest (although the coroner has witness statements from Code A as well).

6. In February 2009, we received the opinion and guidance note from Miss Cutts QC. Copies are attached to this memo.

7. You will note that Ms Cutts agrees with our view that matters should be placed before the PPC as soon as possible.

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10. If this is agreed, we must be ready to proceed quickly once the outcome of the inquest is known. To some extent, the course to be followed will depend upon the outcome of the inquest. However, there are some things we can do to be ready:

    a. Establish the registration status of nurses Code A Code A (all of whom are the subject of the cases currently before the PPC);

    b. Establish the identity and registration status of Staff Nurse Code A Code A named by Mrs Carby in her complaint, which has never been put before the PPC);

    c. Make a decision on how to proceed in the Richards case, and be ready to explain this decision to the complainant. As you may recall, this case was closed by the PPC in 2001. However, in 2002, the complainant was sent a letter in error saying that the case had been adjourned. This case is one that is being considered by the coroner, but not the GMC. Therefore, at the close of the inquest, we should have everything we need to make this decision and communicate it to the complainant.

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12. Please let me know if you would like to discuss further and/or need any further information.

I have now completed my report to the PPC and sent the further instructions to Jo Cutts QC.

You will recall that there was one further matter that needs to be resolved, and which I have not addressed in my report. This is the Richards complaint. In 2001, the PPC considered a complaint from the relatives of Mrs Richards, and closed the case.

There is no evidence that the PPC ever re-opened the case. However, in September 2002, after the PPC adjourned the other cases, letters were also sent to Mrs Richards's relatives, informing her that the case had been adjourned.

Accordingly, Mrs Richards's relatives are under the mistaken impression that the NMC is still dealing with their complaint. This impression needs to be corrected.

The relatives are the leaders of the campaign about the Gosport War Memorial Hospital. Their campaign has led to the police investigations and the coroner's decision to hold inquests. Mrs Richards is one of the cases being considered by the GMC in its proceedings against Dr Barton. She is not one of the patients whose death will be considered by the coroner at the inquest.

My view is that given the sensitivity of this matter, it should be dealt with at director level.

Regards

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A
Nursing & Midwifery Council
23 Portland Place
London W1B 1PZ
www.nmc-uk.org

020 7580 3917 (fax)
020 7637 7181 (switchboard)

Clare Strickland

From:	Clare Strickland
Sent:	25 September 2008 13:41
To:	Code A
Subject:	TRIM: RE: Gosport
&Catalog On Send:	-1
Container URI:	35474
Delete After:	0
Show Dialog:	-1
TRIM Dataset:	TL
TRIM Record Number:	255393
TRIM Record Type URI:	7
TRIM Record URI:	266469

Thanks - I've got some time blocked out, it shouldn't take more than a day or two if I get a clear run at it.

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

From: Code A
Sent: 25 September 2008 11:55
To: Clare Strickland
Subject: RE: Gosport

Thank you.

I will speak with Ian et al about our proposal and let Code A have a cost estimate for JC's input. I don't think that it will make a great deal of difference if you are not able to do finalise the report before early Nov all things considered but perhaps you could block out some time in your diary now.

Code A

From: Clare Strickland
Sent: 24 September 2008 13:51
To: Code A
Subject: Gosport

This is a just a quick note to let you know I haven't forgotten this case. I have started on a report for the PPC, and have identified the documents to go in the bundle. As soon as my report is done, I can send it to you for comments, then on to Jo Cutts so she can prepare her advice. Meanwhile, we need to update Ian Todd/Code A Code A Code A with our plan i.e.:

- Go back to PPC on all cases where there has been a complaint to the NMC
- Inform the registrants that the PPC will be considering them
- Inform the complainants that the PPC will be considering their complaints

It seems to me that before I can finalise everything, someone needs to make a decision on what to do about the Gladys Richards case. This complaint was closed in September 2001, and never re-opened. However, after the PPC adjourned the other complaints in August 2002, letters were sent to the complainants in the Richards case informing them that their complaint had been adjourned. According to Sarah Ellson at FFW, those complainants understandably believe that the NMC is still investigating their complaint.

I want to get all of this done asap, but I am now in back-to-back hearings, and my first free day in the office is at the end of October, so I'm not sure I'll be able to get much done before then. If you think we need to resolve Gosport before then, we will need to cover my hearings another way, but there is no in-house capacity to do that.

Regards

Clare

Clare Strickland
Senior lawyer (hearings)
Code A

Nursing & Midwifery Council
23 Portland Place
London W1B 1PZ
www.nmc-uk.org

020 7580 3917 (fax)
020 7637 7181 (switchboard)

Code A

From: Clare Strickland
Sent: 24 September 2008 13:50
To: Code A
Subject: TRIM: Gosport
TRIM Dataset: TL
TRIM Record Number: 254408
TRIM Record URI: 265421

This is a just a quick note to let you know I haven't forgotten this case. I have started on a report for the PPC, and have identified the documents to go in the bundle. As soon as my report is done, I can send it to you for comments, then on to Jo Cutts so she can prepare her advice. Meanwhile, we need to update Ian Todd Code A Code A Code A with our plan i.e.:

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Regards

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

Nursing & Midwifery Council
23 Portland Place
London W1B 1PZ
www.nmc-uk.org

020 7580 3917 (fax)
020 7637 7181 (switchboard)

Clare Strickland

From: Clare Strickland
Sent: 22 August 2008 14:05
To: Code A
Subject: Gosport - request for papers from 23 PP

Hi, I wonder if you could arrange for some of the Gosport papers to be retrieved from storage (I believe that they are at 23PP)? I need all of the NMC case files (I believe there are 5 or 6 of them, and they are the old light blue cardboard files) together with my file (which I think was marked "legal team" or "IHLT").

We have arranged a consultation with counsel on 8 September 2008. I am on holiday until 1 September 2008, and if possible, I would like to have the files then. At the latest I will need them by Wednesday 3 September so that I can prepare for the consultation.

Many thanks

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

Nursing & Midwifery Council
23 Portland Place
London W1B 1PZ
www.nmc-uk.org

020 7580 3917 (fax)
020 7637 7181 (switchboard)

Clare Strickland

From: Clare Strickland
Sent: 08 August 2008 14:18
To: Code A Ian Todd; Code A
Cc: Code A
Subject: RE: Gosport

Forgot to ask - Code A please can you check the registrations status of the registrants against whom we have outstanding complaints, i.e. Code A Have they got markers on or have they been renewing periodically? If the latter, are they all still registered?

Thanks

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

From: Clare Strickland
Sent: 08 August 2008 14:05
To: Ian Todd; Code A
Cc: Code A
Subject: Gosport

Thank you for your assistance with this case this afternoon.

As agreed, I am emailing with my understanding of what we ha
advise us on the following issues:

- whether any issues arising from the police files concern
a complaint from relatives about named nurses should
- the prospects of establishing misconduct likely to lead
(to include consideration of successfully rebutting any
- the management of the existing complaints in light of t
thereafter.

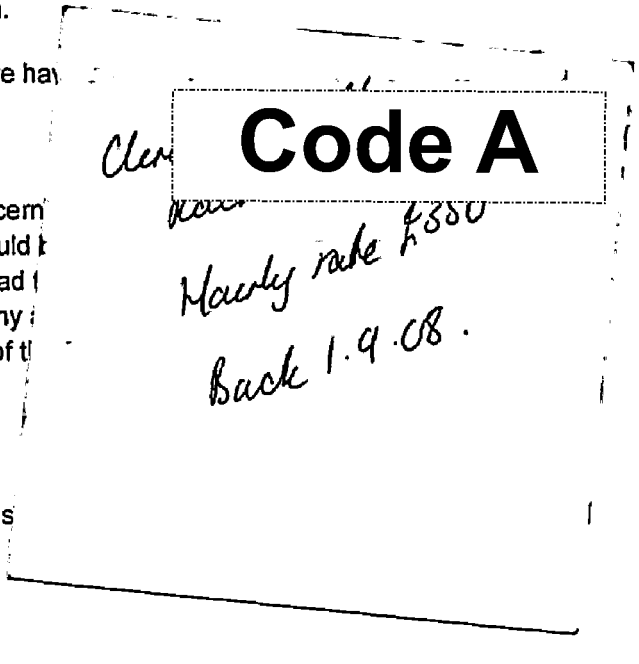
We will also inform the GMC of what we are doing.

Please let me know if I have misunderstood, or if I have mis
draft instructions and proceed to instruct counsel.

Regards

Clare
Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

Nursing & Midwifery Council
23 Portland Place



London W1B 1PZ
www.nmc-uk.org

020 7580 3917 (fax)
020 7637 7181 (switchboard)

NMC INTERNAL MEMORANDUM

To: Ian Todd
Code A
Code A

From: Clare Strickland
Code A

Date: 2 July 2008

CC:

Re: Gosport

Please find attached a letter I have received from Sarah Ellson at Field Fisher Waterhouse. We are due to meet to discuss this case on 5 August 2008.

Clare Strickland

From: Code A
Sent: 08 August 2008 14:30
To: Clare Strickland
Subject: FW: TEL NOTE: Nurses at Gosport Memorial Hospital, 23 July 2008 - 15:30 approx
Importance: High
Sensitivity: Private

Tubritt and Turnbull. I've never heard of these. Any ideas?

From: Code A
Sent: 28 July 2008 09:49
To: Code A
Subject: TEL NOTE: Nurses at Gosport Memorial Hospital, 23 July 2008 - 15:30 approx
Importance: High
Sensitivity: Private

This is a record of a telephone conversation I had with Vivienne Alexander, who had telephoned on 21 July 2008 (see below).

I explained that I had asked Code A to telephone her on 22 July 2008 and asked if she had spoken to him. She explained that she had not received a call.

She explained that she was the manager for three members of staff who were extremely distressed by a memo that had been circulated, which referred to three nurses working out of Gosport Memorial Hospital. As they were the only three, they were surprised not to have heard from the NMC.

There followed a confused conversation between Ms Alexander and I. I began again by explaining the following:

- I was assigned a case that I knew related by the name of Gosport Memorial Hospital. This was from a colleague of mine who had since left, but I had no hands on experience of it. I knew that it had been ongoing for some time and had passed between five case officers. Code A remained the constant figure in the case, as the Code A

- I established that the distress had been caused by an email that had been sent in the Trust by Patrica Radway. Attached to this email were minutes of an internal meeting. The email or the minutes were dated 7 July 2008. It refers to the NMC's enquiries ongoing regarding several nurses but does not name them. The minutes refer to the NMC indicating that the nurses were fit to practise at this practise at this time.

The receipients of the email had included three members of staff and they inferred that this must include them.

The registrants names and PINs given to me by Ms Alexander are as follows:

Code A

Anita Tubbritt
Code A

Code A

I explained, in general terms, that the reason why the registrants had heard not heard from the NMC at this time was that the case was being considered under the 1993 Rules, commonly known as Old Rules. Under these rules, it was not our practice to write to registrants advising that a complaint had been made unless we were asking them to respond to specific allegations. The Preliminary Proceedings Committee would then direct that we write to them if it decided to decline to proceed with a case. At that time, we would write and confirm that a complaint had been made, a summary of the complaint anf that the matter had been considered and dealt with.

In respect of the individual registrants she was calling about, I explained that there was little point in me using our usual line (that we could neither confirm nor deny that the registrant was the subject of an investigation) in respect of Code A given that FtP Admin had confirmed this to her on 21 July 2008 (see below). I explained that I did not know the substance of the allegation.

What I agreed to do was to check each registrant and their PIN against the register and confirm whether or not they were able to practise with their registered qualification, which I did. In each case, I was able to confirm an effective registration.

I explained that Code A would be the best person for her to speak to regarding this matter and it had been his intention to speak to her on Tuesday. I explained that he was in a series of courses until the following week, but I agreed to try and contact him today (text sent, no response). Miss Alexander said that she could wait until early next week and agreed not to discuss the matter with the three registrants until she had spoken to Code A [ends]

Code A please call Miss Alexander on 07920 723 401.

Code A

Nursing & Midwifery Council
23 Portland Place
London
W1B 1PZ
www.nmc-uk.org

Fax 020 7636 6282

020 7637 7181 (switchboard)

From: Code A
Sent: 21 July 2008 14:59

To: Code A
Cc: Code A Code A
Subject: FW: Code A - Code A

Code A

Ok, have since established that this is part of Nurses at Gosport Memorial Hospital.

As I have had nothing to do with this matter, but no that it is potentially high profile, I feel that I need your guidance before attempting to respond to this query.

Thanks,

Code A

Nursing & Midwifery Council
23 Portland Place
London
W1B 1PZ
www.nmc-uk.org

Fax 020 7636 6282

020 7637 7181 (switchboard)

From: Code A
Sent: 21 July 2008 14:52
To: Code A
Subject: FW: Code A - PIN: 72A0602S

This is a matter previously assigned to Code A

Case ref. 12010.

It appears to be part of a multiple case. Other names are Code A Code A

There's a note on Profcon: file in garage.

Do you know anything about this matter before I continue to dig around?

Thanks

Code A

Nursing & Midwifery Council

08/08/2008

23 Portland Place
London
W1B 1PZ
www.nmc-uk.org

Fax 020 7636 6282

020 7637 7181 (switchboard)

From: Code A
Sent: 21 July 2008 14:29
To: Code A
Subject: Code A - PIN: 72A0602S

Hi Code A

Vivienne Alexander telephoned regarding the above case. She is the employer of the above practitioner and would like to know if anything is happening with this case (it has been in the system since 2002) the practitioner says she has not received any correspondence about this.

Could you please telephone Vivenne Alexander on Code A

Thanks
Code A

NMC INTERNAL MEMORANDUM

To: Code A
Ian Todd
Code A
Code A
Code A

From: Clare Strickland
Code A

Date: 16 May 2008

CC:

Re: Gosport Ward Memorial Hospital – meeting with GMC 16.5.08

---

1. Code A and I attended a meeting with the GMC today to discuss this case. Attending on behalf of the GMC were Sarah Ellson of Field Fisher Waterhouse, Peter Swain (Head of Case Presentation) and Juliet St Bernard.

2. We had asked for the meeting in order that we could establish the nature of the GMC case against the doctor concerned. This will be relevant to our proceedings, as identified in my memo of 20 April 2007.

3. I summarised the background to the NMC's involvement, and explained why we sought further information from the GMC. We were then given the following information.

4. The GMC is focussing on 13 cases:

   - Five cases where complaint has been made to the GMC by members of the public;
   - The ten cases that fell into the police's "category 1" (two of these are also the subject of direct complaints)
   - One further case on which the GMC has obtained further expert evidence.

5. The patients are as follows:

   - Code A
   - Elsie Lavender
   - Eva Page
   - Alice Wilkie
   - Gladys Richards
   - Ruby Lake
   - Arthur Cunningham
   - Robert Wilson
   - Enid Spurgeon
   - Geoffrey Packman
   - Elsie Devine
   - Jean Stevens

6. The GMC investigations are advanced. They have identified 30 – 40 witnesses, some of whom merely produce their police witness statements, others of whom

statements and whom the GMC wish to call to give evidence or on whose statements the GMC will rely. They are:

- Carol Ball (provided a statement to the police but cannot be traced now)
- Code A
- Tina Douglas (provided a statement to the police but cannot be traced now)
- Sylvia Giffin (provided a statement to the police, now deceased)
- Shirley Hallman
- Code A
- Sheila Joines
- Anita Tubbritt
- Code A
- Fiona Walker

7. Other nurses mentioned by the GMC as possible witnesses are:

- Code A
- Margaret Wigfall
- Code A
- Ruth Clemow
- RCN steward Betty Woodland

8. The GMC was working towards a hearing date of 8 September 2008, with a hearing time estimate of eight weeks.

9. However, there has been a significant development this week. The coroner has opened an inquest into the deaths of ten patients, and adjourned it to autumn 2008. This would clash with the GMC's proposed hearing date. Accordingly, the GMC needs to consider whether to delay its hearing until after the inquest, or whether to try to press on. The ten patients who will be the subject of the inquest are:

- Code A
- Elsie Lavender
- Ruby Lake
- Robert Wilson
- Enid Spurgeon
- Elsie Devine
- Helena Service
- Arthur (Brian) Cunningham
- Sheila Gregory
- Geoffrey Packman

10. The GMC is anxious that we should not do anything that might discourage the nurse witnesses from co-operating with the GMC proceedings. I explained that the nurses who have already been referred to the NMC are not necessarily aware of the referrals. Under the system in place at the time of the referrals, nurses were not informed of the allegation against them prior to consideration by the PPC. Accordingly, the NMC has not had direct correspondence with the nurses named in the various complaints received (see my memo of 20 April 2007 for full details). However, I have seen correspondence between the NMC and the Trust,

so it may be that at least some of the nurses have been made aware of NMC interest, albeit indirectly.

11. During the course of its proceedings, the GMC has received comments from families to the effect that they do not know what the NMC is doing with their complaints. In particular, Sarah Ellson mentioned that Ms McKenzie, daughter of Gladys Richards, appears to be under the impression that her complaint is still under consideration. In fact, the Richards case was closed by the PPC in 2001, and there is no evidence on the NMC files that it was ever reopened.

12. We explained the NMC approach, namely to wait until the GMC has determined whether the doctor's prescribing was inappropriate and should have been challenged. Once we have that determination, we will be in a position to decide which nurses, if any, we should proceed against for failing to challenge.

13. NMC action could also follow a relevant finding by the coroner.

14. In my memo of 20 April 2007, I identified the two complaints received by the NMC where the general issue of poor prescribing, and failure by the nurses to challenge, was raised. These cases were Wilkie and Devine. The GMC has now confirmed that these two cases will form part of its proceedings.

15. The GMC is not in a position to share witness evidence with the NMC at this stage, but will be able to provide transcripts of its proceedings.

Next Steps

16. I remain of the view that our general approach, i.e. to await the outcome of GMC proceedings before deciding how to proceed is correct. However, there are some specific issues that we must consider, and decide how to deal with:

    - The delay between events and any NMC proceedings;
    - Notification of complaints received to named registrants;
    - Whether the cases should be dealt with under the old rules or the new rules.

17. My view when I considered then old rules/new rules issue last year was that the old rules would be preferable. On balance, I remain of that view for the reasons given in my memo of 20 April 2007. However, because of the significance of this issue, and the potential sensitivity of the two other issues I have identified, we may wish to seek an opinion from leading counsel.

Attachments

18. I attach the following to this memo:

    - My memo 20.4.07
    - Police investigation overview
    - My spreadsheets of the case files referred to the NMC by the police
    - BBC news printouts of press coverage of the coroner's inquest (14.5.08) and the announcement of further police investigation in 2006, when the NMC was mentioned (11.7.06)

Clare Strickland

From: Code A
Sent: 17 April 2008 12:03
To: Code A
Subject: RE: Meeting

Yes I am. Please can you let me know who else is coming so I can arrange to discuss it with them in advance. They will need to read my memo about the case, which is long and will take some time.

Regards

Code A

From: Code A
Sent: 17 April 2008 11:56
To: Code A
Subject: FW: Meeting
Importance: High

Code A

Before i confirm with Juliet are yopu still ok for 16 May meeting?

From: Juliet StBernard Code A) [mailto: Code A
Sent: 14 April 2008 12:52
To: Code A
Cc: Code A Code A
Subject: RE: Meeting
Importance: High

Dear Code A

As Sarah and Tamsin will be travelling from Manchester for this meeting, I would be grateful if you would acknowledge receipt of the email below.

With thanks
Juliet

From: Juliet StBernard (Code A
Sent: 03 Apr 2008 15:28
To: Code A
Cc: Code A Tamsin Hall ffw (formerly Tomlinsor Code A
Subject: Meeting

Dear Code A

Further to our telephone conversation today thank you for confirming that Claire is able to attend the meeting to discuss the Gosport War Memorial Case on the 16th.

The details of the meeting are:

Date: 16 May 2008
Time; 9.30 to 11.30
Venue: GMC, Room 2.18, Second Floor, 350 Euston Road, Regents Place, London NW1 3JN

Please ask Code A to report to our ground floor reception when she arrives.

I will be attending the meeting as well as our Solicitors, Sarah Ellson and Tasmin Hall.

I would be grateful if you would let me know if anyone else from the NMC will accompany Code A

Please acknowledge receipt of this email.

With kind regards
Juliet St Bernard

General Medical Council

St James Building, 79 Oxford Street Manchester. M1 6FQ

Regents Place, 350 Euston Road, London. NW1 3JN

The Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

Regus House, Falcon Drive, Cardiff Bay. CF10 4RU

20 Adelaide Street, Belfast. BT2 8GD

Tel: 0845 357 8001
Fax: 0845 357 9001

NMC Internal Memorandum

To: Code A Code A

From: Clare Strickland
In-house lawyer

Copy to:

Date: 20 April 2007

Re: Gosport War Memorial Hospital

Summary of events to date

1. The NMC has received several complaints about nurses at the Gosport War Memorial Hospital ("GWMH"), and a number of agencies have investigated concerns about clinical practice there in the late 1990s. Three wards are involved: Daedalus, Dryad, and (to a lesser extent) Sultan.

2. Those investigations began in September 1998. A patient named Mrs Richards had died on Daedalus Ward earlier that year, and her relatives made a complaint to the police. The police investigated the complaint, but in March 1999 the CPS advised that there was insufficient evidence to prosecute any member of staff for any offence.

3. The investigation was reopened in 2001. The police obtained an expert report into Mrs Richards' death from Professor Livesey. Three nurses were named in this report – Code A In September 2001, the NMC's PPC considered the matters raised in the Livesey report about Mrs Richards, and decided to close the case.

4. At about the same time, the CPS again advised the police that there was insufficient evidence to prosecute any member of staff.

5. As a result of local media coverage, other families contacted the police with concerns about the deaths of their relatives. The police referred five cases – Richards, Cunningham, Wilkie, Wilson and Page - to another expert, Professor Ford. Professor Ford reported in December 2001.

6. The police made the expert reports available to a number of bodies, including the Commission for Health Improvement ("CHI"), General Medical Council ("GMC") and NMC.

7. The CHI conducted an investigation into the trust's systems since 1998, and reported in July 2002. The CHI's key findings were as follows:

   - There were insufficient local prescribing guidelines in place covering the prescription of powerful pain relieving and sedative medicines;

   - A lack of rigorous routine review of pharmacy data led to high levels of prescribing on wards caring for older people going unquestioned;

- The absence of adequate trust-wide supervision and appraisal systems meant that poor prescribing practice went unidentified;
- There was a lack of thorough multi-disciplinary patient assessment to determine care needs on admission;
- By the time of the report in 2002, the trust had resolved the problems by ensuring that adequate policies and guidelines were in place to govern the prescription and administration of pain relieving medicines.

8. We do not have any formal information from the GMC about its proceedings. We have been told that they are investigating one doctor, Jane Barton, and that she is currently allowed to practise having given undertakings relating to the prescription of opiates.

9. In response to the Ford report, the NMC asked the Trust for comments. The Trust replied on 15 May 2002 with details of its response to the concerns raised. No disciplinary action was taken against any nurse.

10. Also in May 2002, Mr Page, son of Mrs Page, made a direct complaint to the NMC. He named nurses Code A .

11. In June 2002, the NMC received three further complaints:

- Mrs Jackson complained about nurse Code A in respect of her deceased mother Mrs Wilkie;
- Code A complained about nurses Code A in respect of her deceased Code A Mrs Devine;
- Mrs Bulbeck complained about the general care given to her deceased mother Mrs Middleton (she subsequently named Code A as being responsible).

12. In August 2002, the NMC received a further complaint from Mrs Carby against nurses Code A in respect of her deceased husband Mr Carby.

13. In September 2002, the police reopened the case and began a large-scale investigation into 90 deaths at the hospital. Further details of this investigation are given below, and in the attached police summary of the investigation.

14. On 24 September 2002, the PPC considered the following cases:

- Code A allegation from Jackson re: Wilkie
- n – allegations from Code A re: Devine and Page re: Page
- - allegations from Code A re: Divine and Page re: Page
- – allegation from Code A re: Divine
- llegations from Code A re: Divine

The Committee was assisted by a detailed summary of the evidence from Code A Code A These cases were adjourned pending the outcome of the police investigation.

15. Previously, I had been told that the PPC considered the Bulbeck complaint against nurse Code A on 22 October 2002 and declined to proceed. However, I have not seen any papers to this effect, and the agenda for the PPC on 22 October 2002 does not mention this case. Accordingly, I take the view that we must proceed on the basis that this case is open unless contrary information comes to light.

16. There is no evidence to suggest that the PPC has considered the Carby complaint against nurses Code A

17. In October 2004, Detective Chief Inspector Nigel Niven and Detective Superintendent David Williams met with Liz McAnulty, Code A and me to provide the NMC with an update on the police investigation and discuss the way forward.

18. We were informed that the police have looked into 90 deaths. They interviewed relatives of patients. They also commissioned a team of clinical experts: Irene Waters, a nursing expert (and NMC panel member), Robin Ferner, a pharmacologist, Peter Lawson, a geriatrician, and Anne Naysmith, an expert in palliative care. Matthew Lohn of Field Fisher Waterhouse prepared a summary of evidence in most cases for the police.

19. The experts were instructed to review the medical records and provide an analysis of treatment. The doctors rated care given on a scale from 1 to 4, where 1 is optimal, 2 sub-optimal, 3 is negligent and 4 is intended to cause harm. They then assessed the cause of death, with A meaning natural causes, B meaning cause of death is unclear, and C meaning the cause of death is unexplained by illness. Cases were put into one of 3 categories. Cases were put into Category 1 where the experts concluded that treatment was acceptable. Category 2 cases were those where the treatment was considered to be sub-optimal, but did not present evidence of criminal activity. Category 3 cases were considered to warrant further investigation with a view to determining whether criminal activity took place.

20. The police have contacted all of the families of patients whose cases fell into Category 1 to notify them of their findings. We were informed that investigations in Category 3 cases were ongoing, and were not given the names of the patients whose cases fall into these categories.

21. At the meeting with the police, it was agreed that they would provide the NMC with all of evidence gathered in Category 2 cases. They had reached a similar agreement with the GMC. The police informed the relatives, who all consented to this course of action.

22. Throughout 2004, 2005 and 2006 we received files relating to the 80 cases in Category 2. Typically, these contained the following information in respect of each case:

    - Police reports of interviews with family members (not in section 9 statement format)

- Expert summaries
- Summary comments by Matthew Lohn
- Medical records

23. I have carried out the following work on them:

- Logged each file on a spreadsheet recording salient details (copy attached)
- Reviewed the police reports of their interviews with family members
- Reviewed the expert comments on each case
- Review the summaries by Matthew Lohn

24. Except where the documents listed above draw attention to particular points, I have not reviewed the medical records for each patient as I lack the clinical expertise to make this a worthwhile exercise. For each of the 80 patients there is at least one lever arch file of medical records.

25. Of the cases where relatives have made complaints to the NMC, all but one (Devine) fell into the police's Category 2.

26. In December 2006, the police invited the NMC to a stakeholder meeting to discuss the outcome of its investigation into the 10 Category 3 cases. Code A attended on behalf of the NMC. The police reported that the CPS had concluded that no further action should be taken on each of the cases. They also reported that the coroner may decide to hold inquests into the deaths of three patients (Mrs Devine, Mrs Lavender, and Mrs Gregory), as they had been buried rather than cremated.

27. The Category 3 cases were investigated in far greater detail. The police had obtained section 9 statements from family members and all members of staff involved in the patients' care. They had instructed two further experts: Dr Wilcock, a palliative care expert, and Dr Black, a geriatrician. Further experts were instructed to advise on individual cases as required.

28. In March 2007, the police delivered further files to us. These included a large number of generic further statements, full records of police interviews with Dr Barton and Dr Reid (a consultant), expert reports, and witness statements and medical records relating to each of the 10 Category 3 patients. Mrs Devine's case was in this group.

29. I have reviewed this material enough to provide a summary of the issues (set out below), but I should stress that I have not considered every document. This is partly because I lack the clinical expertise to review medical records, but also because to review these files fully would be a full-time job lasting weeks, and I do not have that sort of time available at present.

30. The most recent contact from the police was on 10 April 2007. They informed me that:

- The GMC (advised by Eversheds) will not be in a position to make a decision on proceedings until June/July 2007;

- The Portsmouth coroner has asked the Lord Chancellor to appoint a judge to conduct the inquest

NMC complaint cases

31. Having conducted preliminary reviews of the material available, I am able to summarise the cases as follows.

Evidence in the case of Page

32. On 17 May 2002, Mr Page wrote to the NMC to complain about nurses Hamblin, Shaw and others unnamed. His mother died at GWMH in 1998. He did not express specific concerns about nursing care, but referred to the Ford report. It appears that at the time he wrote to complain, Mr Page had not seen a copy of the Ford report.

33. On 12 June 2002, the NMC wrote to ask Mr Page to provide details of his specific concerns about the nursing care his mother received. I have not seen any further correspondence from Mr Page in the files. The NMC then wrote to him on 12 August 2002 to tell him that the PPC would consider the case, and on 27 September 2002 to inform him of the PPC's decision to adjourn the case.

34. Professor Ford's only significant concern about Mrs Page's treatment is with the decision to commence subcutaneous diamorphine and midazolam on the day of her death. He considers that there was no indication in the notes that she was in pain or distress. In his view, the prescription was poor practice and potentially very hazardous. He would have expected very clear reasons for this prescription to have been recorded in the medical notes. He considers that, apart from this, the medical and nursing records were of adequate quality. He concludes:

> *In my opinion the majority of management and prescribing decisions made by medical and nursing staff were appropriate. The exception is the prescription of diamorphine and midazolam on the day of Mrs Page's death.*

35. Professor Ford does not name any individual nurses. From the medical records, I have been unable to identify whether nurses Code A were on duty on the day of Mrs Page's death.

36. The police experts' agreed that the case fell into category A2. Robin Ferner notes that diamorphine was used for confusion rather than pain, and queries the rapid increase in dose. Peter Lawson concluded:

> *Care being graded as sub-optimal is perhaps a little picky but relates to the changes in opioid and method of administration rather than the doses used.*

Anne Naysmith considers that it was not ideal palliative care, and particularly criticises the dose of Fentanyl.

37. The police record of interview with Mr Page contains no other significant evidence.

Page – conclusion

38. Although Mr Page named nurses Code A he does not make any particular complaint about them. Professor Ford does not refer to either of them. It is not apparent from the medical records whether nurses Code A were in a position to challenge the prescription on the day of Mrs Page's death. The police experts concluded that, on balance, treatment was sub-optimal, but they do not all agree as to what was wrong with it.

39. Taking all of this together, it is my view that there is insufficient evidence to proceed against nurses Code A in connection with Mrs Page's death.

Evidence in the case of Carby

40. On 22 August 2002, Mrs Carby wrote to the NMC alleging that her husband's sudden death in 1999 was caused by the negligence of nurses Code A, and Code A She did not particularise her complaint, but stated that Mr Carby's medical records contained ample evidence of nursing misconduct.

41. On 5 September 2002, the NMC passed the complaint to the Trust for its internal investigation.

42. The Trust instructed an expert, Professor Jean Hooper, to review Mr Carby's medical records. Professor Hooper's report was sent to the NMC on 15 November 2002. She expressed concern about discrepancies as to dates and times in the nursing records, but could find no evidence in the records to indicate that the nurses were negligent in their treatment of Mr Carby.

43. In addition to Professor Hooper's report, the Trust provided the NMC with excerpts from the ward controlled drugs record book, which showed that a syringe driver was set up with 40mgs of diamorphine at 12.15pm. It was discontinued at 1.20pm on the same day, and 9.5 of the original 10mls of fluid discarded.

44. The police experts agreed that this was an A2 case. All criticised the high dose of diamorphine and midazolam, but noted that Mr Carby died within 45 minutes of the syringe driver being set up, before the drugs had time to take effect.

45. In interview with the police, Mr Carby's family criticised Nurse Joice, saying that they did not like her manner. They also suggest that after Mr Carby's death, when one of his daughters became extremely upset, an unnamed nurse suggested giving her an injection to calm her down. This has not been raised with the NMC

Carby – conclusion

46. It is possible to prove that Nurse Code A failed to record the time of her nursing notes entries on 27 April 2004. However, it is my view that this alone would not provide sufficient evidence of misconduct.

47. There is no other evidence before the NMC of misconduct by nurses Code A and Code A

Evidence in the case of Middleton

48. In June 2002, Mrs Bulbeck wrote to the NMC to complain about the general level of care her mother Mrs Middleton received at the Gosport War Memorial Hospital from initial admission on 29 May 2001 to August 2001, when she was transferred to another hospital shortly before her death.

49. Mrs Bulbeck gave a number of examples of her concerns:

- On one visit, she found her mother sitting up with her meal and call bell too far away for her to reach and no cutlery;
- Her mother had a "fluid overload" despite being on a drip and having a catheter, and as a result of this, suffered congestive cardiac failure on 4 July 2001;
- On another visit, she arrived to find her mother sitting in chair with a bowl in front of her and another bowl full of vomit by her. Her mother was being sick and choking. She was covered in sweat, and was unable to call for help because bell out of reach. Mrs Bulbeck called a nurse, who in turn called doctor. The doctor carried out an x-ray, which showed that Mrs Middleton had a blocked bowel;
- Mrs Middleton had to wait 45 minutes for a bedpan;
- When Mrs Middleton told a nurse that she was worried about smelling because of catheter, the nurse said "don't worry all old ladies smell";
- Mrs Bulbeck often found her mother sitting up in a chair, with bare feet/legs and no blankets;
- Mrs Bulbeck was worried about the drugs her mother was given because she "behaved very strangely some days";
- Some of the nurses were uncaring and had an unprofessional attitude to the patients;
- Some of the nurses failed to carry out doctors' orders.

50. Mrs Bulbeck was asked if she could provide further detail, but confirmed that she was unable to name individual nurses. She could only name Code A the clinical manager, as having responsibility for her mother's care.

51. The NMC forwarded a copy of Mrs Bulbeck's letter of complaint to the trust. The trust commissioned an investigation and provided the NMC with a copy of the investigation report, and its letter to Mrs Bulbeck. Some generic issues were identified, but none of these were attributed to named nurses.

52. The police experts reached the following conclusions int this case:

- Irene Waters (Nurse)

  No opinion expressed about the quality of nursing care (although her notes are incomplete).

- Robin Ferner (pharmacologist)

Mrs Middleton received optimal care and died from natural causes.

- Peter Lawson (geriatrician)

  Mrs Middleton was given appropriate doses of analgesia and died from natural causes.

- Anne Naysmith (palliative care expert)

  Mrs Middleton had abdominal pain and aspiration pneumonia, and was very frail (on continuous oxygen). She was started on oral diamorphine PRN, then moved to continuous administration via a syringe driver when the pain became more severe. This was very reasonable treatment. Mrs Middleton had breakthrough pain, so the dose of diamorphine was increased. She was also prescribed midazolam because she became agitated and distressed.

Middleton – conclusions

53. Given the expert conclusions, it is clear that there is no prospect of establishing a case based on failure to challenge inappropriate prescribing

54. Mrs Bulbeck has made allegations about specific incidents, but is unable to name the nurses involved and has not provided any dates. Accordingly, there is no prospect of proving allegations relating to any particular incident against any named nurse.

55. The only nurse she has named is Code A on the basis that he was responsible for poor care because he was the clinical manager. To establish this, we would have to prove poor care, in addition to proving that Mr Beed, as manager, was culpable. Given the material we have received to date, and the passage of time, the PPC may take the view that there is no realistic prospect of proving this.

Evidence in the case of Wilkie

56. On 1 June 2002, Mrs Wilkie's daughter Mrs Jackson wrote to the NMC to complain about the care given to her mother prior to her mother's death in August 1998. She made a number of general points, but I have summarised below those could perhaps be attributed to individual named nurses.

57. She noted that her mother was transferred from Queen Alexandra Hospital to GWMH for rehabilitation – on admission, she could walk and feed herself with assistance. After transfer, her mother appeared increasingly sleepy, weak and unwell, and could not stand unaided. After a few days, she received a call telling her to go to the hospital and spoke to Code A in the office. He told her that her mother was dying and nothing could be done for her. Mrs Jackson told Mr Code A that she did not want her mother to suffer.

58. On 20.8.98, Mrs Jackson considered that her mother was in pain, and told nursing staff, who were dismissive. She had to ask for help twice, and wait one hour, until Code A attended and said that he would arrange pain relief which would make Mrs Wilkie sleepy. When Mrs Jackson left the hospital at 13.55,

nothing had been done to alleviate her mother's discomfort. When Mrs Jackson returned to visit at 20.00, her mother was unconscious.

59. On 21.8.98, Mrs Wilkie's catheter bag contained blood. Late in the afternoon of 21.8.98, the nursing staff persuaded Mrs Jackson to go and take some rest. She only agreed when they assured her that they would call her if anything happened. When she returned to the ward at 18.30, Code A said that Mrs Wilkie has just died, and had heard their voices before she went. From her mother's appearance, Mrs Jackson believes that her mother had not only just died.

60. Having reviewed her mother's records, Mrs Wilkie has the following complaints:

- On 17.8.98, Code A made an entry in the nursing notes "Condition has generally deteriorated over the weekend Daughter seen – aware that mums condition is worsening, agrees active treatment not appropriate and to use of syringe driver if Mrs Wilkie is in pain". Mrs Jackson denies that her conversation with Code A was as recorded. She states that she did not agree that active treatment was not appropriate, and that there was no discussion about a syringe driver. She maintains that she was never told about the syringe driver.

- Nobody carried out a pain assessment a) when Mrs Jackson complained about her mother's pain on 17.8.98 or b) before starting the s/c diamorpine on 20.8.98.

- The drug administration record states that the syringe driver was started at 13.50. Mrs Jackson maintains that she did not leave the hospital until 13.55, and the syringe driver had not been started when she left.

- The nursing records falsely state that Mrs Wilkie's family were with her when she died.

- There are errors in the nursing records. On a nursing care plan there are two incorrect entries:

  - 13.8.98, entry scored through, reads "oramorph 10mgs given at 21.00 as distressed. Settled and slept. Written in error as outside Gladys Richards room!"

  - 21.8.98 "condition remained poorly pronounced dead @ 21.20 hrs by S/N Sylvia Roberts ?? ?? relatives (2 daughters) present". Elsewhere in the nursing notes, it is recorded that Mrs Wilkie died at 18.30, which is around the time when Mrs Jackson returned to the ward.

  These entries are initialled/signed, but I cannot identify the authors.

- There is no mention in the notes about the blood in the catheter bag on 21.8.98.

- Why was her mother given diamorphine, and why was she started on such a high dose? The prescription chart, written by Dr Barton, was undated. She prescribed as a regular daily review (not PRN) diamorphine 20-200mg/24hr, hyoscine 200-800mg/24hr and midazolam 20-80mg/24hr, all to be administered subcutaneously.

61. This case has been reviewed by a number of experts instructed by the police. The first of these was Professor Ford, who reported in December 2001. His conclusions were:

- The initial assessment and plan as noted by Dr Lord on 10.8.98 was reasonable.
- No diagnosis was made to explain the deterioration Mrs Wilkie is reported to have experienced around 15.8.98, and there was no recorded medical assessment.
- There is no clear evidence of pain or explanation of why Mrs Wilkie was started on the syringe driver.
- Oral analgesics could and should have been tried before starting the syringe driver.
- The undated prescription was poor practice and potentially very hazardous, as Mrs Wilkie was a frail elderly underweight patient with dementia.
- The medical and nursing records are inadequate.
- The use of the syringe driver may have hastened death, but Mrs Wilkie was a frail dependant lady with dementia who was at high risk of developing pneumonia even if she had not been administered sedative and opiate drugs.

62. As part of the second police investigation, this case was reviewed by the panel of experts. Their conclusions were:

- Irene Waters (nurse)

No opinion expressed about the quality of nursing care.

- Robin Ferner (pharmacologist)

Noted that there was a high dose of diamorphine from the outset. Concluded that treatment was sub-optimal or negligent, but unclear as to cause of death.

- Peter Lawson (geriatrician)

Unable to assess cause of death and standard of care as medical notes and a section of the drug chart were not available from the police.

- Anne Naysmith (palliative care expert)

Noted that medical notes and a second drug chart appeared to be missing from the material provided by the police, but concluded that the cause of death was unclear and treatment sub-optimal. This conclusion was based on the inadequacy of the medical notes. The patient was in late-stage dementia and had become very dependent following a UTI requiring IV antibiotics. She may have died of dementia in GWMH whatever management had taken place.

<u>Wilkie – conclusion</u>

63. In my view, there is at least one potential allegation of misconduct that could be put t[Code A] and it relates to his disputed note on 17.8.98. Mrs Jackson accepts that there was a conversation about her mother's pain, but denies that she agreed active treatment was inappropriate or that a syringe driver should be used. Accordingly, she alleges that [Code A] falsified the note of their conversation.

64. There are clear evidential issues with this allegation:

- It would appear that the only people present during the conversation were Mrs Jackson an[Code A]
- Mrs Jackson accepts that she was concerned that her mother should not suffer pain;
- The passage of time will make it difficult to prove to the required standard exactly what was said during a conversation almost 10 years ago.

65. Of the other possible allegations, my views are as follows:

- The failure to carry out a pain assessment on 17.8.98 is difficult to attribute to a named nurse, but could potentially form the basis of an allegation against [Code A] as he was the person who eventually dealt with Mrs Jackson's concerns;
- I do not consider that Mrs Jackson's allegation about the start time of the syringe driver on 20.8.98 is capable of proof or that, if proved, would be likely to lead to the removal of the nurse responsible. The most that could be proved would be a 5-10 minutes discrepancy between the time Mrs Jackson says she left the ward and the time the syringe driver is recorded as starting;
- Whilst it may be possible to prove that the notes incorrectly record the time of death, and that the family was present at death, and the PPC may consider that this is unlikely to lead to removal;
- It would be possible to prove that the notes contain an incorrect entry dated 13.8.98 that was then scored through and corrected, but the PPC may consider that this is unlikely to lead to removal;
- We could prove that there was no entry in the notes on 21.8.98 that the patient's catheter bag contained blood. However, we would then have to prove that the catheter bag did contain blood, that an individual named nurse did or should have noticed this and recorded it, and that the individual named nurse failed to record this in the notes. In my view, this is not possible;

66. Finally, there is the wider concern about the alleged poor prescribing, the administration of high starting doses, and the failure of the nurse(s) to challenge. Potential evidential issues relating to these concerns are as follows:

- The identity of the nurse who started the syringe driver is not clear, but his/her initials appear on the prescription records and so it is possible that he/she could be identified.

- We could seek an independent expert to review the material we have and give an opinion on the prescription and whether a nurse should have challenged it/administered medication on the strength of it as per the prescription record. However, I note that two of the experts instructed by the police comment on the apparent absence of a drug chart and the inadequacy of the records. This may make it very difficult for us to prove a positive case.

- We are not in a position to make an allegation of inadequate record keeping against any named nurse(s), as we have no information about who was responsible for the records, who was on duty, etc.

67. One possible course would be to liaise with the GMC and establish whether they are looking into this patient and proposing to take action in respect of the prescription. If they are, we may wish to wait until GMC action is concluded, and then follow their findings. However, there has already been a substantial passage of time since the incident. Alternatively, we may ask the GMC if we can adopt or share any evidence they obtain during the course of any investigation.

Evidence in the case of Devine

68. In June 2002, Code A wrote to the NMC to lodge a formal complaint against Code A in respect of the care received by Code A Elsie Devine at GWMH between admission in October 1999 and Code A death on 21 November 1999.

69. Code A referred to an independent review carried out by the hospital following her complaint to the hospital. Code A gave evidence at that review.

70. Code A complaints may be summarised as follows:

- Sister Hamblin suggested that Mrs Devine was agitated on the morning of 19 November 1999, but none of the family had ever seen her agitated.

- Code A applied a fentanyl patch one day, and the next day, another nurse (LB) gave 50mg chlorpromazine without removing the fentanyl patch first.

- At 8.15am, Code A telephoned Code A Code A to say that Mrs Devine was confused. She did not suggest that there was any urgency, but by 1pm, when Code A attended the hospital, Mrs Devine was unconscious and no one could speak to her again.

- Code A made an unprofessional comment about Code A Code A

- Staff bathed and washed Mrs Devine's hair excessively, apparently because she asked for it.

- There was an incorrect statement in the notes on 3.11.99 that Mrs Devine could not climb stairs.

- Sister Hamblin sent home clothes that had been provided by the family because they were considered "too good" for a hospital stay (they were dry clean only).

- A relative asked to take Mrs Devine to the hospital restaurant and was refused without explanation.

- A kidney infection was diagnosed and antibiotics started, but this was not written up in the notes.

- When Code A arrived at the hospital following Code A sudden deterioration, SN Shaw did not explain the medication and said she could not explain what had happened because she had only just come on duty.

71. The letter contains no specific allegations about SN Barker or EN Bell.

72. In July 2002,the NMC wrote to Code A requesting a copy of the independent review report, and consent to approach the GWMH for documents and evidence relating to Mrs Devine's care. The NMC wrote to Code A again in August 2002 to inform her that her complaint would be considered by the PPC on 27 August 2002, and in September to inform her that the PPC had adjourned the case pending the outcome of the criminal investigation.

73. In October 2002, the Fareham and Gosport NHT PCT wrote to the NMC asking for details of the allegations against Sister Hamblin, SN Shaw, SN Barker and EN Bell, as the PCT had not previously been aware of this referral. There is no indication on the file that the NMC responded to this letter.

74. The police have provided voluminous material relating to this case, as it was one of the 10 cases investigated in full. From this material, it is possible to establish the following:

75. Mrs Devine was born on Code A After the death of her husband in 1979, she lived in Code A house. From January 1999, her health deteriorated. In February 1999, it was suspected that she was suffering from myeloma, but following tests, an expert advised in May 1999 that there was insufficient evidence to support a myeloma diagnosis.

76. Code A

77. On 9 October 1999, Mrs Devine saw her GP complaining of pain when urinating. A suspected kidney infection was diagnosed and she was admitted to Queen Alexandra Hospital for treatment. She was fit to leave by mid-October, but because of Code A circumstances, arrangements were made for her to be transferred to GWMH and she was admitted on 21 October 1999.

78. On the day of admission, she was seen by Dr Barton. The only analgesic prescribed was PRN oramorph (10mg/5ml). No reason for this was given in the notes. In fact, oramorph was never administered during Mrs Devine's admission.

79. On 25 October and 1 November 1999, other doctors noted that Mrs Devine was physically independent and continent but needed supervision with washing and dressing. She was confused and disorientated and wandered during the day.

80. On 11 November 1999, she was prescribed PRN thioridazine, an anti-psychotic. There is no corresponding entry in the notes to explain why. She was also prescribed trimethoprim for a presumed urinary tract infection, but an entry in the notes on 15 November 1999 showed that the urine specimen had not yielded any growth.

81. The thioridazine was first administered on 15 November 1999, when Mrs Devine was reported as being very aggressive and restless at times. It was also administered on 16 November 1999. On that day, Dr Reid the consultant asked for a referral to be made to Dr Luznat, a psychiatrist, as a result of Mrs Devine's worsening confusion, and also noted that renal function was deteriorating. Also, Mrs Devine creatine level had increased from 187 to 360micromol/L between 22 October and 16 November 1999.

82. She was seen on 18 November 1999 by Dr Taylor, who assessed her mental state and agreed that it had deteriorated. Mrs Devine was placed on the waiting list for Mulberry Ward as a result.

83. On 18 November 1999, a fentanyl patch was applied (25micrograms per hour) but there is no explanation for this in the medical or nursing notes. A prescription chart continuation sheet shows that it was prescribed by Dr Barton and administered by Code A at 9.15am.

84. On 19 November 1999, there are records of a marked deterioration, and statements from nurses who came on duty that morning to the effect that Mrs Devine was agitated and physicall aggressive towards them Code A Code A give largely consistent accounts. It is agreed that Code A gave an injection of 50mg chlorpromazine at Dr Barton's direction, but it is not agreed whether Dr Barton was present or gave the instruction by telephone. The chlorpromazine was given at 8.30am. Mrs Devine was then "specialed" by two of the nurses.

85. There is an undated prescription by Dr Barton for 40-80mg diamorphine and 20 – 80mg midazolam, to be administered sub-cutaneously via syringe driver. On 19 November 1999, Code A started the syringe driver with 40mg diamorphine and 40mg midazolam. Dr Barton's note reads:

"Marked deterioration overnight
Confused aggressive
Creatinine 360
Fentanyl patch commenced yesterday
Today further deterioration in general condition
Needs SC analgesia with midazolam
Son seen and aware of condition and diagnosis
Please make comfortable
I am happy for nursing staff to certify death

86. Gill Hamblin's nursing note for 19.11.99 reads:

"Marked deterioration over past 24 hours. Extremely aggressive this am refusing all help from staff. Chlorpromazine 50mg given IM at 08.30 – taken 2 staff to

special. Syringe driver commenced at 09.25 with diamorphine 40mg and midazolam 40mg. Fentanyl patch removed. Code A seen by Dr Barton at 13.00 and situation explained to him. Code A will contact Code A and inform her of Elsie's poor condition."

87. Dr Barton has been interviewed by the police and made prepared statements, then answered "no comment" to all questions asked.

88. The material has been examined by a number of experts, whose conclusions are as follows:

- Dr Wilcock, palliative medicine expert:
    - Use of the fentanyl patch was not appropriate (too strong for the patient, less flexible than morphine solution in dose titration)
    - There was an inadequate assessment and documentation of Mrs Devine's marked deterioration
    - If midazolam was deemed necessary, it would have been more appropriate to give small doses of by intermittent subcutaneous injection as required – to go straight to a syringe driver could only be justified if it was considered without reasonable doubt that Mrs Devine was experiencing agitated confusion as a terminal event and was actively dying
    - In the absence of pain, shortness of breath or cough, there is no justification for use of diamorphine in a syringe driver
- Dr Black, geriatrician
    - There is no apparent justification for prescription of PRN oramorph on admission
    - There is no explanation in the notes for the use of fentanyl patch
    - The fentanyl patch was only removed 3 hrs after s/c diamorphine started
    - The starting doses of diamorphone and midazolam were higher than conventional guidance
    - However, the patient was terminally ill and the drugs given provided good palliation of symptoms
- Dr Dudley, nephrologist
    - Beyond all reasonable doubt, Mrs Devine was dying from amyloidosis, progressive renal failure and dementia
    - Simple measures may have improved or stabilised her condition for a few days, but further deterioration culminating in death was inevitable

89. The police files also contain a copy of the independent review panel report dated 10 August 2001, which concluded that there was inadequate communication

between the hospital staff and Code A gave evidence that Code A gave instructions that Code A Code A Code A accepted that this should have been documented, and that greater care should have been taken to ensure that Code A was kept informed. The panel concluded that Mrs Devine's medical management was appropriate.

90. Dr Reid, the consultant responsible for Mrs Devine's care, has made a police statement. Generally, he is supportive of the medical notes and treatment given, but has some reservations:

- In his view, it was not appropriate to prescribe oramorph PRN on admission, as no pain had been noted at that stage. However, oramorph was never administered;
- Small doses of diamorphine injected over 24 hours may have been more appropriate than the fentanyl patch, but this would have involved multiple injections, which may have increased distress;
- 40mg diamorphine in the syringe driver was a high starting dose. 20-30mg would have been more prudent;
- 50mg chlorpromazine is at the upper limit of dosage range. He would expect to see the effect within 3 – 6 hours. Therefore it is of some concern that midazolam was started before the chlorpromazine may have reached maximum effect. However, the midazolam was being administered slowly over 24 hours.
- It is undesirable that there is no note explaining the reason for high start doses of diamorphine and midazolam

91. Dr Reid also states that he established a good rapport with Code A while she was pursuing her complaints with the hospital, and reports that she told him tbag had she been able to deal him at the time of Code A illness and death, she would never have made a complaint.

92. It should be noted that there are no police statements from Code A Code A as sadly, he has died. It is clear from Code A statement to the Code A

Devine – conclusions

93. In my view, there is no realistic prospect of proving that any of the nurses was guilty of misconduct in the way in which they communicated with Code A about what was happening. Given Code A difficult personal circumstances, and the nurses' account that Code A had instructed that she should not be troubled, a panel is likely to conclude that it was not misconduct for them to communicate with Code A Any attempt to pursue an allegation of this sort would be bound to fail because Code A and could not give evidence, and prior to Code A he never made any statement contradicting what the nurses say about his instruction.

94. I consider that Code A 's comment at the independent review about Code A does not amount to misconduct. Code A comment was made when she was giving evidence (not in patient notes) and was fair and accurate.

95. Further, I do not consider tha Code A refusal to accept the clothes originally sent for Mrs Devine to be misconduct. They were dry clean only, and in my view it was reasonable for Sister Hamblin to ask for more appropriate clothing.

96. There could be grounds for criticising the nurse Code A who gave the chlorpromazine without removing the fentanyl patch (it was not removed until 3 hours later). However, Code A is not the subject of a complaint from Code A Code A Further, a panel may conclude that there is no realistic prospect of this amounting to misconduct likely to lead to removal.

97. I do not consider that Code A account of Staff Nurse Code A comments is capable of supporting a charge of misconduct that is likely to lead to removal. Her account is disputed and in my view there is little prospect of it being proved beyond reasonable doubt, and even if it was, a panel is unlikely to find misconduct in all the circumstances.

98. The other complaints made by Code A are non-specific and do not amount to allegations of misconduct against named nurses that are likely to lead to removal.

99. Therefore, the only potential allegation that could be pursued is the general allegation of failure to challenge inappropriate prescribing. Among the experts (including Dr Reid, Mrs Devine's consultant), there seems to be general agreement that there were defects in Dr Barton's prescribing.

100. Accordingly, this case raises similar issues to those outlined in relation to Wilkie (see above).

The passage of time and delay

101. The events in question took place in 1998 (deaths of Mrs Wilkie and Mrs Page), 1999 (deaths of Mr Carby and Mrs Devine) and 2001 (death of Mrs Middleton).

102. All of the direct complaints to the NMC were made in 2002. Three of those complaints (arising from the deaths of Mrs Wilkie, Mrs Devine and Mrs Page) were considered by the PPC in August 2002 and adjourned. They were in part 1 of the agenda, and the allegations were not served on the registrants Code A Code A

103. The other complaints (arising from the deaths of Mrs Middleton and Mr Carby) have never been before the PPC, and so the registrants involved Code A Code A have never been notified these allegations either.

104. The trust was given the opportunity to comment on the complaints arising from the deaths of Middleton and Carby, and on the report of Professor Ford, which dealt with the death of Mrs Wilkie. There is nothing on file to suggest that the NMC served information on the trust about the complaints arising from the deaths of Mrs Devine and Mrs Page.

105. The passage of time could give rise to an abuse of process argument based on the delay. However, recent authority (*R v S [2006] 2 Cr. App. R. 23)* makes it clear that even where delay is unjustifiable, a stay should be the exception rather than the rule. Where there is no fault on the part of the complainant or prosecution, a stay will be very rare. No stay will be granted in the absence of serious prejudice to the defendant such as no fair trial can be held. The trial process itself can ensure that relevant factual issues arising from the delay are considered by the decision-maker(s).

106. I am satisfied that there has been no fault on the part of the NMC in delaying the case until now (although it would perhaps have been desirable to notify practitioners of the complaints when they were adjourned in 2002). Accordingly, I am of the view that there is little prospect of an abuse argument on the grounds of delay being upheld.

107. Everyone is guaranteed the right to a fair trial under the European Convention on Human Rights, and this includes the right to trial within a reasonable time. This guarantee runs from the point at which the defendant is subject to a charge (i.e. from when the defendant is officially notified or substantially affected by proceedings taken against him). In my view, none of the registrants complained of have yet been charged, because they have not been formally notified of or affected by the NMC's proceedings.

108. Although the passage of time is not yet a fatal block to any future NMC proceedings, it does interfere with the ability to prove facts to the required standard. The more time that passes, the more difficult it becomes to establish facts beyond reasonable doubt.

109. The NMC needs to ensure that any delays from now on are for good reasons which are carefully documented.

Old rules or new rules?

110. The complaints from patient relatives were received by the NMC in 2002, and as such, fall to be considered under the old rules.

111. We were first notified provided with material from the police after the meeting in October 2004.

112. It seems to me that the patient relative complaints were non-specific enough to encompass any concerns arising from the care given to the patients prior to their deaths. Accordingly, I take the view that any allegations relating to misconduct arising from the deaths of Mrs Page, Mr Carby, Mrs Middleton, Mrs Wilkie and Mrs Devine should be dealt with under the old rules.

113. However, there may be issues arising out of the other cases that were referred to us by the police. I have reviewed all of them with a view to finding any particular criticism of named nurses by patient relatives. I particularly noted the case of Cunningham (one of the police's Category 3 cases), where the family suggested to the police that Code A was part of a conspiracy to practise euthanasia.

114. It could be argued that, because this material was received after 1 August 2004, it falls to be considered under the new rules. Although no allegation has

been received, the NMC could refer it to the Investigating Committee in accordance with Article 22(6), and start proceedings on that basis.

115. In my view, this would be undesirable for a number of reasons:

- Although I have not reviewed the evidence in the Cunningham case in detail, it seems likely that it will raise similar issues to those in the cases of Mrs Wilkie and Mrs Devine. It would be highly unsatisfactory to have two sets of proceedings running parallel about similar issues arising from similar times;

- The new rules are less favourable to registrants (e.g. lower standard for referral to CCC). It would be more appropriate to take the course least prejudicial to the nurse in these circumstances.

116. I consider it could properly be argued that, insofar as the NMC seeks to rely on material first made available to it after 1 August 2004, it is merely using that material as evidence in support of allegations first made under the old rules.

117. Accordingly, as there are no issues arising from the police files that are wholly different in character from those raised in the patient relatives' complaints, I am of the view that it would be proper and fair for all matters to proceed under the old rules.

NMC record keeping

118. From reviewing the FTP blue files, I have identified the following Profcon case numbers:

- 11978
- 12010
- 12011
- 10212
- 12013
- 12053

119. In respect of each of these I have asked the case officer and case manager to retrieve the following information:

- Name of registrant
- Names of complainant
- Date complaint received
- Current status of case

120. I have not yet received this information. It should be obtained.

121. Once we have this, it will be necessary to ensure that all of the complaints we have received are properly recorded on Profcon and case tracker.

Next steps

122. In my view, the most helpful next step would be to seek a meeting with the GMC and their advisers to get full information about the progress of their proceedings. Once the NMC knows which cases (if any) the GMC intends to

focus upon, and the timescale for the GMC proceedings, it will be in a better position to determine a final strategy.

123. At this stage, I do not recommend obtaining formal expert evidence about the nurses' duty to challenge inappropriate prescribing. However, it may be helpful to obtain informal advice from senior nurses within the NMC.

124. I am very happy to discuss this further. Please let me know if you have any questions, or if you would like to meet to discuss. It would be helpful to book MR4 for any meetings, as all of the files relating to this case are stored there.

125. Finally, I have been the first point of contact for the police in this case since October 2004. I consider it would be more appropriate for this role to shift to the case officer (and case manager). I will of course continue to provide legal advice and assistance on the case, but in my view it should not be managed by me.

Clare Strickland

From: Clare Strickland
Sent: 05 March 2007 12:24
To:
Cc: Code A
Subject: RE: Re Filing space for case files

Thanks Code A

As discussed, if things can be rearranged so that all of the Goport files are in one room, that would be best.

As you have kindly agreed to arrange collection by courier, here is the information you need:

- Contact DS Code A, Fareham Police Station, on 07880 900921;
- There are 10-12 boxes of material
- The address for Fareham Police Station is Quay Street, Fareham, Hants, PO16 0NA, and the phone number is 01329 823904 (open Monday - Saturday 10am - 2pm).

I hope this is everything you need - please let me know if you need anything else from me.

Thanks

Code A

-----Original Message-----
From: Code A
Sent: 05 March 2007 11:56
To: Clare Strickland
Cc: Code A
Subject: Re Filing space for case files
Importance: High

Hi Clare

Further to your email re filing space please note thagt we have identified a cabinet for retention of such documentation.

Code A

Cubpard 73 is available in meeting room 3 for above. I have the keys to this cupboard whenever the supporting document files are recevied.

Many thanks

Code A

Code A

Code A

From: Clare Strickland
Sent: 28 February 2007 15:30
To: Code A
Cc:
Subject: RE: Gosport

I've just received a message from DS Code A to say that he has 10 - 12 boxes of material ready for us to collect.

I'm reluctant to arrange collection until the space has been arranged - please could you let me know what the position is?

Thanks

Clare

-----Original Message-----
From: Code A
Sent: 13 February 2007 17:10
To: Clare Strickland
Subject: RE: Gosport

No preoblem i'll speak to Code A about finding a set of cupboards that free

----Original Message----
From: Clare Strickland
Sent: 13 February 2007 17:08
To: Code A
Subject: Gosport

I have had a call from Code A from Hampshire Police in response to my email about outstanding disclosure.

He is going to arrange for us to receive:

- in respect of the 10 outstanding patient cases:
  - clinical records
  - expert summaries
  - witness statements from family members
  - witness statements from healthcare workers
  - medical/legal summaries from Matthew Lohn (not prepared in every case)
- the results of their generic investigations into practices at the hospital, including the staff concerns that were raised in 1991
- copies of all expert reports, with the exception of the Baker report, which was commissioned by the Chief Medical Officer - although the police have this report, if we want disclosure of it we will have to apply to the CMO.

Code A said that the material will be ready in 3-4 weeks. He said it will run to about 30 lever arch files, so please can you ask the admin team to make suitable arrangements for its storage. We need to keep all of the material in this case in one place (i.e. the material we already have and the new material, when we receive it), and it should be readily accessible while we are working on it over the next few months. DS Stephenson also suggested that someone would need to come and collect the material, and receive a briefing on what is contained - I'm not sure that this is necessary, but I'll speak to him about that once everything is ready for us.

Please let me know if you have any questions.

Regards

Code A

Clare Strickland
In-house lawyer
Nursing and Midwifery Council
23 Portland Place
London W1B 1PZ

Code A

Clare Strickland

From: Clare Strickland
Sent: 13 February 2007 17:08
To: Code A
Subject: Gosport

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Please let me know if you have any questions.

Regards

Clare

Clare Strickland
In-house lawyer
Nursing and Midwifery Council
3 Portland Place
Code A

Clare Strickland

From: Clare Strickland
Sent: 13 February 2007 08:46
To: Code A
Subject: FW: Operation Rochester

Attached is the response I have received from the police. Hopefully we will receive the outstanding cases soon. I do not think that we should be delayed by the decision of the coroner, as it is unlikely to have a significant impact on the issues under our jurisdiction.

Regards

Clare

-----Original Message-----
From: Clare Strickland
Sent: 13 February 2007 08:45
To: '
Cc: r
:hris
dick.
Subject: RE: Operation Rochester

Code A

Strickland

Code A

Many thanks for your help. I look forward to hearing from DS Stephenson.

Regards

Clare Strickland
In-house lawyer
Nursing and Midwifery Council
23 Portland Place
London W1B 1PZ

Code A

-----Original Message-----
F
[
Sent: 13 February 2007 06:46
To: Clare.Strickland@NMC-UK.ORG

Code A

Code A

Subject: RE: Operation Rochester

Dear Claire..

The Coroner is minded to hold inquests in respect of the ten most serious cases following advice from the Shipman coroner and the lord Chancellors office but has yet to make the final decision following review of the evidence.

The coroner David HORSLEY (Portsmouth) does not expect to take a final decision until some time in March given his current workload..

I have copied this E mail to Detective Code A)N who will manage the material you request to be forwarded asap.. I will ask DS Code A to let you know when you might expect this..

In the interim I have forwarded you a copy of the summary prepared as a briefing note to the coroner..

Regards..

David WILLIAMS
Detective Superintendent.

-----Original Message-----
From: Clare Strickland [redacted]
Sent: 12 February 2007 15:52
To: Williams, David
Subject: Operation Rochester

Dear Detective Superintendant Williams

This message is further to the stakeholder meeting on 19 December 2006, which was attended by my colleague [redacted]

I understand that at that meeting, it was suggested that the coroner may decide to hold an inquest into some of the deaths, and that any such decision was expected early in the new year. Please could you let me know if there have been any developments on this?

As you will know, the NMC is anxious to proceed with its enquiries into this case now that we have received confirmation that there will be no criminal proceedings. However, before we can do this, we will need to receive from you copies of the files relating to the remaining 10 cases that were the subject of the police referral to the CPS. I would be very grateful if you could let me know when we can expect to receive the following in respect of each of those cases:

* Full clinical records
* Expert reports/summaries
* Police memos re: conversations with family members
* Summaries prepared by Matthew Lohn

Please do not hesitate to contact me if there is anything you wish to discuss, or if you need any further information from me.

Many thanks

Clare Strickland
In-house lawyer
Nursing and Midwifery Council
23 Portland Place
London W1B 1PZ
[redacted]

Clare Strickland

From: Clare Strickland
Sent: 12 February 2007 15:56
To: Code A
Subject: Gosport

I have reviewed everything we have and prepared an update memo for you (attached). This follows on from my memo dated 13.12.04, which is also attached.


Gosport memo 12.2.07.doc


Gosport memo 13.12.04.doc

Please let me know what you think.

Regards

Clare

Clare Strickland
[redacted]-house lawyer
Nursing and Midwifery Council
23 Portland Place
London W1B 1PZ
Code A

NMC Internal Memorandum

To: Code A From: Clare Strickland, IHLT

Copy to: Date: 12.2.07

Re: Gosport

---

1. Following our recent conversation, I have now had an opportunity to review all of the files in this case.

2. I attach a copy of my memo dated 13 December 2004. This sets out the position at the outset of the case.

3. Since then, there have been the following developments:

    - In January 2005, the police confirmed that the death of Mrs Devine (one of our outstanding complaint cases) was a category 3 case. This means that it was the subject of a continuing police investigation and the police files were not released to us.

    - On 19 December 2006 Code A the IHLT attended a "stakeholder meeting" with Hampshire Police. She was informed that:

        - the police had referred 10 cases to the CPS for a decision on whether there should be any criminal prosecutions;

        - the CPS decided that there should be no further action in respect of those 10 cases;

        - the coroner may decide to hold inquests into the deaths of Elsie Devine, Elsie Lavender and Sheila Gregory, as they were buried (not cremated). The coroner was expected to make a decision on this early in 2007;

        - Mrs Devine's family is represented by Alexander Harris Solicitors, who acted for a number of families in the Shipman case;

        - The police will seek the consent of the families in the 10 cases to release the material to the NMC. Code A requested disclosure to the NMC of all outstanding material.

    - Paul Hylton of the GMC also attended this meeting. He said that the GMC is only investigating Dr Barton, and that its investigation will continue now that the police investigation is complete. The GMC requested disclosure from the police of the expert reports in the 10 outstanding cases.

4. I will contact the police today to reiterate our request for disclosure of the outstanding 10 cases. I will also ask whether there has been any decision from the coroner about holding inquests.

5. I have not yet been able to establish what cases are outstanding on our system. I have asked Code A to carry out checks on all of the Profcon case numbers that appear in the NMC files, and report back to me with the results. Once I have that information, I will be in a better position to advise further.

6. When I wrote my memo dated 13 December 2004, I had been informed that the complaint from Mrs Bulbeck agains Code A has been considered by the PPC on 22 October 2002 and closed. I noted this, but also noted that I had seen no evidence to support it on the paper files. I have today checked the PPC agenda for 22 October 2002, and could not find any reference to Mr Beed on it. Accordingly, I advise that we treat this matter as an open complaint unless and until we have clear evidence to the contrary.

7. Accordingly, the outstanding complaints are in respect of the following patients:

Page

Complainant:	Mr Page
Date of complaint:	May 2002
Named nurses:	Code A
Material received from police?	Yes
Previously considered by PPC?	Yes (24.9.02) – adjourned pending criminal investigation

I have previously conducted an analysis of the evidence in this case, and my conclusions are set out in paragraphs 27 and 28 of my memo dated 13.12.04.

Carby

Complainant:	Mrs Carby
Date of complaint:	August 2003
Named nurses:	Joice, Beed, Neville
Material received from police?	Yes
Previously considered by PPC?	No

I have previously conducted an analysis of the evidence in this case, and my conclusions are set out in paragraphs 35 and 36 of my memo dated 13.12.04.

Wilkie

Complainant:	Mrs Jackson (Ms Yeats)
Date of complaint:	June 2002
Named nurses:	Beed
Material received from police?	Yes
Previously considered by PPC?	Yes (24.9.02) – adjourned pending criminal investigation

I have not yet carried out an analysis of the evidence in this case, but will do so as soon as possible.

Devine

Complainant:	Mrs Reeves
Date of complaint:	June 2002
Named nurses:	Code A

Material received from police? No
Previously considered by PPC? Yes (24.9.02) – adjourned pending criminal investigation

I am unable to carry out an analysis of the evidence in this case until we have received the material from the police, along with an indication of the coroner's decision on whether to hold and inquest. As noted above, I have requested this information today.

Middleton

Complainant: Mrs Bulbeck
Date of complaint: June 2002
Named nurses: Code A
Material received from police? Yes
Previously considered by PPC? No

I have not yet carried out an analysis of the evidence in this case, having previously been informed that it had been considered by the PPC and closed. However, as noted above, I can find nothing to support that, so I am intending to carry out an analysis as soon as possible.

8. Finally, there is the issue of what we should do about the remainder of the cases that have been investigated by the police, but in respect of which the NMC has not received a specific complaint from anyone. We have received files in respect of 76 such cases so far, and can expect a further nine.

9. I remain of the view expressed in my memo dated 13 December 2004 that insofar as any of these cases are to give rise to allegations, they should be dealt with under the new rules.

10. The more pressing issue is whether any of these cases are to give rise to allegations.

11. I have reviewed the police reports, expert reports, and Matthew Lohn's summaries (he was instructed by the police) in each of the 76 cases we have received to date. There is no direct criticism of any named nurse in any of the expert reports. It will be remembered that one of the experts was Irene Waters, an NMC member and nursing expert. There are some examples of criticisms of named nurses being made to the police by family members.

12. I have not reviewed the files containing the patients' medical records, as I lack the clinical expertise to make this a worthwhile exercise.

13. I have not yet reached a view on what should be done about these cases. It may be that this is a decision that should only be made by the director in any event. I suggest that we should discuss this further.

14. Please do not hesitate to let me know if any questions you have arising from this memo.

Clare Strickland

From: Clare Strickland
Sent: 12 February 2007 13:25
To: Code A
Cc: Code A
Subject: Gosport

I have been going over the files and making some good progress. However, I would welcome your help with a check on Profcon (which I cannot access). I have tracked down the following case numbers:

- 11978
- 12010
- 12011
- 12012
- 12013
- 12053

Please could you let me have the following info in respect of each of these case numbers:

- Name of registrant against whom the allegation is made
  Name of complainant
- Date complaint received
- Current status of case

Plus anything else that would help me to clarify this case.

Thanks

Clare

Clare Strickland
In-house lawyer
Nursing and Midwifery Council
23 Portland Place
London W1B 1PZ
Code A

Clare Strickland

From: Code A
Sent: 05 September 2006 16:24
To: Code A
Cc: Code A; Code A; Code A; Code A
Subject: RE: Gosport

Clare - Thanks for your help with this.

All - This matter is in hand.

In the first instance Code A eam will gather the material that is in the Mews garage and join it with the papers already in the Chamber.

We are assured that there is space at 180 OS for ALL FtP documents, files etc.

Material such as this may be ideal for storing in the filing cabinets located in the hearing rooms.

If it transpires that there is not adequate space at 180 we can consider off-site storage.

Code A at some point soon after we have moved, I think it is necessary for a schedule of all the Gosport material to be mpiled. Can I leave this with you, please?

Thanks

Code A s)

-----Original Message-----
From: Clare Strickland
Sent: 05 September 2006 14:23
To: Code A
Cc: Code A; Code A; Code A
Subject: RE: Gosport

I've just checked in the chamber and there are a further 11 boxes of files containing patient notes there. I have marked them all up with an orange sticker.

-----Original Message-----
From: Clare Strickland
Sent: 05 September 2006 14:00
To: Code A
Cc: M Code A; Code A; Code A
Subject: Re: Gosport

Further to my last email, Code A has just checked for me and established that all of the boxes that were in the basement have been moved to the council chamber. I am going to go over there now to identify the Gosport boxes.

Regards

Clare

-----Original Message-----
From: Clare Strickland
Sent: 05 September 2006 13:53
To: Code A
Cc: N Code A
Subject: RE: Gosport

In preparation for our clear-up on Friday, I have gone through all of the material in the Mews House

garage that relates to this case. It consists of:

- 1 box of NMC case files and correspondence
- 4 files containing the reports of the police experts on each set of patient notes
- 9 boxes of files containing patient notes
- my working file

As I have said before, it is my view that all of this material, together with the other boxes that are on the 3rd floor/in the basement need to be archived, as they are not going to be required at short notice in the foreseeable future.

Who is responsible for arranging this?

Regards

Clare

-----Original Message-----
From: Code A
Sent: 14 August 2006 11:07
To: Clare Strickland
Cc: Code A
Subject: RE: Next tuesday Hampshire Police will be delivering two more boxes of "stuff"

its being stored on the floor up here at the moment. 4 boxes behind Code A desk. I'm not sure what the storage space is like in the basement but if there is room we can put the most recent arrivals down there until on site storage has been arranged.

-----Original Message-----
From: Clare Strickland
Sent: 14 August 2006 10:04
To: Code A Code A
Cc: Maintenance
Subject: RE: Next tuesday Hampshire Police will be delivering two more boxes of "stuff"

Please could you let me know if this material arrived, and if so, where it is being stored?

I have previously emailed everyone in an attempt to track down all material in this case, as it seems to me it should all be sent to off-site archiving before we move. There are a number of boxes in the Mews House garage, and I understand that maintainance did have a number of boxes in the basement. It is really important that these records are stored properly - perhaps we could ask Code A to sort it out for us?

Regards

Clare

-----Original Message-----
From: Code A
Sent: 03 August 2006 12:04
To: Code A Code A Clare Strickland
Subject: RE: Next tuesday Hampshire Police will be delivering two more boxes of "stuff"

Code A
It is probably worth alerting Code A so that she or one of her team can take receipt of the information.

Please let reception know that we are expecting the delivery and give them a contact in FtP (?
Code A

Code A

-----Original Message-----
From: Code A
Sent: 03 August 2006 11:56
To: Code A Clare Strickland; Code A
Subject: Next tuesday Hampshire Police will be delivering two more boxes of "stuff"

re Operation Rochester.
I'll be in 180 they're coming mid morning so can someone take receipt of the info please.

Clare Strickland

From: Clare Strickland
Sent: 05 September 2006 14:23
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Cc: Code A | Code A | Code A
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Who is responsible for arranging this?

Regards

Clare

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From: Code A
Sent: 14 August 2006 11:07
To: Clare Strickland
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Sent: 14 August 2006 10:04
To: Code A | Code A
Cc: Maintenance
Subject: RE: Next tuesday Hampshire Police will be delivering two more boxes of "stuff"

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Regards

Clare

-----Original Message-----
From: Code A
Sent: 2:04
To: Code A; Clare Strickland
Subject: RE: Next tuesday Hampshire Police will be delivering two more boxes of "stuff"

Code A

It is probably worth alerting Code A so that she or one of her team can take receipt of the information.

Please let reception know that we are expecting the delivery and give them a contact in FtP (? Code A

Code A

-----Original Message-----
From: Code A
Sent: 03 August 2006 11:56
To: Code A Clare Strickland; Code A
Subject: Next tuesday Hampshire Police will be delivering two more boxes of "stuff"

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Code A

Clare Strickland

From: Clare Strickland
Sent: 05 September 2006 14:00
To: Code A
Cc: Code A | Code A | Code A
Subject: RE: Gosport

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Clare

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To: Code A
Cc: Code A
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Who is responsible for arranging this?

Regards

Clare

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To: Clare Strickland
Cc: Code A
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To: Code A | Code A
Cc: Maintenance
Subject: RE: Next tuesday Hampshire Police will be delivering two more boxes of "stuff"

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Regards

Clare

-----Original Message-----
From: Code A
Sent: 03 August 2006 12:04
To: Code A, Clare Strickland
Subject: RE: Next tuesday Hampshire Police will be delivering two more boxes of "stuff"

M Code A
It is probably worth alerting Code A so that she or one of her team can take receipt of the information.

Please let reception know that we are expecting the delivery and give them a contact in FtP (Code A).

Code A

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From: N Code A
Sent: 03 August 2006 11:56
To: Code A, Clare Strickland; Code A
Subject: Next tuesday Hampshire Police will be delivering two more boxes of "stuff"

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Code A

Clare Strickland

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Cc: Code A
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Clare

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Subject: RE: Next tuesday Hampshire Police will be delivering two more boxes of "stuff"

Please could you let me know if this material arrived, and if so, where it is being stored?

I have previously emailed everyone in an attempt to track down all material in this case, as it seems to me it should all be sent to off-site archiving before we move. There are a number of boxes in the Mews House garage, and I understand that maintainance did have a number of boxes in the basement. It is really important that these records are stored properly - perhaps we could ask Code A team to sort it out for us?

Regards

Clare

-----Original Message-----
From: Code A
Sent: 03 August 2006 12:04
To: Code A; Clare Strickland
Subject: RE: Next tuesday Hampshire Police will be delivering two more boxes of "stuff"

Code A

It is probably worth alerting Code A so that she or one of her team can take receipt of the information.

Please let reception know that we are expecting the delivery and give them a contact in FtP (Code A).

Code A

-----Original Message-----
From: Code A
Sent: 03 August 2006 11:56
To: Code A; Clare Strickland; Code A
Subject: Next tuesday Hampshire Police will be delivering two more boxes of "stuff"

re Operation Rochester.
I'll be in 180 they're coming mid morning so can someone take receipt of the info please.

Code A

Clare Strickland

From: Clare Strickland
Sent: 28 July 2006 12:29
To: Code A
Subject: FW: OP Rochester..Gosport War Memorial Investigation.

Attached is an update on the Gosport Hospital case.

I will be away from the office for the next two weeks, but I will let you know of any further developments when I return.

Regards

Clare
-----Original Message-----
From: david.williams@hampshire.pnn.police.uk Code A
Sent: 28 July 2006 12:11
To: PHylton@gmc-uk.org
Cc: Code A
jenifer.smith@southcentral.nhs.uk; Code A
christopher.mckeown@hampshire.pnn.police.uk; dave.grocott@hampshire.pnn.police.uk;
David.Horsley@portsmouthcc.gov.uk; roy.stephenson@hampshire.pnn.police.uk
Subject: OP Rochester..Gosport War Memorial Investigation.

Dear Paul Hylton(GMC)/ Clare Strickland(NMC) /Jenifer Smith(SHA) David HORSLEY (H.M.Coroner)

Please find attached a family group update letter that I am sending today to relatives of the 10 remaining cases under investigation.

<<Operation ROCHESTER Family Group Update 28/7/2006.>>

All files have now been forwarded to the CPS and I am meeting with Treasury Counsel next week Wednesday the 2nd August to discuss the outcome.

We have also been interviewing (under caution)a consultant Geriatrician Dr Richard Ian REID in respect of 2 cases (of the 10 above) the deaths of Edith SPURGIN and Geoffrey PACKMAN. The final interview with Dr REID is being held on 8th August 2006.. The police investigation into these matters is then essentially complete.

Once the decision in respect of any prosecution is made (in my view not all of these cases meet the standard of evidence required to prosecute criminally and the public interest hurdle remains to be addressed) then we will need to get together to discuss further disclosure to the GMC and NMC.

I spoke with Dr BARTON's legal rep Ian BARKER last week, he confirmed that Dr BARTON was still adhering to the voluntary agreement not to prescribe Opiates and Benzodiazepines.. She has however now taken a senior practice partner position at her surgery..

I will be in touch post 2nd August to discuss the way forward.. It may be appropriate to pull all stakeholders together to talk this through including the local Portsmouth Coroner Mr David HORSLEY.

Regards..

Dave WILLIAMS Det Supt..

Code A

Clare Strickland

From: Clare Strickland
Sent: 29 September 2005 09:02
To: Code A
Subject: RE: Kate Robinson - Gosport Memorial Hospital

I've just had a reply to my enquiry from the officer in charge, which tells us nothing - I will forward it on to you.

I suggest that we put the three new boxes in storage with all the other material we received on this case (it's in the basement at 23), as there is nothing we can do with it at this stage.

I'll forward on the email I received to you, and I'll give you a copy of his letter when it arrives, and we can discuss the position then.

Regards

Clare

-----Original Message-----
From: M Code A
Sent: 28 September 2005 12:14
To: Clare Strickland
Subject: Kate Robinson - Gosport Memorial Hospital

Clare

The above nemaed is a police officer who has been investigating gosport. She is coming tomorrow around 10.30-11.00 to "drop off" another three boxes of patient records relating to their investigation. I'll receive the stuff. God knows what we do with it then.

Code A

Clare Strickland

From: Clare Strickland
Sent: 26 September 2005 16:11
To: Code A
Subject: Gosport

I've now had a look through all my papers and reminded myself of where these cases have got to.

Attached is a copy of my last memo on the case (dated 13.12.04) - this contains a full summary of the history of the case, and considers our options in the cases we have open. To my knowledge, no action has been taken since then.

Gosport memo 13.12.04.doc

I have not heard anything from the police since January 2005 - at that stage, they informed us that they were starting to refer their category 3 (potential criminal proceedings) cases to the CPS for a decision on prosecution, and that they hoped to have all cases with the CPS during 2005. I have sent an email to the police asking for an update.

I have also spoken to Paul Hylton at the GMC, who is the case officer with conduct of the case against the doctors. He o has been told nothing by the police. The GMC has recently started receiving calls from relatives saying that they ..ave been have been told that the police are not prosecuting in their cases, but that the GMC are now dealing with matters. However, the police have still not disclosed any further material to the GMC, and the police position has always been that they will not disclose any material that may potentially prejudice a criminal trial. Accordingly, the GMC can do nothing yet either.

I will let you know what sort of response I get from the police. Would you like me to keep the files here, or would you like to have them at 23? Please let me know if there's anything else I can do.

Regards

Clare

Clare Strickland GMC 0845 357 8001

From: Clare Strickland
Sent: 11 January 2005 16:37
To: Liz McAnulty
Subject: Gosport Nurses

I have just spoken to Paul Hylton at the GMC.

They are very keen to get on as the doctor involved, Dr Barton, was referred to their Conduct Committee in 2002. They have considered the category 2 cases, but their Committee did not consider that the evidence would justify an interim suspension.

Accordingly, they need details of the Category 3 cases, and are getting frustrated that the police timetable appears to keep slipping. They are meeting the police on Thursday 13 January to try to resolve this problem. If they are unable to do so, they will (reluctantly) consider seeking a court order to force the police to disclose the category 3 material.

I explained our position, and Paul confirmed that the GMC had not come across any issues relating to the nursing care, other than the overarching issue of whether they failed to challenge inappropriate prescribing.

Paul will contact me after the meeting with the police to give me an update.

Attached is my draft text for your reply to DC Niven. I will leave his letter with Code A I hope that this is alright.

Regards

Clare

Gosport draft letter text 11.1...

Paul Hylton - 31.1.05

~~- GMC to tell pol re. possib of ct order~~

~~- Re. ct order, don't expect to get it, bel pol will resist~~

~~- Legal advice~~

- GMC have advised police they will seek ct order for disclosure
- GMC does not expect Ct to make order, but believe they have to make application to stave off potential criticism in future.
- Matter is with Counsel now.

NMC Internal Memorandum

To:	Liz McAnulty, Code A J Code A	Date:	13 December 2004
Copy to:		Ref:	Code A
From:	Clare Strickland	File:	Gosport

History

1. A number of agencies have investigated or are investigating concerns about clinical practice at the Gosport War Memorial Hospital in the late 1990s. Three wards are involved: Daedalus, Dryad, and (to a lesser extent) Sultan.

2. Investigations began in September 1998, when the relatives of Mrs Richards, who had died on Daedulus ward earlier that year, made a complaint to the police. The police investigated the complaint, but in March 1999 the CPS advised that there was insufficient evidence to prosecute any member of staff for any offence.

3. The investigation was reopened in 2001. The police obtained an expert report into Mrs Richards' death from Professor Livesey. Three nurses were named in this report – Code A In September 2001, the NMC's PPC considered the matters raised in the Livesey report about Mrs Richards, and decided to close the case.

4. At about the same time, the CPS again advised the police that there was insufficient evidence to prosecute any member of staff.

5. As a result of local media coverage, other families contacted the police with concerns about the deaths of their relatives. The police referred five cases – Richards, Cunningham, Wilkie, Wilson and Page - to another expert, Professor Ford. Professor Ford reported in December 2001.

6. The police made the expert reports available to a number of bodies, including the CHI, GMC and NMC. The CHI conducted an investigation into the Trust's systems since 1998, and reported in July 2002. We understand that the GMC is still investigating. We do not know if it has commenced proceedings against any individual doctors.

7. In response to the Ford report, the NMC asked the Trust for comments. The Trust replied on 15 May 2002 with details of its response to the concerns raised. No disciplinary action was taken against any nurse.

8. Also in May 2002, Mr Page, son of Mrs Page, made a direct complaint to the NMC. He named nurses Code A

9. In June 2002, the NMC received three further complaints:

   - Mrs Jackson complained about nurse Code A n respect of her deceased mother Mrs Wilkie;
   - Mrs Reeves complained about nurses Code A in respect of her deceased mother, Mrs Divine;
   - Mrs Bulbeck complained about the general care given to her deceased mother Mrs Middleton (she subsequently named Code A as being responsible).

10. In August 2002, the NMC received a further complaint from Mrs Carby against nurses Code A in respect of her deceased husband Mr Carby.

11. In September 2002, the police reopened the case and began a large-scale investigation into 88 deaths at the hospital. Further details of this investigation are given below.

12. On 24 September 2002, the PPC considered the following cases:

    - Code A llegation from Jackson re: Wilkie
    - – allegations from Reeves re: Divine and Page re: Page
    - llegations from Reeves re: Divine and page re: Page
    - allegation from Reeves re: Divine
    - legations from Reeves re: Divine

    The Committee was assisted by a detailed summary of the evidence from Code A Code A These cases were adjourned pending the outcome of the police investigation.

13. I have been told that the PPC considered the Bulbeck complaint against nurse Beed on 22 October 2002 and declined to proceed (although I have not seen any papers). The Trust had provided the NMC with its response to the Bulbeck complaint, which raised general issues but did not name any individual nurses.

14. It appears that the PPC has not yet considered the Carby complaint against nurses Code A

15. In October 2004, Detective Chief Inspector Nigel Niven and Detective Superintendent David Williams met with Liz McAnulty, Jennifer Drummond and me to provide the NMC with an update on the police investigation and discuss the way forward.

16. As noted above, the police have looked into 88 deaths. They interviewed relatives of patients. They also commissioned a team of clinical experts: Irene Waters, a nursing expert (and NMC panel member), Robin Ferner, a pharmacologist, Peter

Lawson, a geriatrician, Anne Naysmith, an expert in palliative care. A summary of evidence was prepared for the police by Matthew Lohn of Field Fisher Waterhouse.

17. The experts were instructed to review the medical records and provide an analysis of treatment. The doctors rated care given on a scale from 1 to 4, where 1 is optimal, 2 sub-optimal, 3 is negligent and 4 is intended to cause harm. They then assessed the cause of death, with A meaning natural causes, B meaning cause of death is unclear, and C meaning the cause of death is unexplained by illness. Cases were put into one of 3 categories. Cases were put into Category 1 where the experts concluded that treatment was acceptable. Category 2 cases were those where the treatment was considered to be sub-optimal, but did not present evidence of criminal activity. Category 3 cases were considered to warrant further investigation with a view to determining whether criminal activity took place.

18. The police have contacted all of the families of patients whose cases fell into Category 1 to notify them of their findings. Investigations in Category 3 cases are ongoing. We have not yet been given the names of the patients whose cases fall into these categories.

19. At the meeting with the police, it was agreed that they would provide the NMC with all of evidence gathered in Category 2 cases. They have reached a similar agreement with the GMC. The police have informed the relatives, who have consented to this course of action.

20. To date, we have received files in respect of 19 patients, including Page and Carby.

Evidence in the case of Page

21. On 17 May 2002, Mr Page wrote to the NMC to complain about nurses Hamblin, Shaw and others unnamed. He did not express specific concerns about nursing care, but referred to the Ford report. It appears that at the time he wrote to complain, Mr Page had not seen a copy of the Ford report.

22. On 12 June 2003, the NMC wrote to ask Mr Page to provide details of his specific concerns about the nursing care his mother received. I have not seen any further correspondence from Mr Page in the files. The NMC then wrote to him on 12 August 2002 to tell him that the PPC would consider the case, and on 27 September 2002 to inform him of the PPC's decision to adjourn the case.

23. Professor Ford's only significant concern about Mrs Page's treatment is with the decision to commence subcutaneous diamorphine and midazolam on the day of her death. He considers that there was no indication in the notes that she was in pain or distress. In his view, the prescription was poor practice and potentially very hazardous. He would have expected very clear reasons for this prescription to have been recorded in the medical notes. He considers that, apart from this, the medical and nursing records were of adequate quality. He concludes:

In my opinion the majority of management and prescribing decisions made by medical and nursing staff were appropriate. The exception is the prescription of diamorphine and midazolam on the day of Mrs Page's death.

24. Professor Ford does not name any individual nurses. From the medical records, I have been unable to identify whether nurses Code A were on duty on the day of Mrs Page's death.

25. The police experts' agreed that the case fell into category A2. Robin Ferner notes that diamorphine was used for confusion rather than pain, and queries the rapid increase in dose.Peter Lawson concluded:

    Care being graded as sub-optimal is perhaps a little picky but relates to the changes in opioid and method of administration rather than the doses used.

    Anne Naysmith considers that it was not ideal palliative care, and particularly criticises the dose of Fentanyl.

26. The police record of interview with Mr Page contains no other significant evidence.

Page – conclusion

27. Although Mr Page named nurses Code A, he does not make any particular complaint about them. Professor Ford does not refer to either of them. It is not apparent from the medical records whether nurses Code A were in a position to challenge the prescription on the day of Mrs Page's death. The police experts concluded that, on balance, treatment was sub-optimal, but they do not all agree as to what was wrong with it.

28. Taking all of this together, it is my view that there is insufficient evidence to proceed against nurses Code A in connection with Mrs Page's death.

Evidence in the case of Carby

29. On 22 August 2003, Mrs Carby wrote to the NMC alleging that her husband's sudden death was caused by the negligence of nurses Joice, Beed, and Neville. She did not particularise her complaint, but stated that Mr Carby's medical records contained ample evidence of nursing misconduct.

30. On 5 September 2002, the NMC passed the complaint to the Trust for its internal investigation.

31. The Trust instructed an expert, Professor Jean Hooper, to review Mr Carby's medical records. Professor Hooper's report was sent to the NMC on 15 November 2002. She expressed concern about discrepancies as to dates and times in the nursing records, but could find no evidence in the records to indicate that the nurses were negligent in their treatment of Mr Carby.

32. In addition to Professor Hooper's report, the Trust provided the NMC with a excerpts from the ward controlled drugs record book, which showed that a syringe driver was set up with 40mgs of diamorphine at 12.15pm. It was discontinued at 1.20pm on the same day, and 9.5 of the original 10mls of fluid discarded.

33. The police experts agreed that this was an A2 case. All criticised the high dose of diamorphine and midazolam, but noted that Mr Carby died within 45 minutes of the syringe driver being set up, before the drugs had time to take effect.

34. In interview with the police, Mr Carby's family criticised Nurse Joice, saying that they did not like her manner. They also suggest that after Mr Carby's death, when one of his daughters became extremely upset, an unnamed nurse suggested giving her an injection to calm her down. This has not been raised with the NMC

Carby – conclusion

35. It is possible to prove that Nurse Code A failed to record the time of her nursing notes entries on 27 April 2004. However, it is my view that this alone would not provide sufficient evidence of misconduct.

36. There is no other evidence before the NMC of misconduct by nurses Code A and Code A It may be possible to obtain further evidence by interviewing the family, but I would query whether this would be appropriate.

Future conduct of the case

37. We now need to decide whether refer the cases against nurses Code A Code A in connection with patients Page and Carby to the PPC with a view to closure, or whether to keep them open.

38. Closure would enable us to give the complainants a final decision. I see no procedural difficulty in this course for nurses Joice and Neville, as there are no other outstanding complaints against them before the NMC. However, nurses Code A are the subject of other allegations. I do not know whether it is possible to refer them to the PPC with a view to closing part of the case against them, whilst allowing the other allegations to remain outstanding. I would welcome your views on this.

39. We are expecting to receive another batch of Category 2 cases from the police. If this batch includes evidence relating to patients Wilkie and Divine, we will be in a position to determine whether there is enough evidence to proceed against nurses Code A in connection with their treatment of those patients.

40. If the cases relating to patients Wilkie and Divine do not fall into the police's Category 2, I consider that we should contact the police and ask them to confirm which category they do fall into. If it is Category 1, this would mean that the police have no evidence of sub-optimal treatment, and we will have to make a decision on the evidence we have. If it is Category 3, the cases will have to remain

on hold until the police investigation, and any resulting criminal proceedings, have concluded.

41. We also need to make a decision about how to deal with the other Category 2 files sent to us by the police (i.e. those cases where there has been no direct complaint to the NMC from another source). It seems to me that we will have to make a decision about whether the cases should be dealt with under the old or new rules. To the extent that they involve nurses who are the subject of complaints received by the NMC prior to 1 August 2004 and still outstanding at that date, it could be argued that they are merely further material, and should be considered under the old rules.

42. However, my understanding is that we were not alerted to the material, and certainly did not receive it, until October 2004. Given this, it could also be argued that all of these cases, even those involving nurses who are also the subject of allegations being considered under the old rules, should be dealt with under the new rules. This is another issue that I seek your view on.

43. I have reviewed the police experts' comments on the other 17 Category 2 cases we have received. None of them makes any specific criticism of any named nurse. Given this, we may need some assistance in identifying any potential matters for concern in the medical records. As I have previously suggested, it may be helpful to seek advice from Irene Waters, who was the nursing expert used by the police.

44. Apart from those mentioned above, police reports of their dealings with family members do not contain any direct criticism of individual nurses, but a number make generalised complaints about the standard of care on the ward.

Clare Strickland

From: Clare Strickland
Sent: 09 November 2004 08:56
To: Liz McAnulty; Code A
Cc: Code A
Subject: Gosport nurses - progress report

We have now received papers in the first 19 cases from the police. Code A and I have had a look at what we have been given. Our preliminary report is as follows:

1 The papers consist of a number of files. The first is a summary file containing the following documents in respect of each of the 19 patients:

a) Nursing expert report from Irene Waters - this amounts to a summary of the significant information in the patient records;
b) Extract from report of Dr Robin Ferner, medic and expert in pharmacology;
c) Extract from report of Dr Peter Lawson, geriatician;
d) Extract from report of Dr Anne Naysmith, expert in palliative care;
e) Case review by Matthew Lohn - this amounts to a summary of the conclusions of the experts.

Each of the doctors was asked to assess 2 things:

(i) The standard of care received by the patient - this was graded from 1 - 4, where 1 was optimal, 2 was sub-optimal, 3 was negligent and 4 was intentionally harmful; and
(ii) The cause of death - this was graded from A - C, where A was natural, B was unclear and C was unexplained by illness.

Accordingly, in respect of each patient, each doctor has given a grading, such as B2, together with a short statement of their reasons for the grading.

I attach a table I have prepared summarising the information that can be gleaned from this summary file.

Gosport review of police cases...

2 The remainder of the files consist of the medical records for each patient that were considered by the expert. In a couple of cases, these are very brief, but in others they run to two lever arch files. Code A and I have looked at some of these files, but without further assistance, we lack the medical/practical expertise to be able to identify any evidence of misconduct.

3 Two of the cases about which the NMC has already received complaints are included in this batch of 19 - they are Carby and Page. Code A and I are going to review the medical records in these cases with a view to obtaining evidence in relation to the specific complaints made.

4 When I met Irene Waters at the new legislation conference, she suggested that she would be very happy to discuss this case with us. Given my second point above, I am of the view that we will need expert assistance if we are to take this case forward. Given that Irene Waters is already familiar with the case (and I understand that she still has all of her papers), you may take the view that this would be a sensible way to proceed. I am aware that she is a panel member, but I do not consider that this prevents us from using her expertise, provided that she does not participate in the NMC's proceedings as a panel member, and provided that there can be no suggestion of contamination of the panel members that do consider the complaints.

5 Similarly, if any aspect of this case needs to be sent to solicitors, it would probably be sensible to use FFW/ Matthew Lohn, as he will be very familiar with the case. However, we will have to be alert to any suggestion of prejudice or unfairness.

6 Obviously, the 2 cases in which we have already received complaints must be dealt with under the old rules. Our preliminary view is that if we find any evidence of misconduct in relation to any other patient, it should be dealt with as a new allegation under the new rules, even if it involves one or more of the nurses about whom we have already received a complaint.

We will continue with the work indicated above; however, we would welcome your views on how else to proceed, particularly with regard to involving Irene Waters.

Regards

Clare

Clare Strickland
Lawyer - FTP
7 Portland Place
Code A

Thanks Code A - I will forward it on to Code A and Code A

Regards

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
(Code A

From: (Code A
Sent: 26 May 2009 15:00
To: Clare Strickland
Subject: RE: Gosport War Memorial Hospital Freedom Of Information requests.

Hi Clare:

Apologies, for not have replied before to your e mail as I was on holidays.

Code A or Code A are the ones dealing with the first stage process of the Freedom of Information requests.

Regards,..

Code A

From: Clare Strickland
Sent: 18 May 2009 14:20
To: Code A
Subject: FW: Gosport War Memorial Hospital Freedom Of Information requests.

Hi Code A

Do you deal with FOI/DPA requests? If so, please could I give you this for your information. If not, please could you let me know who I should be sending it to?

Many thanks

Clare

Clare Strickland
Senior lawyer (hearings)
Code A

From: Clare Strickland
Sent: 18 May 2009 14:17
To: Code A
Subject: RE: Gosport War Memorial Hospital Freedom Of Information requests.

Dear D/Insp Grocott

Thank you very much for informing us of your position. I will forward this to the relevant person at the NMC.

Regards

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

From: Dave.grocott[redacted] Code A
Sent: 07 May 2009 15:14
To: Clare Strickland
Cc: roy.stephenson@hampshire.pnn.police.uk
Subject: Gosport War Memorial Hospital Freedom Of Information requests.

Clare,

Operation Rochester: Gosport War Memorial Hospital

You will be aware that HM Coroner Andrew Bradley has recently concluded 10 inquests relating to patients from GWMH. The verdicts in those inquests were death due to natural causes, all be it that in some cases the administration of opiate medications was considered to have contributed more than minimally or negligibly to the death.

I have just received the first of what I imagine to be a number of formal requests for information under the terms of the Freedom of Information act. I wanted to communicate with you my position as the SIO regarding information requests.

The police investigation has concluded and in due course we will have to consider what we are prepared to publish. At present I am aware that there are further hearings to take place, Fitness to Practice hearings, possible further inquests etc. To that end my decision which has been ratified by the Chief Constable is as follows.

I intend to publish such material as is requested and appropriate in line with the Freedom of Information Act once all hearings connected with the investigation have been concluded. To inform this process I will create a publishing strategy which should address the immediate needs and concerns of family members connected with the investigation. I reasonably expect the publication of material to occur no sooner than January 2010 once all hearings have concluded.

This being our position, any requests for information will be passed to our FOI office at police headquarters. An exemption to release material will be sought and probably applied under Section 22 of the FOI act.

As the NMC holds similar if not identical information to the police I would be obliged if you could pass my email to the relevant department. I would like to think that there might be a similar response from yourselves?

Once everything has finished we can and will respond to requests but in the meantime I don't want anything to adversely affect any other agency hearings. I shall be passing similar information to the GMC.

Please feel free to contact me if you wish to discuss or clarify anything further.

Regards

Dave
D/Insp Dave Grocott
Serious Crime Review Team
Hampshire Constabulary

Code A

Clare Strickland

From: david.williams Code A
Sent: 10 April 2007 15:02
To: Clare.Strickland Code A
Cc: dick.law Code A roy.stephenson Code A
Subject: FW: Operation Rochester

Dear Clare..

I am catching up with Operation ROCHESTER matters today..

A brief update..

1. I am told that the GMC/Eversheds will not be in a position to make any decision regarding professional conduct hearing until June/ July this year.

2. Have you now received all material that you require to finalise NMC matters and are you able to let us know of the likely outcome/timescales?.

3. I am meeting with HM Coroner David HORSLEY (Portsmouth) tomorrow to discuss inquest issues.. The latest is that he has invited the Lord Chancellor to appoint a judge to hold the inquest..

Regards..

David WILLIAMS Det Supt.

-----Original Message-----
From: Clare Strickland Code A
Sent: 12 February 2007 15:52
To: Williams, David
Subject: Operation Rochester

Dear Detective Superintendant Williams

This message is further to the stakeholder meeting on 19 December 2006, which was attended by my colleague Code A

I understand that at that meeting, it was suggested that the coroner may decide to hold an inquest into some of the deaths, and that any such decision was expected early in the new year. Please could you let me know if there have been any developments on this?

As you will know, the NMC is anxious to proceed with its enquiries into this case now that we have received confirmation that there will be no criminal proceedings. However, before we can do this, we will need to receive from you copies of the files relating to the remaining 10 cases that were the subject of the police referral to the CPS. I would be very grateful if you could let me know when we can expect to receive the following in respect of each of those cases:

* Full clinical records
* Expert reports/summaries
* Police memos re: conversations with family members
* Summaries prepared by Matthew Lohn

Please do not hesitate to contact me if there is anything you wish to discuss, or if you need any further information from me.

Many thanks

Clare Strickland

In-house lawyer
Nursing and Midwifery Council
23 Portland Place
London W1B 1PZ

Code A

NMC File Note

Subject: Gosport

Date: 28.2.07

Reference: Code A

Telephone conversation with Code A Fareham Police Station. He has 10-12 boxes of material ready for collection.

I asked him if he could hold the material until I have sorted out storage – agreed I would call him back late this week/early next week.

I said I would not be able to collect the files in person, but would have to send a courier. He had previously offered to talk me through the material, but I have had to decline as it is not practical. I can call him if I need any help once I have the material though.

I have emailed Code A to ask about storage – Code A s on leave until 2.3.07. Code A suggested that Code A could also ask Code A about storage.

Clare Strickland

From: Clare Strickland
Sent: 13 February 2007 08:45
To: 'david.williams Code A Clare Strickland
Cc: roy.stephenson Code A ; christopher.mckeown dick.law Code A dave.grocott Code A
Subject: RE: Operation Rochester

Many thanks for your help. I look forward to hearing from DS Stephenson.

Regards

Clare Strickland
In-house lawyer
Nursing and Midwifery Council
23 Portland Place
Code A

-----Original Message-----
From: david.williams Code A
[mailto:david.willian
Sent: 13 February 200
To: Code A
Cc: Code A Code A
ch Code A ; dave.grocott@hampshire.pnn.police.uk
Subject: RE: Operation Rochester

Dear Claire..

The Coroner is minded to hold inquests in respect of the ten most serious cases following advice from the Shipman coroner and the lord Chancellors office but has yet to make the final decision following review of the evidence.

The coroner David HORSLEY (Portsmouth) does not expect to take a final decision until some time in March given his current workload..

I have copied this E mail to Detective Sergeant STEPHENSON who will manage the material you request to be forwarded asap.. I will ask DS STEPHENSON to let you know when you might expect this..

In the interim I have forwarded you a copy of the summary prepared as a briefing note to the coroner..

Regards..

David WILLIAMS
Detective Superintendent.

-----Original Message-----
From: Clare Strickland [mailto: Code A
Sent: 12 February 2007 15:52
To: Williams, David
Subject: Operation Rochester

Dear Detective Superintendant Williams

This message is further to the stakeholder meeting on 19 December 2006, which was attended by my colleague Code A

I understand that at that meeting, it was suggested that the coroner may decide to hold an inquest into some of the deaths, and that any such decision was expected early in the new year. Please could you let me know if there have been any developments on this?

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* Full clinical records
* Expert reports/summaries
* Police memos re: conversations with family members
* Summaries prepared by Matthew Lohn

Please do not hesitate to contact me if there is anything you wish to discuss, or if you need any further information from me.

Many thanks

[redacted]Clare Strickland
[redacted]n-house lawyer
Nursing and Midwifery Council
23 Portland Place
London W1B 1PZ

Code A

Code A

From: Code A
Sent: 12 February 2007 15:52
To: 'david.williams Code A
Subject: Operation Rochester

Dear Detective Superintendant Williams

This message is further to the stakeholder meeting on 19 December 2006, which was attended by my colleague Code A Code A

I understand that at that meeting, it was suggested that the coroner may decide to hold an inquest into some of the deaths, and that any such decision was expected early in the new year. Please could you let me know if there have been any developments on this?

As you will know, the NMC is anxious to proceed with its enquiries into this case now that we have received confirmation that there will be no criminal proceedings. However, before we can do this, we will need to receive from you copies of the files relating to the remaining 10 cases that were the subject of the police referral to the CPS. I would be very grateful if you could let me know when we can expect to receive the following in respect of each of those cases:

- Full clinical records
- Expert reports/summaries
- Police memos re: conversations with family members
- Summaries prepared by Matthew Lohn

Please do not hesitate to contact me if there is anything you wish to discuss, or if you need any further information from me.

Many thanks

Clare Strickland
In-house lawyer
Nursing and Midwifery Council
23 Portland Place
London W1B 1PZ
Code A

NMC File Note

Subject: Stakeholders meeting re investigation at Gosport WMH

Date: 19th December 2006

Reference: Gosport War Memorial Hospital

Code A attending a stakeholders meeting at Fareham police station, regarding the CPS decision re investigation into deaths at Gosport War Memorial Hospital.

Attendees – See attached sheet.

ACCSO Steve Watts:

Allegations were originally made to police by family members in 1998. 92 separate cases have been investigated since that date. Of these, 10 cases were passed to the CPS. These have been reviewed by Paul Close of the CPS and Mr Perry of counsel.

The CPS was satisfied that the police investigation was thorough and properly structured.

The CPS has concluded that no further action should be taken in relation to this matter.

Since receipt of this decision, S Watts has attempted to engage with Mr Close to discuss the reasons for this decision and to discuss any areas of dispute, but has been unable to speak to him to date. As this conversation has not happened, there is a very small possibility that there may be evidence which Close has highlighted is not available, which the police could still investigate. However, this is very remote possibility.

The CPS provided letters to the families today, and the decision was communicated to all families in person. It is likely that some family members will be dissatisfied with the decision and media interest is anticipated.

DS David Williams:

The clinical team appointed by the police looked at all 92 cases and found 10 which gave cause for concern.

Two further experts – one palliative care expert and one geriatrician – reviewed these 10 cases (including all medical notes; responses from Dr Barton and Dr Reid when interviewed under caution; all witness statements). 6 or 7 experts were also instructed to assist with this task.

The opinions of the two experts regarding whether the patients were in the final stages of life, and therefore whether the care provided was palliative, were

diametrically opposed to each other. This was probably the reason for the CPS's decision.

The coroner may hold an inquest into the deaths of Elsie Divine, Elsie Lavender and Sheila Gregory as they were buried. The other patients were cremated and he is therefore not obliged to conduct an inquest into their deaths. The coroner will make this decision in the new year.

Elsie Divine's family is represented by Alexander, the lawyer who acted for some families in the Shipman case.

The CPS letter to the families offers them the opportunity to meet with a representative of the CPS and counsel. Early indications are that at least one or two families wish to take up this offer.

The police have also offered to meet with the families.

The police will request the consent of the families to release all relevant information to the GMC/NMC. Early indications from some families are that they are happy to sign the release consent.

The CPS advice from Mr Close was released on a strictly confidential basis. The letters to the families refers to the case of *R v Adomoko,* which sets out the requirements to prove gross negligence, which the CPS decided were not met in this case. Causation and negligence to a criminal standard were not made out regarding the administration of diamorphine.

ACCSO Steve Watts:

Mr Close chose not to attend today. There has been some conflict between S Watts and Mr Close. Mr Close asked specifically that his advice be kept confidential.

DS David Williams:

Interested parties may wish to contact Mr Close directly to request reasons for the CPS advice.

ACCSO Steve Watts:

The CPS has provided a press release saying that there is insufficient evidence to prosecute. Whilst there is some evidence of errors, there is insufficient evidence for a realistic conviction of gross negligence manslaughter.

Paul Hyton, GMC:

The GMC is currently only investigating Dr Barton.

5 cases were referred to the GMC 3 or 4 years ago. These have been on hold pending the results of the police investigation.

GMC would like to see the expert reports for the final 10 cases, although these would not be in a format which the GMC could use.

CPS decision is not binding on the GMC but PH could not say at present whether any additional cases will be pursued. Those referred already will go to hearing.

Delay will no doubt be raised by doctor's representatives at that hearing, even though it was out of the hands of the GMC.

ACCSO Steve Watts:

The police will release all papers they can to the GMC.

Paul Hyton, GMC:

The GMC does have methods to request papers from the CPS. They would like to see the experts' advice as they don't know at present where the experts disagree.

It is impossible for the GMC to predict a timescale for this matter as it will depend on how quickly information is released to them and whether they will need to instruct new experts.

Code A ***NMC:***

NMC did receive number of complaints from families which related mostly to general care. Possible issue of whether nurses should have challenged prescriptions.

Similar position to GMC in that everything has been on hold pending outcome of police investigation.

Richard Samuel, Primary Case Trust and Strategic Health Authority:

They have no concerns regarding the care currently being provided to patients at Gosport WMH. They are loathe to commence their own investigation at this stage.

Dr Barton is now practising as a GP with restrictions on prescribing certain drugs.

He will contact CPS to find out if they have any information which suggests that the PCT needs to take any further action.

The CPS press release refers to "errors".

D Williams:

Both experts recognised significant levels of negligence in care provided to patients.

R Samuel:

RS was concerned that we have not been told details of the "errors" referred to in CPS press release or "negligence" referred to in letters to families. The only information he will be able to give if approached about this is that the PCT and SHA have only seen the press release. This is clearly unsatisfactory.

The PCT and SHA will pick up on the results of the coroners inquests/GMC/NMC decisions at a later date, but have no intention to undertake their own investigation at present.

Police:

IPCC will be making similar disclosure requests to CPS.

PCA and IPCC spent 4 years investigating complaints about the police investigation, but no officers were disciplined. Any further complaints will have to be investigated separately from these historical complaints.

Hawkins, Hampshire CPS:

Hampshire CPS will take a blanket line that any queries will be redirected to CPS headquarters, London, where decision was taken. Hawkins does not want to appear deliberately unhelpful, but has been told that he can't disclose anything.

ACCSO S Watts:

S Watts is satisfied that the police investigation was thorough and effective. The health authorities have been very supportive of the police investigation. The police have also worked closely with the GMC and NMC and will look to disclose to them any information required.

Of the 82 cases which did not proceed from the police investigation, only one family has complained about the decision not to pursue – Mackenzie. (Paul Hyton advised that they have already contacted the GMC today).

8 ot the 10 remaining families have indicated that they were satisfied with the police investigation and with the CPS decision. The other two have been the principal and most vociferous complainants throughout.

Dibden, Police Media

Read police press release. Some suggestions for minor amendments made.

R Samuel:

The PCT and HAS will need to work closely with the GMC and NMC regarding the issue of "negligence" as identified by the CPS.

Requested that Lucy Dibden ask CPS to remove reference to "errors" from their press release. LD will do so immediately after this meeting.

DS Goodall:

There is some prospect of civil action by the families, which means that the evidence will then be aired in the public arena.

Paul Hyton:

GMC does not intend to make pro-active press release on this ubject.

Code A

I have not been advised that there is intention to make press release.

S Watts:

Confirmed that Dr Bartons' representative was told of the decision this morning.

Hawkins:

Contact details for Paul Close, CPS are as follows:

Paul Close
Special Crime Division
50 Ludgate Hill
London
EC4 M7EX
Code A

Meeting concluded.

Code A spoke to David Williams, who confirmed that he will look into release of case summaries of final 10 cases to NMC tomorrow.

Operation ROCHESTER.

Stakeholder meeting.

Fareham Police Station Hampshire.

1530hrs Tuesday 19th December 2006.

Attendees.

ACCSO Steve WATTS.
Chief Supt PEACOCK.
Chief Supt GOODALL.
Det Supt David WILLIAMS.
Det Insp GROCOTT.

Paul HYLTON (General Medical Council)
Louisa MORRIS (Solicitor for GMC)
Richard Samuel (Primary Care Trust, Strategic Health Authority)
Sarah Tiller (Media for SHA)
Code A
Nick Hawkins (CPS)
Lucy Dibdin (Media Police)

Meeting objective.
To achieve multi - agency understanding in terms of organisational objectives following the NFA decision by CPS in respect of the criminal investigation into deaths at Gosport War Memorial Hospital.

Agenda.

1. Introduction/case overview. ACCSO WATTS Det/Supt WILLIAMS.
2. General Medical Council situation report and future objectives.
3. Primary Care Trust/Strategic Health Authority situation report and future objectives.
4. Nursing and Midwifery Council situation report and objectives.
5. Hampshire CPS.
6. Media issues/approach.
7. A.O.B.

Last Updated: Tuesday, 19 December 2006, 18:15 GMT

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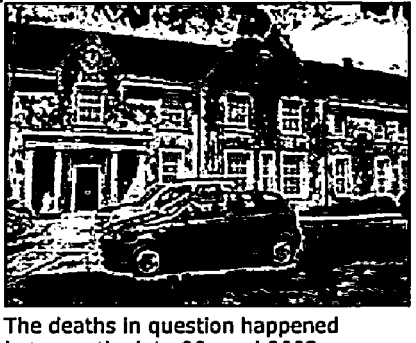
No charges over hospital deaths

No one will face prosecution over the deaths of 10 elderly patients at a Hampshire hospital.



The deaths in question happened between the late 90s and 2002

The deaths at Gosport War Memorial Hospital between the late 1990s and 2002 were the subject of a lengthy investigation by Hampshire police.

Some families claimed that patients had died after sedatives like diamorphine were over-prescribed by staff.

But the Crown Prosecution Service (CPS) said there was insufficient evidence to prosecute any person over the deaths.

Hampshire Police conducted two investigations into the deaths, the first of which is the subject of complaints to the Independent Police Complaints Commission (IPCC).

> **"Errors alone do not, of themselves, amount to gross negligence"**
>
> Paul Close, CPS

The second investigation, which looked into the deaths of 90 patients, resulted in 10 files being passed to the CPS.

Paul Close, of the CPS, said: "I considered whether the evidence gathered by the police showed that a criminal offence had been committed, and particularly the offence of gross negligence manslaughter.

"After looking at all the evidence - including that of experts - and seeking the advice of counsel, I decided there was insufficient evidence for a realistic prospect of conviction.

"Errors alone, no matter how catastrophic the consequences may be, do not, of themselves, amount to gross negligence.

"I have written to the families explaining my decision and offering my deepest sympathy for their bereavement.

"I have offered to meet them to discuss how I reached my decision."

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L Code A

From: Clare Strickland
Sent: 18 December 2006 12:22
To: 'dave.grocott(Code A
Cc: Code A
Subject: RE: Operation Rochester

Thank you for your call and email. Unfortunately, I am not able to attend, but have arranged for another member of the NMC's in-house legal team, Code A o attend on behalf of the NMC. She is one of our Code A

We look forward to receiving your update at the meeting tomorrow.

Regards

Clare Strickland
In-house lawyer
Nursing and Midwifery Council
23 Portland Place
London W1B 1PZ
Code A

-----Original Message-----
From: dave.grocott@hampshire.pnn.police.uk [mailto:dave.grocott(Code A
Sent: 18 December 2006 11:49
To: Clare.Strickland Code A
Subject: Operation Rochester

Clare,

As per our conversation,

ACC Watts is holding a Stakeholder conference in respect of Operation Rochester at 1530hrs tomorrow afternoon here at Fareham Police Station. You or your representative are invited.

The address is
Fareham Police Station
Quay st
Fareham
PO16 0NA

It is only a short taxi ride from the train station.

If you could let me know who is attending I'd be very grateful

Dave Grocott
Detective Inspector
Review Team
Code A

Clare Strickland

From: Clare Strickland
Sent: 28 July 2006 12:37
To: 'david.williams@ Code A
Subject: RE: OP Rochester..Gosport War Memorial Investigation.

Thank you very much for the update. I will be out of the office for the next two weeks, so please could you copy in any further updates to Code A the case manager, as well as to me. Code A email address is Code A

Many thanks

Clare Strickland
In-house lawyer
Nursing and Midwifery Council
23 Portland Place
London W1B 1PZ
Code A

-----Original Message-----
From: david.williams@ Code A
Sent: 28 July 2006 12:11
To: PHylton@gmc-uk.org
Cc: Code A
jenifer.smith@southcentral.nhs.uk; Code A
Code A dave.grocott@ Code A
David.Horsley@portsmouthcc.gov.uk; roy.stephenson@ Code A
Subject: OP Rochester..Gosport War Memorial Investigation.

Dear Paul Hylton(GMC)/ Clare Strickland(NMC) /Jenifer Smith(SHA) David HORSLEY(H.M.Coroner)

Please find attached a family group update letter that I am sending today to relatives of the 10 remaining cases under investigation.

<<Operation ROCHESTER Family Group Update 28/7/2006.>>

All files have now been forwarded to the CPS and I am meeting with Treasury Counsel next week Wednesday the 2nd August to discuss the outcome.

We have also been interviewing (under caution)a consultant Geriatrician Dr Richard Ian REID in respect of 2 cases (of the 10 above) the deaths of Edith SPURGIN and Geoffrey PACKMAN. The final interview with Dr REID is being held on 8th August 2006.. The police investigation into these matters is then essentially complete.

Once the decision in respect of any prosecution is made (in my view not all of these cases meet the standard of evidence required to prosecute criminally and the public interest hurdle remains to be addressed) then we will need to get together to discuss further disclosure to the GMC and NMC.

I spoke with Dr BARTON's legal rep Ian BARKER last week, he confirmed that Dr BARTON was still adhering to the voluntary agreement not to prescribe Opiates and Benzodiazepines.. She has however now taken a senior practice partner position at

her surgery..

I will be in touch post 2nd August to discuss the way forward.. It may be appropriate to pull all stakeholders together to talk this through including the local Portsmouth Coroner Mr David HORSLEY.

Regards..

Dave WILLIAMS Det Supt..
07707 700040
Code A

Clare Strickland

From: david.williams@ Code A

Sent: 28 July 2006 12:11

To: PHylton Code A

Cc: Code A
jenifer.smith@southcentral.nhs.uk; Clare.Strickland@NMC-UK.ORG;
Code A jave.grocott@hampshire Code A
David.Horsley@portsmouthcc.gov.uk; Code A

Subject: OP Rochester..Gosport War Memorial Investigation.

Dear Paul Hylton(GMC)/ Clare Strickland(NMC) /Jenifer Smith(SHA) David HORSLEY (H.M.Coroner)

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I will be in touch post 2nd August to discuss the way forward.. It may be appropriate to pull all stakeholders together to talk this through including the local Portsmouth Coroner Mr David HORSLEY.

Regards..

Dave WILLIAMS Det Supt..
Code A

HAMPSHIRE Constabulary

Chief Constable Paul R. Kernaghan CBE QPM LL.B MA

PRIVATE

Our Ref. :
Your Ref. :

Fareham Police Station
Quay Street
Fareham
Hampshire
PO16 0NA

Tel: 0845 045 45 45
Direct Dial: Code A
Fax: 023 9289 1663
Email:

28 July 2006

Dear Mr. LAVENDER

I write at this time to inform you that the police investigation into deaths at Gosport War Memorial hospital during the 1990's is essentially complete. I confirm that all remaining cases classified by the team of clinical experts as of 'most concern' in terms of the care afforded and cause of death have been submitted to the CPS.

In addition a significant amount of supporting material and documentary exhibits continue to be reviewed by the Crown Prosecution Service who I meet with Treasury counsel next week Wednesday 2nd August 2006

To date in excess of 800 witness statements have been taken principally from family members, healthcare staff and expert witnesses.

Approaching 4,000 documents have been evidenced, reviewed and considered by the investigation team and 1700 nominal records created, a 'nominal' containing information in respect of people connected to the investigation.

Our Geriatric and Palliative care experts alone have spent the best part of two years reviewing the mountain of documentation to produce their incredibly detailed evidential expert reports and subsequent findings.

Operation ROCHESTER presents as an investigation into some of the most complex and challenging problems in geriatric medicine. Importantly all significant representations previously made by family members have been included for consideration by the CPS.

In support of case papers prepared by the Operation ROCHESTER team I have compiled individual case comprehensive summaries distilling the key issues to assist in providing focus for examining counsel. This has entailed my reading in detail each and every witness statement pertaining to every case.

HAMPSHIRE Constabulary

Operation ROCHESTER has been one of the most demanding highly resourced investigations ever undertaken by the Constabulary. I am entirely content that this fulsome investigation has led to the position that the CPS have all available material to properly consider whether or not there is a sufficiency of evidence to launch criminal proceedings.

The ongoing continued interests of the General Medical Council and Nursing and Midwifery Council and remain, a significant proportion of the original body of complaints having been passed to them for their attention. I have also continued to update the Chief Medical Officer, the Coroner and the Strategic Health Authority.

Whilst I appreciate the frustrations that this investigation has been lengthy I am afraid that this situation has been inevitable given the volume of work, the complexity of issues to be considered by our experts and the detailed investigation processes put in place to ensure that no stone has been left unturned. I am confident that the investigation has been both expeditious and diligent when reviewed against all the circumstances.

I am satisfied that the Primary Care Trust and staff have and continue to co-operate fully with the police investigation despite considerable disruption to their day to day routine, this has been a substantial piece of work requiring many thousands of hours of police and healthcare staff time.

I would like to take this opportunity to reassure you that I have not disbanded the investigation team, I will consider ongoing resource requirements in the light of the CPS decision which I will ensure is communicated to you on an individual family basis as soon as we are able.

Once the decision as to criminal prosecution or otherwise has been made, then further 'interests' in terms of GMC, NMC and Coroner involvement may be resolved, again I will keep you updated as to these matters.

Finally may I thank you for your continued patience under difficult circumstances.

Yours Sincerely

David WILLIAMS
Detective Superintendent
Senior Investigating Officer.

PRIVATE

Private and confidential
Deputy SIO Nigel Niven
Hampshire Constabulary
Fareham Police Station
Quay Street
Fareham
Hampshire PO16 0NA

Code A

Email: clare.strickland Code A

29 November 2005

Dear Mr Niven

Operation Rochester

Thank you for your letter of 22 November 2005.

We are grateful for the indication that your criminal investigation is ongoing. Please could you keep us informed of any future developments.

Yours sincerely

Clare Strickland
Lawyer

HAMPSHIRE CONSTABULARY

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Fareham Police Station
Quay Street
Fareham
Hampshire
P016 ONA

Tel. 0845 0454545
Fax. 023 92891663

Our Ref. Op Rochester

Your Ref.

22nd November 2005

Ms Clare Strickland
In-House Lawyer
Nursing and Midwifery Council
23 Portland Place
Code A

Dear Clare

Re: Operation Rochester

Thank you for your email of the 21st November 2005 and please accept my apologies for not providing you with a written update sooner.

As you are aware, we have been conducting an investigation into a number of deaths at the Gosport War Memorial Hospital (GWMH). During the course of the investigation the number of deaths has risen to allow for cases being belatedly brought to our attention. So fare we have reviewed in excess of 90 deaths.

From our previous discussions, you are aware that each of the cases is reviewed by a team of experts in order to consider that treatment and identify the appropriateness or otherwise of that treatment. This has allowed our investigation to focus on those cases that provoked the most concern to our team of experts. The cases that have provoked the more serious concerns have then been subjected to an evidential examination by alternative experts. Whilst we have been undertaking that process we have also been interviewing, on a case by case basis, a Doctor from the GWMH.

We have submitted a number of these specific cases to the Crown Prosecution Service for their consideration. We anticipate that we will have submitted all of the cases that provoke the more serious concern to the CPS by the end of this year.

In the meantime, we have set about providing both your body and the General Medical Council with copies of all the cases reviewed by our experts, where the treatment received by the various patients was considered to be optimal or sub-optimal. To date, I understand that we have delivered the notes of 80 patients to your offices.

Our criminal investigation is very much ongoing and is likely to continue into the early part of next year.

I hope the above information is sufficient by way of an update. I will, of course, seek to answer any specific question you may have. In addition, either David Williams or I will be only too happy to meet with you to discuss this matter further, should you think that is desirable.

If I can assist you any further, please do not hesitate to contact me again.

Yours sincerely

Code A

Nigel Niven
Deputy SIO

Clare Strickland

From: Clare Strickland
Sent: 21 November 2005 11:51
To: 'nigel.niven@ Code A
Cc: david.williams
Subject: RE: Operation Rochester and the NMC

DCI Niven

We have today received a further 5 boxes of files from your officers, in addition to the 3 boxes we received on 29.9.05, but have not yet received your update of your current position.

I would be very grateful if you could provide this as a matter of urgency, as we are receiving queries from members of the public, and are unable to answer them without knowing what is happening with the criminal investigation.

Many thanks

Clare Strickland
n-House Lawyer
ursing and Midwifery Council
3 Portland Place
Code A

-----Original Message-----
From: nigel.niven@hampshire. Code A
[mailto:nigel.niven@hampshir
Sent: 28 September 2005 11:39
To: Clare.Strickland Code A
Cc: david.williams Code A
Subject: RE: Operation Rochester and the NMC

Clare,
Thanks for your email. We are still on course. I will be out of the office for a day or 2 but I will write to you soon with an update of our position.
With best wishes
Nigel

-----Original Message-----
rom: Clare Strickland Code A
ent: 26 September 2005 15:51
o: Niven, Nigel
Subject: Operation Rochester and the NMC

Dear DCI Niven

We last heard from you in January 2005, when you indicated that you were continuing to investigate your category 3 papers and had started to submit papers to the CPS. At that stage, you indicated that you were aiming to have all category 3 cases with the CPS during the course of 2005.

I would be very grateful if you could provide the NMC with an update of the current position regarding your criminal investigation.

Please do not hesitate to telephone me on Code A if there is anything you wish to discuss in person.

Regards

Clare

Clare Strickland
In-House Lawyer

Nursing and Midwifery Council
23 Portland Place
London W1B 1PZ

Clare Strickland

From: nigel.niven@ Code A
Sent: 28 September 2005 11:39
To: Clare.Strickland Code A
Cc: david.williams@ Code A
Subject: RE: Operation Rochester and the NMC

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With best wishes
Nigel

-----Original Message-----
From: Clare Strickland [mailto:Clare. Code A
Sent: 26 September 2005 15:51
To: Niven, Nigel
Subject: Operation Rochester and the NMC

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Regards

Clare

Clare Strickland
In-House Lawyer
Nursing and Midwifery Council
23 Portland Place
London W1B 1PZ

Clare Strickland

From: Clare Strickland
Sent: 26 September 2005 15:51
To: 'nigel.niven Code A
Subject: Operation Rochester and the NMC

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Please do not hesitate to telephone me on Code A if there is anything you wish to discuss in person.

Regards

Clare

[redacted]lare Strickland
[redacted]n-House Lawyer
Nursing and Midwifery Council
23 Portland Place
London W1B 1PZ

[redacted]

NURSING & MIDWIFERY COUNCIL

Protecting the public through professional standards

Detective Chief Inspector N Niven
Operation Rochester
Hampshire Constabulary
Fareham Police Station
Quay Street
Fareham
Hampshire PO16 0NA

25 January 2005
N Code A Letters/Operation Rochester.4

Direct line: Code A
Fax No: 020 7031 0459
Email: Code A

Dear Nigel

Operation Rochester

Thank you for your response to my letter dated 12 January 2005.

I have passed the correspondence on to Clare Strickland, our Lawyer dealing with the case.

She will be in contact with you, should the need arise.

Yours sincerely

Code A

Liz McAnulty
Director of Fitness to Practise

HAMPSHIRE CONSTABULARY

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Fareham Police Station
Quay Street
Fareham
Hampshire
P016 ONA

Tel. 0845 0454545
Fax. 023 92891663

Our Ref. Op Rochester

Your Ref.

6th January 2005

Elizabeth McAnulty
Nursing & Midwifery Council
23 Portland Place
London
W1B 1PZ

Dear Liz,

Re: Operation Rochester

Thank you for your letter of the 12th January 2005, the content of which I have noted.

You raised in this letter two questions, one regarding the current time table regarding criminal proceedings and the second regarding the death of Mrs Devine.

As far as the time table for any proceedings is concerned, I am able to tell you that we are currently continuing to investigate the category 3 cases and have started to submit papers to the CPS. Our initial view is that the CPS will need to consider all of the category 3 cases holistically in order to determine whether criminal proceedings are warranted. As you will appreciate, this is an involved process which is demanding both of police and, more importantly, our expert's time. We regard it a realistic prospect to have all the category cases with the CPS during the course of 2005.

I am able to confirm that the death of Mrs Devine is being investigated as a category 3 case.

If I can assist you any further, please do not hesitate to contact at the above address.

Yours sincerely

N Code A
Detective Inspector

NURSING & MIDWIFERY COUNCIL

Protecting the public through professional standards

Detective Chief Inspector N Niven
Operation Rochester
Hampshire Constabulary
Fareham Police Station
Quay Street
Fareham
Hampshire PO16 0NA

12 January 2005
N/Code A/Letters/Operation Rochester.2

Direct line: 020 7333 6548
Fax No: 020 7031 0459
Email: Code A

Dear Nigel

Operation Rochester

Thank you for your letter dated 6 January 2005.

Having considered the material provided to us, it is our current view that we are unlikely to be taking any further action at the moment. In the circumstances, it appears to us that any NMC action must follow any criminal proceedings.

Accordingly, we will not be doing anything that may have any affect on your proceedings or generate publicity in the near future.

We would welcome an update from you on the current timetable for any criminal proceedings. I would be more than happy to meet with you to discuss this, or to deal with this in correspondence if that would be more convenient to you.

We are seeking a similar indication from the GMC.

There is one specific matter that you could assist with. As we discussed, the NMC has received complaints from a number of families, most of which have either been closed, or related to patients who fell within your category 2. However, we have one outstanding complaint relating to the death of Mrs Divine. I would be grateful if you could confirm whether this is one of the cases you have investigated and, if so, which of your categories it falls into. This would be for our information only, and would not be disclosed to anyone.

I look forward to hearing from you.

Yours sincerely

Code A

Liz McAnulty
Director of Fitness to Practise

Clare Strickland

From: Clare Strickland
Sent: 11 January 2005 16:37
To: Liz McAnulty
Subject: Gosport Nurses

I have just spoken to Paul Hylton at the GMC.

They are very keen to get on as the doctor involved, Dr Barton, was referred to their Conduct Committee in 2002. They have considered the category 2 cases, but their Committee did not consider that the evidence would justify an interim suspension.

Accordingly, they need details of the Category 3 cases, and are getting frustrated that the police timetable appears to keep slipping. They are meeting the police on Thursday 13 January to try to resolve this problem. If they are unable to do so, they will (reluctantly) consider seeking a court order to force the police to disclose the category 3 material.

I explained our position, and Paul confirmed that the GMC had not come across any issues relating to the nursing care, other than the overarching issue of whether they failed to challenge inappropriate prescribing.

Paul will contact me after the meeting with the police to give me an update.

.ttached is my draft text for your reply to DC Niven. I will leave his letter with Code A I hope that this is alright.

Regards

Clare

Gosport draft letter text 11.1...

GOSPORT

DRAFT TEXT FOR LETTER FROM LIZ MCANULTY TO DETECTIVE INSPECTOR NIGEL NIVEN

Dear Detective Inspector Niven

Re: Operation Rochester

Thank you for your letter dated 6 January 2005.

Having considered the material provided to us, it is our current view that we are unlikely to be taking any further action at the moment. In the circumstances, it appears to us that any NMC action must follow any criminal and GMC proceedings.

Accordingly, we will not be doing anything that may have any effect on your proceedings or generate publicity in the near future.

We would welcome an update from you on the current timetable for any criminal proceedings. I would be more than happy to meet with you to discuss this or to deal with this in correspondence if that would be more convenient to you.

We are seeking a similar indication from the GMC.

There is one specific matter that you could assist with. As we discussed, the NMC has received complaints from a number of families, most of which have either been closed, or related to patients who fell within your category 2. However, we have one outstanding complaint relating to the death of Mrs Divine. I would be grateful if you could confirm whether this is one of the cases you have investigated, and if so, which of your categories it falls into. This would be for our information only, and would not be disclosed to anyone.

I look forward to hearing from you.

HAMPSHIRE CONSTABULARY

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Fareham Police Station
Quay Street
Fareham
Hampshire
PO16 ONA

Our Ref. Op Rochester

Your Ref.

Tel. 0845 0454545
Fax. 023 92891663

Code A

6th January 2005

Elizabeth McAnulty
Nursing & Midwifery Council
23 Portland Place
London
W1B 1PZ

Clare can you advise please.
Liz

Dear Liz,

Re: Operation Rochester

I write regarding the above matter. As you are aware, following our meeting of the 6th October 2004, we agreed through subsequent correspondence, the basis of our referral of category 2 cases to your organisation. Since that time we have delivered a total of 47 such cases to your office in Portland Place.

The purpose of this letter is to seek to establish the current situation in respect of your assessment of these cases. It would clearly be of use to us to have some understanding of your early thoughts and to discuss, to the extent that it is appropriate, any action you are considering.

We are due to meet with GMC to discuss issues in relation to Operation Rochester in the near future. Should you wish, we would be only to happy meet with you and your team to discuss this matter further.

I very much look forward to hearing from you regarding the above and if I can assist you in any way, please do not hesitate to contact me.

Yours sincerely

Code A

Nigel Niven
Detective Inspector

Clare Strickland

From: Clare Strickland
Sent: 15 December 2004 14:28
To: 'nigel.niven@ Code A
Subject: RE: Gosport

Thank you for your enquiry. I have spoken to Chris McKeown, who is going to deliver the next set of files tomorrow.

As you will appreciate, we have not been able to reach any firm decisions about the material we have reviewed to date without having seen the remainder of the material that is coming to us. However, I have found all of the material I have considered to be clearly presented and likely to be useful to us.

I will let you know as and when any developments are about to occur at our end.

May I take this opportunity to wish you a very happy Christmas and New Year.

Regards

Clare

-----Original Message-----
From: nigel.niven@ Code A
[mailto:nigel.niven Code A
Sent: 15 December 2004 14:19
To: Clare.Strickland Code A
Subject: RE: Gosport

Clare,
You are probably now aware that we intend to deliver the next consignment of category 2 cases to you tomorrow. Are you able to give me an early indication of how you assessment of the 1st batch of cat 2 cases went?
Very best wishes
Nigel Niven

-----Original Message-----
From: Clare Strickland [mailto:Clare.Strickland Code A
Sent: 13 December 2004 14:09
To: Niven, Nigel
Subject: RE: Gosport

Thanks for your quick reply. We do not shut down over the Christmas period, so if it would be convenient for one of your officers to deliver the files at that time, there will be someone here to receive them. However, I will be on leave from 23 December to 3 January, so if the new year would be easier for you, that would also be fine.

Regards

Clare

-----Original Message-----
From: nigel.niven@ham Code A
[mailto:nigel.niven@h
Sent: 13 December 2004 13:36
To: Clare.Strickland Code A
Cc: c Code A
Subject: RE: Gosport

Clare,

Thank you for your email. At the present time we have a number of competing priorities which demand the attention of my team. Depending on

events, we may be able to get a further batch to you before Christmas. Is your organisation closing for a particular period over the Christmas recess?

Regards

Nigel

-----Original Message-----
From: Clare Strickland Code A
Sent: 13 December 2004 13:05
To: Niven, Nigel
Subject: Gosport

Good afternoon

As you will recall, we have been given files relating to 19 patients in your Category 2. Please could you let me know when we may receive the remaining files - as far as we are concerned, the sooner the better.

Regards

Clare

Clare Strickland
Lawyer
Fitness to Practise Directorate
Nursing and Midwifery Council
23 Portland Place
London W1B 1PZ
Code A

NMC File Note

Subject: Gosport

Subject Index Ref:

Date: 15.12.04

Reference: Code A

Tel call from Code A, Fareham Police Station (contact number 0845 Code A - he is going to drop off 6 boxes to us at 7PP tomorrow. I told him that I would not be in tomorrow, but that he should ask at reception for Code A Code A knows that the delivery is due, and will arrange for the boxes to go into the meeting room for storage.

NURSING & MIDWIFERY COUNCIL

Protecting the public through professional standards

Detective Chief Inspector N Niven
Operation Rochester
Hampshire Constabulary
Fareham Police Station
Quay Street
Fareham
Hampshire PO16 0NA

19 November 2004
N/Code A/Letters/Operation Rochester.1

Direct line: Code A
Fax No: 020 7031 0459
Email: Code A

Dear Nigel

Operation Rochester

Thank you for letter dated 12 November 2004.

I am happy to confirm that we will notify you in advance of any stage where it appears that material may have to enter the public domain, and give you an opportunity to discuss your position with us.

We look forward to receiving the next batch of cases from you.

Yours sincerely

Code A

Liz McAnulty
Director of Fitness to Practise

HAMPSHIRE CONSTABULARY

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

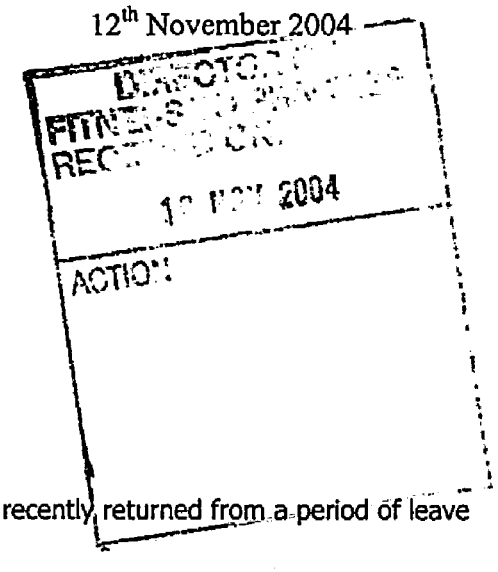
Fareham Police Station
Quay Street
Fareham
Hampshire
P016 ONA

Our Ref.

Your Ref.

Tel. 0845 0454545
Fax. 023 92891663

12th November 2004



Elizabeth McAnulty
Nursing & Midwifery Council
23 Portland Place
London, W1N 4JT

Dear Liz,

Re: Operation Rochester

Thank you for your letter of the 20th October 2004. I have recently returned from a period of leave and would like to apologise for not responding sooner.

In your letter you kindly explain your procedures in respect of the various stages of proceedings and highlight the areas of the process where material may be at risk of entering the public domain. We accept that you must follow these procedures but respectfully request that we have an opportunity to discuss with you our position, when such stages are being approached.

I am confident that with our ongoing communication and by displaying interagency consideration, we will be able to successfully address the concerns that may arise from our shared investigations.

You will be aware that, in advance of this letter, we have served 19 cases upon your staff. We are currently finalizing some review work in respect of the next batch of cases. Once this has been done will again deliver further cases to your office.

Please do not hesitate to contact me if you think I can assist any further. I very much look forward to cooperating with you and your Council in the future.

Yours sincerely,

Code A

Niger Niven
Detective Chief Inspector
Operation Rochester

Paul Hylton @ GMC.
Betty Woodland - Union rep.
Detective Superindendent.
Nigel Niven & David Williams

Prev 2 March 2004(?)

Investigated 88 deaths at GMH.
© 1999 family of Gladys Richards came forward.
file of evidence to CPS in 2002
not basis of criminal investigation.
papers handed to PCT highlight problems with diamorphine & syringe drivers.
In ~~Stigated~~ investigated in 2002 and concluded within a few months
1/2 of publicity → more people came forward.
Any evidence of unlawful activity? Investigation began Sept 02
Analysed all medical records + reach prelim - conclusions.
Categorised according to level of concern.
50% of cases had some problems.
25% of cases really cause some concern.
A lot couldn't be classed as criminal conduct.
19 cases submitted to GMC. Proceeding against a doctor & ~~y~~ soon.
- disclosures → appraisal of treatment, brief summary of issues, concerns raised by family members + All the med records.
Need to come to some agreement with the police around certain issues i.e. approaching witnesses
Send over a current state of case. The names we have.
Irene Walters → expert can't be on the committee.
Need to find out, once we've looked at the info, which nurses we are proceeding with so that they can check if any of those are category 3 cases and take different steps.
Provisionally meet again in December?

CAMBRIDGE

NURSING & MIDWIFERY COUNCIL

Protecting the public through professional standards

Detective Chief Inspector N Niven
Operation Rochester
Hampshire Constabulary
Fareham Police Station
Quay Street
Fareham
Hampshire PO16 0NA

20 October 2004
N/Code A/Letters/Operation Rochester

Direct line: Code A
Fax No: 020 7031 0459
Email: Code A

22 OCT 2004

Dear Nigel

Operation Rochester

Thank you for letter dated 12 October 2004, which helpfully summarises our discussions on 6 October 2004. We welcome your proposal to provide us with your records relating to category 2 cases.

With regard to your criteria for disclosure, it is necessary for me to set out our position on criteria 1 and 2 in a little detail.

As you are aware, our Preliminary Proceedings Committee (PPC) has already considered allegations against some nurses. These allegations fall to be dealt with under our old rules. Any material provided by you relating to these allegations will be considered by the PPC, which sits in private. However, in the course of the PPC proceedings it may be necessary to disclose material to others such as the nurse in question, his or her representatives, expert witnesses, complainants and witnesses.

Any new allegations received after 1 August 2004 must be dealt with under our new rules. They will be considered in the first instance by an Investigating Committee (IC). When considering allegations, the IC's position is similar to the PPC in that it sits in private, but its procedures may require the disclosure of material to third parties.

As I mentioned during our meeting, our old rules contain provisions allowing the PPC to order that a practitioner's registration be suspended on an interim basis pending resolution of the allegations. Again, the PPC's deliberations take place in private. However, any interim suspension order must be made public.

Under the new rules, the IC has the power to make an interim suspension order or an interim conditions of practice order. The new rules require that interim orders hearings take place in public unless, having considered representations from the parties and any third parties, the IC considers that it is in the interests of any party or third party, or the

public interest, to hold the hearing in private. Even if an IC interim order hearing has taken place in private, the fact that an interim order has been made must be made public.

From this, you will appreciate that I am unable to give a categorical assurance that there will be no publicity of the NMC's proceedings prior to any criminal trial. In cases where there is no interim order, matters will be private. However, it is up to the PPC (or IC, under the new rules) to decide whether an interim order is necessary.

In cases where the IC decides to consider making an interim order, we would represent to the IC that the hearing should be held in private in light of the public interest in avoiding potentially prejudicial publicity, and it would be open to the police to submit their own representations in support of this. However, the final decision is the Committee's.

Our powers and procedures in this respect are very similar to those of the GMC. It may be that you have already discussed these issues with the GMC and found a way forward. If that it the case, perhaps we could agree to proceed on a similar basis.

With regard to your criteria 3, 4 and 5, I do not see any difficulty.

Finally, with regard to criteria 6, I confirm that our normal practice is to wait until the conclusion of any relevant criminal investigation and trial before holding a substantive hearing into the allegation made to the NMC.

Please do not hesitate to contact us if you require any further information about our procedures. No doubt you will wish to revert to me once you have considered the matters I have raised relating to interim orders.

Please be assured of our continued desire to co-operate with you to achieve a satisfactory arrangement for the early disclosure of the material.

Yours sincerely

Code A

Liz McAnulty
Director of Fitness to Practise

HAMPSHIRE CONSTABULARY

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Fareham Police Station
Quay Street
Fareham
Hampshire
P016 ONA

Tel. 0845 0454545
Fax. 023 92891663

Our Ref. Op Rochester

Your Ref.

12th October 2004

Elizabeth McAnulty
Nursing & Midwifery Council
23 Portland Place
London, W1N 4JT

Dear Liz,

Re: **Operation Rochester – Investigation into deaths at Gosport War Memorial Hospital (GWMH)**

I write further to our useful meeting of the 6th October 2004. You will recall that during this meeting I provided you with an update as to the present stage of our investigation. I explained that we were investigating the deaths of 88 patients at the GWMH. To assist us in this investigation we commissioned a team of clinical experts to review the medical records of these patients and provide us with an analysis and categorisation of treatment.

The categorisation fell into 3 sections. The treatment of patients that fell into category 1 was considered to be acceptable. The treatment of patients that fell into category 2 was considered to be sub optimal but did not present evidence of unlawful criminal activity. Category 3 cases were considered to warrant further detailed investigation to determine whether unlawful criminal activity could be identified.

I was able to tell you that we had written to all those patient families who fell into category 1 and notified them of the findings. The category 3 cases are, as I described, subject to continued investigation.

The particular purpose of this letter is to allow us to discuss the issue of the category 2 cases, of which there are in excess of 50 cases. To date we have been able to provide records in respect 19 cases to your colleagues in the GMC. It is our proposal to provide your Council with the same documentation. However, before we can do that we would need to agree, in writing, the terms of reference in respect of this disclosure.

At our meeting I verbally outlined the broad conditions of the agreement we reached with the GMC. In general terms you considered such conditions as being reasonable but, quite rightly, we all felt that such should be put into writing to allow for further deliberation.

The below constitutes our criteria which has been agreed in conjunction with the Crown Prosecution Service (CPS).

1. That the information supplied is towards a private Preliminary Proceedings Committee

2. That there is no adverse publicity prior to or during any criminal proceedings.

3. Statements taken by the NMC from witnesses, who are subsequently witnesses in criminal proceedings, will be subject to disclosure.

4. The NMC should liaise with the police informing them of the identity of proposed witnesses before taking statements from those individuals.

5. Permission will be sought from category 2 case witnesses to reveal their statements etc to the NMC.

6. The NMC should not institute further disciplinary proceedings until any criminal investigation and criminal trial have been concluded.

I would very much appreciate you reviewing the above and letting me know your thoughts. We will, of course, consider any alterations or additional points you may wish to raise.

Once we have reached an agreement in writing, I will undertake to deliver the material in respect of these 19 cases. For your information, we will provide in respect of each of the 19 cases a full copy of the patient notes, the précis notes of each of our clinical team, a summary prepared by our expert advisor and the concerns raised by the patient's families.

In due course, we will supply your Council with the remaining category case papers and I would anticipate you will have all such papers in respect of all of the category 2 cases by the end of this year.

I very much look forward to hearing from you in the near future. If, however, I can be of any assistance to you in the mean time, please do not hesitate to contact me.

Yours sincerely

Code A

Nigel Niven
Detective Chief Inspector
Operation Rochester

GOSPORT WAR MEMORIAL HOSPITAL

Code A NOTES 30.10.04

1991	Nurses (including H Code A raise concerns with RCN (MURRAY), Community Tutor (WHITNEY) and Patient Care Manager (EVANS)
10.7.01	LIVESEY report on d. RICHARDS – names Code A and J Code A
18.9.01	PPC decides no action against Code A re: d. RICHARDS
12.12.01	FORD report on d. RICHARDS, d. CUNNINGHAM, d. WILKIE (criticises drug regime but does not single out individual nurses), d. WILSON, d. PAGE (concludes nursing care appropriate and adequate
29.4.02	NMC asks NHS for further info re: d. CUNNINGHAM, d. WILKIE and d. WILSON in light of FORD's conclusions
15.5.02	NHS provides further info – queries factual accuracy of info in FORD and LIVESEY reports – provides details of NHS investigation – no disciplinary action against individual nurses
17.5.02	Complaint against Code A and unnamed others by PAGE re: PAGE (d. Nov 1999)
6.6.02	Complaint against Code A and BELL Code A REEVES re: DIVINE (d. Nov 1999)
19.6.02	Complaint by BULBECK re: MIDDLETON (d. Aug 2001) – general at first Code A subsequently named
July 02	CHI report Code A report on case to PPC
22.8.02	Complaint against Code A re: CARBY (d. April 1999)
27.8.02	PPC consider complaints:

- Code A legation from JACKSON re: WILKIE
- Code A – allegation from REEVES re: DIVINE
- Code A llegation from REEVES re: DIVINE

  (NB: Code A were also named in a general complaint from PAGE re: PAGE)
- Code A llegation from REEVES re: DIVINE

Code A allegation from REEVES re: DIVINE

? Case adjourned pending outcome of police referral to CPS?

Sep 02 Complainants notified

3.10.02 NHS report on BULBECK complaint re: MIDDLETON – general issues raised – no individual nurses named

5.11.02 BBC report re: DoH investigation

15.11.02 NHS report on CARBY complaint re: CARBY – no evidence of nurse negligence

26.1.04 BULBECK notifies NMC of further patient death – open verdict recorded by coroner

FURTHER ACTION

1 In August 2002, PPC adjourned consideration of JACKSON (d. WILKIE), REEVES (d. DIVINE), and PAGE (d. PAGE), apparently pending outcome of police referral to CPS.

ACTION: Obtain PPC minutes to confirm purpose of adjournment

Contact police for current status/outcome of referral to CPS

2 There is nothing in the files to show that the PPC has considered the complaints from Code A

ACTION: Consider whether it is necessary to refer these complaints to PPC

3. In January 2004, BULBECK notified NMC of a further death

ACTION: Check whether any complaints received in respect of this death

Gosport War Memorial Hospital
Pre-Inquest Hearing Report
19th January 2009 10am
Portsmouth Guild Hall

Those Attending:

Ms Hill of Blake Lapthorn
John White Blake Lapthorn
Alan Jenkins MDU for Dr Barton
Stuart Knowles Mills & Reeve
Ms Bhoghl The PCC
Michael Tyrer for Charles Farthing
Elaine Williams for Hampshire PCT
Deborah Watts from Mills & Reeve
Dennis Blake BBC
Pauline Gregory
Ian Wilson
Alan Lavender
Betty Packman
Vicky Packman
Peter Mellor

1.Properly Interested Persons

Dr Barton
The families of the deceased
The Health Trust
The PCT

2.Witness Schedule:
see attached.

3. Document Bundle
This will be prepared by the Coroners Office and circulated prior to the Inquest.

4. Hospital Notes
have now been annotated and copies were made available to the properly interested persons.

5. The Drug Register
will be annotated by Mills & Reeve and copies made available.

6. Jury Proforma.
This was prepared by The Coroner but will be expanded to include background information of each deceased giving an outline of dates, condition etc and that will be circulated as soon as it is prepared.

7. A working bundle of documents in addition to the advanced disclosure will be prepared and an Index circulated.

a. The Wessex guidelines are to be sent to the Coroners Office from the PCT and copies of those are to go to the Experts.

b. It was fully accepted that Professor Black is an appropriate expert but doubt was expressed about the suitability of Dr Wilcock. The Coroners Office will contact Dr Wilcock to express those concerns and will await his comments.

c. The Ford & Munday Reports are to be disclosed by the police.

d. This is not an Article 2 Inquest.

e. Concern was expressed about any possible Rule 43 Reports. This is not a case where it would be appropriate on the basis of the previous care to request a report under Rule 43.

Witness Schedule

March 18th
Opening Jury and Submissions
19. Lavender
Code A

23. Service
24. Professor Black
25. Professor Black
26. Lake
27. Cunningham

30. Wilson
31. Wilson & Hamblin

April
1. Spurgeon
2. Packman
3. Devine

6. Dr Wilcock
7. Dr Wilcock
8. Devine
9. Gregory

14. Dr Barton
And onwards

David C. Horsley LLB
Her Majesty's Coroner
for Portsmouth and
South East Hampshire

Coroner's Office
Room T20
The Guildhall
Guildhall Square
Portsmouth
PO1 2AJ

Fax: 023 9268 8331

6th January 2009

GOSPORT PRE-INQUEST HEARING

19th January 2009 10.00am

Portsmouth Guildhall

1. Representation of Properly Interested Parties.
2. Witness schedule – see attached.
3. Document Bundle
4. Hospital Notes
5. Drug Register
6. Jury Pro- Forma
7. Aob

David C. Horsley LLB
Her Majesty's Coroner
for Portsmouth and
South East Hampshire

Coroner's Office
Room T20
The Guildhall
Guildhall Square
Portsmouth
PO1 2AJ

Fax: 023 9268 8331

6th January 2009

GOSPORT LIVE WITNESS LIST

Code A

Sheelagh JOINES
Alexander TUFFEY
Anita TUBBRITT
Charles Stuart FARTHING

Code A

Iain WILSON
Neil WILSON
Carl JEWELL
Victoria PACKMAN
Anne REEVES
Richard REID
Pauline GREGORY
Prof BLACK
Dr WILCOCK
Dr BARTON

NMC File Note

Subject: Gosport

Date: 9.9.08

Author: Clare Strickland

Telephone call to HM Coroner, Portsmouth and South East Hampshire (02392 688326). I explained that I was seeking information about the forthcoming GWMH inquest, and that I had been given the name Mr Bradley as a possible contact. The lady I spoke to said that Mr Bradley is dealing with the inquest. She said she would ask him to call me.

Telephone call from Mr Bradley (01256 478119). He said that:

- The inquest is scheduled to start in March 2009 and is to be listed for 6 weeks.
- Mr Bradley will conduct the inquest with a jury.
- It will be held at Portsmouth Combined Court Centre.
- Mr Bradley has just prepared bundles and the witness list, which he is forwarding to the police. He will arrange for me to be sent a copy of the witness list by post as soon as possible.
- The witness list has been prepared by deceased patient, so there will be some repetition of witnesses.
- None of the nurses are represented at present.

Mr Bradley was extremely friendly and helpful, and should be willing to help with any requests we have in the future. He has my contact details.

Clare Strickland

From: Ellson, Sarah [Code A
Sent: 08 June 2009 06:51
To: Clare Strickland
Subject: Re: Last day of Gosport Inquests/First day of GMC hearing

Dear Clare

My apologies in replying to this email.

I do not know if you are planning to attend the GMC today or tomorrow - if not I am sure you will be able to read our opening to Dr Barton's case in due course.

The GMC have confirmed I should share the inquest transcripts with you. The delay was while I waited for the transcription fees which are still outstanding. The cost will have been several thousand pounds and as you may recall we were unable to co-ordinate this amongst the various interested parties. The GMC would be grateful if you made a contribution to the costs they have incurred.

In the meantime - I can email the transcripts to you - I believe these will fill up your inbox so we may want to co-ordinate when I do this - perhaps some time tomorrow when I am back in the office.
Sarah Ellson | Partner

for Field Fisher Waterhouse LLP
dd: +44 (0)161 200 1773 I m: +44 (0)7879 842535

From: Clare Strickland
To: Ellson, Sarah
Sent: Thu May 07 09:19:06 2009
Subject: RE: Last day of Gosport Inquests

Thank you very much for this Sarah.

We would like to have a copy of the full transcript, and we will be happy to reimburse your administrative costs.

Regards

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

From: Ellson, Sarah [mailto:Sarah.Ellson@ffw.com]
Sent: 29 April 2009 17:39
To: Clare Strickland
Subject: Last day of Gosport Inquests

Dear Clare

It is not the easiest to read but here is the transcript of the last day of the Inquests which contains the verdicts.

If you think you might like the whole transcript can you let me know - I may be asked to make a

small charge for this - the GMC would appreciate it if we could at least cover our administrative costs on this.

Sarah Ellson | Partner
for Field Fisher Waterhouse LLP
dd: +44 (0)161 200 1773 I m: Code A

Consider the environment, think before you print!

Field Fisher Waterhouse LLP 27th Floor City Tower Piccadilly Plaza Manchester M1 4BD
Tel+44 0161 200 1770 **Fax**+44 0161 200 1777
E-mail info@ffw.com **Web** www.ffw.com **CDE823**

Clare Strickland

From: Ellson, Sarah Code A
Sent: 08 June 2009 06:51
To: Clare Strickland
Subject: Re: Last day of Gosport Inquests/First day of GMC hearing

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Sarah Ellson | Partner

for Field Fisher Waterhouse LLP
dd: +44 (0)161 200 1773 I m: +44 Code A

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Regards

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

From: Ellson, Sarah [mailto:Sarah. Code A
Sent: 29 April 2009 17:39
To: Code A
Subject: Last day of Gosport Inquests

Dear Clare

It is not the easiest to read but here is the transcript of the last day of the Inquests which contains the verdicts.

If you think you might like the whole transcript can you let me know - I may be asked to make a

small charge for this - the GMC would appreciate it if we could at least cover our administrative costs on this.

Sarah Ellson | Partner
for Field Fisher Waterhouse LLP
dd: +44 (0)161 200 1773 I m: +4 Code A

Consider the environment, think before you print!

Field Fisher Waterhouse LLP 27th Floor City Tower Piccadilly Plaza Manchester M1 4BD
Tel+44 0161 200 1770 Fax+44 0161 200 1777
E-mail info@ffw.com Web www.ffw.com CDE823

Clare Strickland

From: Ellson, Sarah [Sarah Code A
Sent: 28 April 2009 08:39
To: Clare Strickland
Cc: Cooper, Rachel
Subject: RE: Gosport

Many thanks for this Clare - I wait for a copy of McNicholas although Mary Timms and I have been highlighting in our recent induction training that as a result Committees are likely to be pressed harder on reasons even if it is just for adjourning for investigation.

On Gosport although it is not officially in the public domain I can confirm the GMC hearing is due to start on 8 June and run for 10 weeks - this is intended to be sufficient time to deal with the case which will focus on 12 patients.

We have arranged for a transcript of the whole inquest to be prepared this is coming through daily. I will check with the GMC but I am sure that they will have no difficulty with me passing this on to the NMC. We expedited the transcript of the final day although I am not sure if we have it yet - I will ask a colleague to follow up.

If you need anything further for your case please let me know. You should know that Gill Hamblin who is a nurse is extremely ill (with a terminal condition). She was not well enough to attend the inquest and we are looking at whether to try and video interview her if she has a few better days as we do not expect her to be able to attend the GMC.

Sarah Ellson | Partner
for Field Fisher Waterhouse LLP
dd: +44 (0)161 200 1773 | Code A

Consider the environment, think before you print!

Field Fisher Waterhouse LLP 27th Floor City Tower Piccadilly Plaza Manchester M1 4BD
Tel+44 0161 200 1770 Fax+44 0161 200 1777
E-mail info@ffw.com Web www.ffw.com CDE823

From: Clare Strickland [Code A
Sent: Friday, April 24, 2009 9:39 AM
To: Ellson, Sarah
Subject: Gosport

Dear Sarah

I hope you are well.

Following the conclusion of the Gosport inquest last week, we are preparing to put our live complaints back to the PPC so that they can decide whether any should be closed or adjourned further pending the outcome of the GCM procedure/further investigation. We will be writing to all of the registrants involved to explain the position to them.

It would be very helpful if you could let me know if you have any idea of the GMC's current timescale for its final hearing.

Also, do you have a copy of the narrative verdict of the inquest that you could let me have? Please don't worry if that's not possible, I will go direct to the coroner otherwise.

If you would like any further information from the NMC please do not hesitate to ask. I will keep you informed of developments.

Finally, on a different point, we are still waiting for the final judgement in the McNicholas case. As soon as we receive it I will forward it to you.

Regards

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

First Floor
Centrium
61 Aldwych
London
WC2B 4AE

Clare Strickland

From: Clare Strickland
Sent: 07 May 2009 09:19
To: 'Ellson, Sarah'
Subject: TRIM: RE: Last day of Gosport Inquests
TRIM Dataset: TL
TRIM Record Number: 368799
TRIM Record URI: 383897

Thank you very much for this Sarah.

We would like to have a copy of the full transcript, and we will be happy to reimburse your administrative costs.

Regards

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
020 7462 5861

From: Ellson, Sarah [mailto:Sarah. Code A
Sent: 29 April 2009 17:39
To: Clare Strickland
Subject: Last day of Gosport Inquests

Dear Clare

It is not the easiest to read but here is the transcript of the last day of the Inquests which contains the verdicts.

If you think you might like the whole transcript can you let me know - I may be asked to make a small charge for this - the GMC would appreciate it if we could at least cover our administrative costs on this.

Sarah Ellson | Partner
for Field Fisher Waterhouse LLP
dd: +44 (0)161 200 1773 I m: +44 (0)7879 842 535

Clare Strickland

From: Clare Strickland
Sent: 24 April 2009 09:39
To: Code A
Subject: TRIM: Gosport
TRIM Dataset: TL
TRIM Record Number: 360140
TRIM Record URI: 375079

Dear Sarah

I hope you are well.

Following the conclusion of the Gosport inquest last week, we are preparing to put our live complaints back to the PPC so that they can decide whether any should be closed or adjourned further pending the outcome of the GCM procedure/further investigation. We will be writing to all of the registrants involved to explain the position to them.

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Finally, on a different point, we are still waiting for the final judgement in the McNicholas case. As soon as we receive it I will forward it to you.

Regards

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

First Floor
Centrium
61 Aldwych
London
WC2B 4AE

NMC File Note

Subject: Gosport

Date: 17.2.09

Author: Clare Strickland

Telephone call from Sarah Ellson, FFW Code A I confirmed that the coroner has kept us fully informed about what is happening with the inquest.

The GMC is sending a paralegal to day 1 of the inquest, but they are not proposing to stay beyond that. They will be happy to answer any questions we have arising from day 1.

The GMC has written to the coroner enquiring about transcripts – they do not yet know who will have to bear the costs. I did not make any offer to share costs at this stage, but it may be something we will consider in due course.

The BBC and AvMA will be attending the inquest, so there will be publicity. Also, more material is being put into the public domain, so there may be further questions.

I thanked her for keeping me informed.

NMC File Note

Subject: Gosport

Date: 9.9.09

Author: Clare Strickland

Telephone call to Juliet St Bernard at the GMC.

She was away for the coroner's pre-meeting and so does not know what happened at it. The coroner contact is Mr A M Bradley, Assistant Deputy Coroner, Guildhall, Portsmouth.

The case against Dr Barton is under the old rules. She does not know if criminal or civil standard will apply.

She confirmed that the case against Dr Barton was initiated by five complaints from patient relatives. In addition to these, they will be looking at the 10 cases in police category 3 (only two of which overlap with the relative complaint cases).

I asked if she was aware of any cases where the GMC's decision to proceed under old or new rules had been challenged – she was not.

I explained that we have to deal with these issues because we may have to consider more than one registrant.

Nursing & Midwifery Council
NMC

Private & Confidential
Sarah Ellson
Field Fisher Waterhouse LLP
Portland Tower
Portland Street
Manchester M1 3LF

Code A

clare.strickland Code A

4 July 2008

Dear Sarah

Gosport War Memorial Hospital

Thank you for your letter dared 26 June 2008. We are grateful for the information regarding the listing of the GMC hearing and the coroner's inquest.

As you may know, Ian Todd has recently taken up his position as the NMC's director of fitness to practice. There will be an internal NMC meeting on 5 August 2008 to discuss this case with him. We will keep you informed of any relevant developments.

Yours sincerely

Code A

Clare Strickland
Senior lawyer (Hearings)

NMC File Note

Subject: Gosport

Date: 25.6.08

Author: Clare Strickland

Telephone call from Sarah Ellson, FFW, on behalf of the GMC. They are writing to interested parties to confirm that, in light of the coroner's decision to hold inquests, the GMC will be postponing its proposed proceedings against Dr Barton (probably until early 2009). The coroner is holding a pre-inquiry meeting on 14.8.08.

SE also mentioned that, when reviewing the CHI material, she saw that CHI had publicly noted that the NMC was looking at prescribing issues.

Field Fisher Waterhouse

Received by Legal Team
27 JUN 2008

Strictly Private & Confidential

Ms Clare Strickland
Nursing & Midwifery Council
23 Portland Place
London
W1B 1PZ

Our ref: SLE/GML/00492-15579/7750395 v1
Your ref:

Sarah Ellson
Partner
0161 238 4945 (Direct Dial)
07879 842535
Code A

26 June 2008

Dear Clare

General Medical Council - Dr Jane Barton

I write further to our meeting with you and Code A Peter Swain and Juliet StBernard (GMC) on 16 May 2008.

Listing of GMC hearing

When we met we discussed the then recent announcement by the Portsmouth and South East Hampshire Coroner of his intention to open Inquests into the deaths of ten people who died at Gosport War Memorial Hospital.

After careful consideration the GMC has now decided to postpone the Fitness to Practise Panel Hearing regarding Dr Jane Barton until the inquests have been held. Eight of these patients were amongst those due to be considered at the Fitness to Practise Panel Hearing which had been provisionally listed to commence on 8 September 2008. The GMC has taken legal advice and has decided that on balance, it is preferable to await the outcome of the inquests. The inquests could give rise to further fitness to practise allegations or could lead to the GMC revising the charge that it proposed to bring and so could be highly relevant to the GMC proceedings. Giving the inquest primacy over GMC proceedings will also allow Dr Barton to deal with that inquiry and her evidence for that process, ahead of her having to finalise her response to the Fitness to Practise Panel.

As I indicated when we spoke on the telephone this week the Coroner has indicated that there will be a pre-hearing meeting to discuss the listing of the inquests and other matters. We have been advised that the date will be Thursday 14 August 2008 and I am currently clarifying with the General Medical Council who will attend on their behalf.

The GMC Fitness to Practise Panel Hearing will be relisted once we have further information from the Coroner about the proposed date of the inquests.

Review of evidence and information in the public domain

I understand you are familiar with the Commission for Health Improvement ("CHI") Investigation Report (published in July 2002). When reviewing it very recently I noted that the CHI said in 2002 that the NMC were considering any issues of professional misconduct in relation to any of the nurses referred to in police documentation. CHI also highlighted, as you identified at our meeting, the requirement that nurses act in the best interests of their patient at all time, including challenging the prescribing of other clinical staff, if appropriate.

NMC and GMC investigations and disclosure

Whilst the Notice of Hearing has yet to be finalised we have advised Dr Barton's solicitors that the GMC charge is likely to include reference to the prescribing to 12 patients.

When we met to discuss the GMC and NMC investigations you indicated that the NMC currently have a number of complaints based on correspondence from families and relating to five nurses. However your indication was that those written complaints were unlikely to result in onward referrals. You also indicated those nurses referred to have not be informed that there has been a "complaint" about them to the NMC.

In relation to the review of conduct which might arise from the police investigation, we understand that at present the NMC intend to await the outcome of the GMC's proceedings which, it is anticipated, will result in a finding as to whether the prescribing by Dr Jane Barton was inappropriate and/or not in the best interests of her patients. Again no individual nurses have been notified by the NMC that their conduct could fall to be considered as a result of the police documentation.

We have discussed the situation with our barrister. To date most, if not all, of the nurse witnesses whom we have approached have had support from their union or RCN representative. We have, throughout, indicated that any concerns about professional conduct by nurses would be matters to be dealt with by the NMC.

We have been advised that, prior to any nurse being called to give evidence, we should remind them in writing of their right to seek legal advice (and our power to summons them to give evidence). We are of course concerned about issues of self-incrimination by witnesses who have not been fully informed of the potential for their conduct to be scrutinised by their own regulator.

We would also invite the NMC to confirm to us any decisions to refer or close complaints against particular nurses. We would like to be able to then disclose this information to Dr Barton's legal advisers. We should also like to be able to be open with our witnesses if we are aware of any confirmed NMC proceedings and it would be helpful to discuss disclosure to any nurse witnesses in due course.

In the meantime in our discussions with families it is possible that we will be advised of complaints made against nurses (indeed when we spoke I indicated some families had repeated their concerns about the nursing staff to us directly). We will have to comply with our disclosure obligations by letting Dr Barton's lawyers know about family complaints about nursing staff where this is relevant. Our barrister has suggested that we ought to explicitly ask families to confirm whether they have complained about any other medical or nursing staff and that we should obtain copies of any letters of complaint. Such documents would be subject to disclosure.

All of the above matters are now somewhat secondary given that the GMC now intends that the inquests should have primacy over their own investigation for the time-being. We anticipate that many of the nursing and medical staff will give evidence at the Inquest which may be relevant to the regulatory proceedings.

If you have any questions in relation to this matter you should feel free to contact either Juliet StBernard at the GMC or me directly if appropriate.

Yours sincerely

Code A

Sarah Ellson
for **Field Fisher Waterhouse LLP**

Received by Legal Team

27 JAN 2009

Professional Fees of
MISS JOHANNAH CUTTS QC

VAT Registration No: 494 7059 07

9-12 Bell Yard
London WC2A 2JR
Tel: 020 7400 1800
Fax: 020 7404 1405
DX: LDE 390
clerks@9-12bellyard.com
www.9-12bellyard.com

Nursing and Widwifery Council
Legal Team,
23 Portland Place,
London
W1B 1PZ

F.A.O. Code A

Solicitor Ref. Code A/gosport | Date 26 January 2009 | Case Ref No. 135700

RE; 'NMC' AND GOSPORT WAR MEMORIAL HOSPITAL

Criminal Private

		FEES £	VAT £
08 Sep 2008	Advising in Conference + Preparation 15 hrs	4500.00	787.50

REMINDER

TOTAL FEES	**£ 4500.00**
TOTAL VAT	**£ 787.50**
TOTAL DUE	**£ 5287.50**

Rendered on: 19 Jan 2009

VALID ONLY WHEN RECEIPTED

PLEASE QUOTE CASE REFERENCE NO. ON ALL CORRESPONDENCE

Clare Strickland

From: JOHANNAH CUTTS Code A
Sent: 09 February 2009 22:39
To: Clare Strickland
Subject: RE: FW: TRIM: RE: TRIM: RE: Gosport War Memorial Hospital
Attachments: NMC-GWMH Opinion 9.2.09.doc; NMC GWMH. Guidance Note 9.2.09.doc

Dear Clare,

Please find enclosed my opinion and guidance note in this case. I am sorry that it has taken a while but I confess it took me longer than I first thought it would. Please let me know if this is what you are looking for. If you want me to add or expand on anything please let me know. I will send hard copy soon. I am involved in a case in Crotdon at the moment so will do that asap.

You will see from my advice that although I think the PPC could consider an abuse argument I think they would have to be very careful before they did so. I don't see them having enough info to make the decision. If they don't find this is the exceptional clear cut case in which they form the view that no fair trial can be held that is an end to it. I don't think it would be right for them to then 2nd guess what the outcome of any such application would be should it be argued before the Conduct Committee and use that speculation as a means by which to refuse to refer the case.

I am interested by the argument concerning the change in the standard of proof. I take it there is no way the NMC can agree that the criminal standard should apply in these cases? If that could happen that significantly lessens the chance of a successful application.

Good luck with it all and please let me know what happens.

I hope all is well with you. Let me know if you are around for a drink or heading to or through Somerset soon.

Jo

--- On **Thu, 5/2/09, Clare Strickland** Code A

From: Clare Strickland <Code A>
Subject: RE: FW: TRIM: RE: TRIM: RE: Gosport War Memorial Hospital
To: "JOHANNAH CUTTS" <Code A>
Date: Thursday, 5 February, 2009, 2:55 PM

Dear Jo

Sorry not to reply sooner.

The earlier you can get it done, the better, as far as we're concerned.

Many thanks

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

From: JOHANNAH CUTTS [Code A]
Sent: 28 January 2009 19:35
To: Clare Strickland
Subject: Re: FW: TRIM: RE: TRIM: RE: Gosport War Memorial Hospital

Hi Clare,

A belated happy new year.

I am sorry not to have done this before now. It has also been a busy time for me. I am in a trial at Croydon at the moment but have your papers with me. I hope to look at this to refresh my memory over the weekend and will try to get advice out by following weekend. Will this work for you?

Am on my mobile if you would like to chat.

Regards

Jo

--- On **Tue, 27/1/09, Clare Strickland** < Code A wrote:

From: Clare Strickland < Code A
Subject: FW: TRIM: RE: TRIM: RE: Gosport War Memorial Hospital
To: "JOHANNAH CUTTS" < Code A
Date: Tuesday, 27 January, 2009, 10:27 AM

Hello Jo, hope you are well, and that you are enjoying the new year.

I'm sorry not to have been in touch for so long, but it's been a busy time.

I have received information from the coroner that the inquest into the Gosport Hospital deaths will start on 18 March 2009. Accordingly, we need to press on with our proceedings as soon as possible, so please can you let us have your advice as soon as possible?

Regards

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
020 7462 5861

From: Clare Strickland
Sent: 17 November 2008 09:02
To: 'JOHANNAH CUTTS'
Subject: RE: TRIM: RE: Gosport War Memorial Hospital

That will be fine - thanks.

Enjoy your busy time!

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

From: JOHANNAH CUTTS [mailtc Code A
Sent: 14 November 2008 13:28
To: Clare Strickland
Subject: RE: TRIM: RE: Gosport War Memorial Hospital

Hi Clare,

I have received the additional papers today although not looked at them yet. I will do my best to get the advice to you asap but am afraid that after a period of calm next week heralds the beginning of the storm. I am at a JSB seminar tomorrow, lecturing at a JSB seminar in Warwick on Monday morning and then starting a serious child abuse trial (defending) at Maidstone on Monday afternoon. That is set down for 3 weeks. I think the best I can say is that you will have the advice by the beginning of December. Is that ok? If you need it before I will make every effort to get it to you.

Hope all well

Jo

--- On **Thu, 13/11/08, Clare Strickland** < Code A wrote:

> From: Clare Strickland < Code A
> Subject: RE: TRIM: RE: Gosport War Memorial Hospital
> To: "JOHANNAH CUTTS" < Code A
> Date: Thursday, 13 November, 2008, 11:50 AM
>
> Hi Jo
>
> I have finally managed to get everything finished and so have sent your further instructions to chambers. Please let me know if you have any questions arising from them, or if there is anything you want to discuss. We don't have a fixed timescale at this end. My best estimate is that we will have a PPC meeting scheduled early in the new year. It would be really helpful if you could let me have a time estimate for completion of your work.
>
> All the best.
>
> Clare
>
> Clare Strickland
> Senior lawyer (hearings)
> In-house legal team
> Code A

From: Clare Strickland
Sent: 10 October 2008 13:01
To: 'JOHANNAH CUTTS'
Subject: TRIM: RE: Gosport War Memorial Hospital

Hi Jo - sorry for not getting back to you sooner. I got all the extra information we need. We've agreed here that we will try to go back to a PPC for possible closure as soon as possible. Before that, I need to adapt my memo into a summary report for the PPC, and prepare the bundles. I have been booked solid with hearings, so haven't been able to do that at the moment, but am aiming to get it done by the end of the month. Once I have the report, I will pass it to you so that you know exactly what information the PPC will be given, and at that stage, you can prepare your advice. Sorry if the timetabling is not great now that your other case has moved, but I don't think it'll take too much of your time once you do get started.

I'll be in touch again asap.

Take care, and enjoy yourself!

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

From: JOHANNAH CUTTS [mailto: Code A
Sent: 10 October 2008 11:04
To: Clare.Strickland(Code A
Subject: Gosport War Memorial Hospital

Hi Clare,

I hope all is well with you.

I have been thinking about our case. I have had a case moved into November and have some time to concentrate upon it. I know you were going to obtain some information before I put together the advice and just wondered how that was coming along. No worries if it is not yet all to hand. I suppose I could use these sunny days to walk the dogs and have a pub lunch - such hardship!!

No seriously if we are ready I could get the advice to you by the end of next week. I am working from home and my mobile usefully doesn't work here so if you need to contact me do call on Code A

Code A

Code A

IN THE MATTER OF:

NURSING AND MIDWIFERY COUNCIL ("NMC")

GOSPORT WAR MEMORIAL HOSPITAL

OPINION

Introduction

1. A number of complaints have been made to the NMC regarding the clinical practice of nurses at the Gosport War Memorial Hospital in the late 1990s. This hospital is a 113 bed community hospital. Elderly patients were generally admitted to it through referrals from local hospitals or general practitioners for palliative, rehabilitative or respite care. In all cases where complaints have been made the patients cared for at the hospital have sadly died. To avoid repetition I have not set out the alleged facts of those complaints here. I have relied on the summary of events succinctly set out in the report from the in-house legal team dated 14th November 2008.

2. Allegations were made in 2002 against a number of named nurses by the relatives of 5 patients. In September 2002 the Preliminary Proceedings Committee (PPC) considered complaints of the care of 3 of those named patients (Wilkie, Devine and Page). The cases were adjourned pending the outcome of the police investigation into these and the deaths of many other patients at the hospital. The allegations concerning the 2 remaining patients (Middleton and Carby) do not yet appear to have been considered by the PPC.

3. The police investigation examined the circumstances of 90 patient deaths. The care of each was considered by a number of experts. Their conclusions had then to be considered by the Crown Prosecution Service. During the course of the police investigation the experts were instructed to categorise their view of the treatment afforded to the patients in question. If the experts considered the treatment acceptable cases were put into category 1. Category 2 cases were those where the treatment was said to be sub-optimal but which did not present evidence of criminal activity. Category 3 cases were considered to warrant further investigation with a view to considering whether criminality was involved. The scale of the criminal investigation meant that it took some considerable time. In December 2006 the police announced the outcome of their final investigations into the category 3 cases. The Crown Prosecution Service had decided that no criminal charges should be brought.

4. In cases where relatives had made complaints to the police all but one (Devine) fell into category 2. In October 2004 the police had agreed to provide the NMC with all of the evidence gathered in category 2 cases. There were considerably more of these than the 4 patients already the subject of complaint to the NMC. In 2004-2006 the police sent files relating to all 80 cases in category 2. These have been reviewed with the exception of the

medical records as the lawyer concerned did not have the requisite medical expertise to be able to properly assess those.

5. The exercise conducted by the experts instructed by the police resulted in 10 cases placed in category 3. These are currently subject to a coroner's inquest. I understand that this is set down for March 2009. One of the cases (Devine) is also the subject of a complaint to the NMC. It is expected that nurses will give evidence at the inquest although the NMC has not yet had sight of a witness list. None of the nurses are represented. I do not know if this is because they are not considered "interested parties" entitled to take part in the questioning of witnesses at the inquest.

6. In addition some of the allegations also involve complaints against Dr Jane Barton who in 1988 took up a part time position at the hospital as Clinical Assistant in Elderly Medicine. I understand that the allegations are of serious professional misconduct based on inappropriate prescribing. These have been referred to the General Medical Council ("GMC") for their consideration. The GMC enquiry will focus on 12 patients. In 3 of those cases (Page, Wilkie and Devine) relatives of the patients concerned have also made complaints to the NMC. The GMC intends to call a number of nurse witnesses at their hearing into Dr Barton's conduct, including most of the nurses who have been named in complaints to the NMC. The GMC have decided to postpone their hearing until the conclusion of the inquest. 8 of the cases to be considered at the inquest form part of the evidence in the misconduct case. The GMC is of the view that the inquests could give rise to further fitness to practise allegations or lead to the GMC revising the charge it proposed to bring. Postponing the GMC misconduct hearing would also allow Dr Barton to concentrate on the preparing for the inquest.

Advice

I am asked to advise on a number of questions arising from this complex inquiry:

1. Whether any issues of misconduct arising from police files concerning patient deaths where the NMC has not received a complaint about named nurses should be dealt with under the old or new rules?

2. The prospects of establishing misconduct likely to lead to removal in any case against any registrant against whom the NMC has already received an allegation (to include consideration of successfully rebutting any abuse of process argument)?

3. In any other case, the prospect of establishing misconduct likely to lead to removal/a case to answer in respect of impairment of fitness to practise by reason of misconduct (test to be applied to depend on whether the case is to be dealt with under the old or new rules).

4. The management of the existing allegations in light of the forthcoming inquest and GMC proceedings thereafter.

5. Whether, as the existing complaints are likely to be referred to the PPC, a legal assessor should be instructed by the NMC to assist the panel.

6. To advise whether, in considering whether to refer the case, the PPC are entitled to consider a potential abuse of process argument based on delay.

7. To draft a guidance note to assist the PPC in the steps that need to be taken in reaching the decision whether to refer any case.

Old or new rules.

1. The Statutory framework

This question arises as the rules which govern the procedure for allegations made to the NMC about the fitness to practise of any registrant changed in 2004.

a. The old rules

i. Prior to 1st August 2004 the NMC's fitness to practise procedures were governed by the Nurses, Midwives and Health Visitors Act 1997 and the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 Approval Order 1993 (SI 1993:893). These are together known as "the old rules."

ii. These governed the test to be applied by the PPC when determining whether any allegation should be referred to the Conduct Committee. Rule 9(3)(a) states:

(3) Where a Notice of Proceedings has been sent to a practitioner the Preliminary Proceedings Committee shall consider any written response by the practitioner and, subject to any determination under Rule 8(3), shall-

(a) refer to the Conduct Committee a case which it considers justifies a hearing before the Conduct Committee with a view to removal from the register;

iii. This test means that in looking at any allegation received by the NMC prior to 1st August 2004 the PPC must consider whether there is a real prospect of the factual element of the allegation being established and if so whether there is a real prospect that the Conduct Committee might decide to remove the registrant's name from the register as a result.

b. The new rules

i. The procedures for allegations received by the NMC on or after 1st August 2004 are governed by the Nursing and Midwifery Order 2001 (SI 2002:253) and the Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004:1761). These are known together as "the new rules."

ii. The test to be applied by the Investigating Committee in determining whether to refer an allegation to the Conduct and Competence Committee under these rules is a different one. Rule 26(2)(d)(i) states:

(2) Where an allegation is referred to the Investigating Committee, it shall-

(d) consider in the light of the information which it has been able to obtain and any representations or other observations made to it under sub-paragraph (a) or (b), whether in its opinion-

(i) in respect of an allegation of the kind mentioned in article 22(1)(a), there is a case to answer.

iii. Article 22(1)(a) concerns allegations made against any registrant that his fitness to practise is impaired by reason of misconduct. The test set out in the new rules means that in looking at any allegation of misconduct received by the NMC on or after the 1st August 2004 the Investigating Committee must consider whether there is a case to answer in respect of impairment of fitness to practise by reason of misconduct.

c. The transitional provisions

i. The Nursing and Midwifery Order 2001 (Transitional Provisions) Order of Council 2004 (SI 2004:1762) covers the transition from the old rules to the new rules. Section 2 of this Order states:

> "Subject to the following provisions of this Order, where an allegation of misconduct has been received by the Council before 1st August 2004, the Council shall deal with allegation in accordance with Section 10 of the Act and the Conduct Rules as if they remained in force."

ii. Section 16 of Schedule 2 of the Nursing and Midwifery Order 2001 also states that where disciplinary proceedings are pending or have begun but have not been communicated the matter shall be disposed of as if the 1997 Act remained in force.

d. It is plain therefore that the rules which are to govern the procedure for any allegation and the test to be applied by the PPC/Investigating Committee depend on when the allegation was received by the NMC or when it can be argued that disciplinary proceedings have commenced.

2. The rules to be applied in this case.

a. Whether the proceedings should be governed by the old or new rules is not a difficult question when looking at the complaints already made to the PPC in 2002. These were plainly made before the rules changed and so fall to be dealt with under the old rules. Similarly the two complaints made in 2002 but not yet considered by the PPC (concerning patients Middleton and Carby) are governed by these rules.

b. There were a large number of additional cases referred to the NMC by the police piece meal in 2004-2006 (their category 2 cases). These have been reviewed by Miss Strickland and I have seen a schedule prepared by her giving some basic information in relation to each case. I have not seen the evidence myself. I note that some of the named nurses in allegations already before the NMC are also named in these further cases. No actual complaints have been made to the NMC regarding the named nurses' care of these patients and I know not whether they are to form the basis of any allegation to the NMC. Should the PPC not close the current cases against these nurses and this occur it is arguable that these other allegations be dealt with under the new rules as they came to the attention of the NMC after 1st August 2004. I am however of the view that, given these nurses are already the subject of allegations before the NMC in the same time period, these should be dealt with under the old rules. The same should apply to any new allegations against those nurses which may arise from the inquest or GMC proceedings.

c. There is a final category to be considered. The schedule prepared by Miss Strickland contains cases involving alleged sub-optimal care of certain patients by nurses other than those currently the subject of allegations before the NMC. It is also possible that

the inquest and/or GMC proceedings could reveal fresh allegations against new nurses. If allegations were to be made to the NMC from either of these sources it seems to me that there is no reason why they could not be dealt with under the new rules. Parliament made its intention clear in the transitional provisions. These cases came to the attention of the NMC after 1st August 2004 and as such should be dealt with under the new rules.

The prospects of establishing misconduct likely to lead to removal in any case against any registrant against whom the NMC has already received an allegation (to include consideration of successfully rebutting any abuse of process argument)

1. I have not been asked to review the large volume of paperwork in this case. In answering the first question therefore I rely solely on the summary of the evidence prepared by Miss Strickland.

2. I have considered the conclusions of Miss Strickland in her report of 14th November 2008. I cannot fault her reasoning on the information that I have that there is insufficient evidence to proceed with any allegation of misconduct in the cases of Page, Carby and Middleton.

3. The situation is somewhat different in the cases of Wilkie and Devine. In each case there are a number of allegations made against named nurses relating to the care of the patient concerned. Miss Strickland has summarised these in her report. I cannot fault her reasoning in coming to the conclusion that there is insufficient evidence to proceed with any allegation relating to general care of these patients and communication between nursing staff and relatives. There are, however, concerns about the prescribing of drugs given to these 2 patients. Both these cases form part of the misconduct allegations against Dr Barton to be heard by the GMC. The case of Devine is to be considered at the inquest.

    a. <u>The allegations concerning Mrs Wilkie</u>

        i. It is plain from the Code of Professional Conduct in force at the time that each registered nurse had a duty to

            - Safeguard and promote the interests of individual patients;
            - Ensure that no act or omission on their part was detrimental to the interests, condition or safety of patients;
            - Report to an appropriate person or authority any circumstances in which safe and appropriate care for patients could not be provided.

        ii. This clearly included a duty to report poor prescribing on the part of the doctor concerned. If poor prescribing is proved and the nurse who administered the drug can be identified then in my view there would be sufficient evidence to proceed with an allegation of misconduct against the nurse concerned.

        iii. I note the evidential difficulties involved in proving such a charge so long after the event. However the issue of the prescription of these drugs is to be looked into by the GMC who must have come to the conclusion that there is sufficient evidence to prove their case. Of course the evidential issues are not

precisely the same and it is necessary to identify the nurse/s concerned. If that can be done then subject to any successful abuse of process argument an allegation of misconduct could be pursued.

iv. It is for the PPC to decide whether to pursue this allegation at this stage. The panel may take the view that given the passage of time a single allegation of failure to challenge or report inappropriate prescribing would be insufficient to lead to removal of the registrant concerned. If that is the panel's view it could deal with the case at this stage. If the panel were to take the opposite view and consider this could be sufficient to lead to removal then a prudent course would, in my view, be to wait for the outcome of the GMC proceedings. If inappropriate prescribing cannot be proved against the doctor there then there is clearly no prospect of any case against a nurse being proved at the NMC. This will result in further delay but I do not agree that the likely further delay will have a significant impact on the ability to prove misconduct likely to lead to removal. There has already been, for understandable reasons, significant delay in this case. A few further months will not substantially alter the position.

v. The remaining possible allegation is that of the falsification of records against Philip Beed. This, if true, is a serious matter. I agree with the concerns as to the ability to prove to the required standard the detail of exactly what was said in a conversation 10 years ago. It was also a time when Mrs Jackson was under considerable stress. I agree that the prospects of proving that the conversation alleged by Mrs Jackson at this point in time are slim.

b. <u>The allegations concerning Mrs Devine</u>

i. Much of what I have said in relation to Mrs Wilkie applies equally to the case of Mrs Devine. This is plainly a serious matter, and part of the subject of both the inquest and the GMC hearing. If the nurses can be identified it is for the PPC to decide whether the failure to challenge or report inappropriate prescribing could be sufficient to lead to removal of the nurse concerned. If that is their view they could deal with the case at this stage. If they are of the view that it could then again in my view it would be prudent to wait until the conclusion of the inquest and GMC hearing before deciding whether to refer the nurses concerned to the Conduct Committee.

4. <u>Abuse of process</u>

a. There has been a considerable delay between 2002 when these complaints were made and the likely date of any hearing should any individual case be referred to the Conduct Committee. It is likely that this will form the part of an abuse of process hearing by the defence, that is an argument mounted by them that by reason of the delay the nurses concerned can no longer have a fair hearing.

b. Putting aside the fact that the standard of proof to be applied by the Conduct Committee has changed from the criminal to the civil standard (see paragraphs (h) and (i) below), I have seen no evidence that would lead me to the conclusion that it is likely to succeed. There is a considerable volume of case law confirming that the staying of proceedings because of delay should only occur in exceptional circumstances. Even when the delay is unjustifiable, a permanent stay should be the exception rather than the rule. [See **R v S (SP) [2006] 2 Cr.App.R 341**].

c. A deliberate delay is likely to be held an abuse of process. [See **R v Brentford Justices ex parte Wong [1981] QB 445**]. That is far from the present case when in my view the NMC is not responsible for the delay and cannot be criticised for the course so far adopted. The reason that no decision has yet been made as to whether to initiate proceedings against the registrants has been based on the volume of material to be reviewed, the time at which such material was received and the outcome of other investigations, including the police investigation, the inquests and the GMC hearing. Indeed the GMC, which has decided to pursue allegations against Dr Barton dating from the same time period, has decided to postpone their hearing until after the inquests. Certainly it cannot be suggested that there has been any deliberate delay in bringing about proceedings given the lengthy and detailed investigations that have had to take place and the scale of the investigations undertaken. The Court of Appeal has held that there should be no stay where the delay has been caused by the complexity of the case. [**A.G's Ref (No. 1 of 1990) [1992] QB 630**]

d. Where delay has amounted to an abuse of process it has been held that two key elements would need to be present:

   i. The delay must cause prejudice to the accused; and

   ii. The delay must be unjustified [**R v Derby Crown Court ex parte Brooks (1985) 80 Cr.App.R. 164**]

   That prejudice must be genuine and must cause unfairness. [**R v Bow Street Magistrates, ex parte DPP (1989) 91 Cr.App.R 283**]

e. The Court of Appeal have held that prejudice to the accused can be inferred from a delay of 15 or 16 years [**R v Telford Justices ex parte Badhan [1991] 2 QB 78**] but much will depend on the circumstances. However in some cases even a long delay will not justify a stay of proceedings. In **R v Central Criminal Court ex parte Randle and Pottle 92 Cr.App.R. 323** a delay of 20 years in bringing a prosecution was, on the exceptional facts, held not to amount to an abuse of process. In **R v Sawoniuk [2000] 2 Cr.App.R. 220** the delay was one of 56 years and the Court of Appeal said a fair trial was not impossible where the case turned on the eye witness evidence of 2 witnesses who had been cross examined and where the jury went to the location in question. Trials of historic allegations of sexual abuse going back 20 or 30 years are often tried in the courts and so the length of the delay does not of itself result in a successful argument. Where for example cases turn largely on documentary evidence (from which witnesses can refresh their memories) a delay in bringing the case has been held not to cause prejudice to the accused [**R v Buzalek [1991] Crim LR 115**].

f. As I have not seen all of the papers in this case I cannot advise specifically in each case whether the defence can show real prejudice. Much will depend on the documentary evidence available. Although it will have been 7 years before some of the present cases are dealt with by the PCC any possible inference of prejudice could be rebutted by the existence of medical notes that could aid the registrants' memories. It may also be that the registrants have made witness statements in the course of the other investigations and so would be able to refer to those. Clearly neither the inquest nor the GMC proceedings, both looking at events over the same time period, have been deterred by the possibility of an abuse of process argument. I can also say from personal experience in defending police officers at professional

tribunals that it is not infrequent for there to be some considerable delay in those hearings while criminal investigations are ongoing and indeed resulting from criminal trials first taking place. I have never been able to mount a successful abuse of process argument on the grounds of delay alone.

g. Of some concern is the fact that the nurses against whom allegations were made in 2002 were not notified of it at the time. I accept that there was no need to do so under the rules but had they been notified they could have thought about and prepared their case much closer in time to the events in issue. However whilst it is regrettable that this did not occur I am not of the view that the circumstances are sufficiently exceptional to make an abuse of process argument succeed.

h. There is one area of possible prejudice that may be argued by the defence in any abuse of process argument. The standard of proof to be applied in each case has changed since 2002 from the criminal to the civil standard. In any hearing after 3rd November 2008 it is for the NMC to prove on the balance of probabilities rather than beyond reasonable doubt that the registrant is guilty of misconduct. I am unaware of any transitional provisions to cover cases where the investigation began before that date. It may be that the registrant will seek to argue that she is prejudiced by that fact and the position would have been different if it were not for the delay. She may argue that had her case been heard earlier misconduct could only have been proved against her if the Conduct Committee were sure of her guilt. The delay, so the argument may go, has meant that now misconduct can be proved if the Committee is only of the view that her guilt is more probable than not.

i. I know not whether the change in the standard of proof for hearings before the NMC has been qualified in any way. There have been frequent changes to the law over the years which have changed the rights of those who are accused of criminal offences. For example the Criminal Procedure and Investigations Act 1996 changed the rules on disclosure and also reduced the defendant's right of silence in that adverse inferences could be drawn if he failed to answer questions in his police interview or failed to give evidence without reasonable excuse. However it was stated within the Act that this only applied to cases where the investigation began after 1st April 1997, thereby protecting the existing rights of the defendant where the investigation commenced before that date. If there is no such qualification in the amendment from the criminal to the civil standard of proof this is the area where the nurses concerned are most likely to be able to show prejudice. I have found no directly relevant authority on the point. It is not certain that such an argument would succeed but in my view the chances of an abuse argument succeeding are considerably increased by virtue of this change. It may be that the NMC would not wish as a point of principle to concede at this stage that the change in the standard of proof inevitably leads to any hearings after the 3rd November 2008 being an abuse of process where the investigation began some time before. This is a point which the NMC may wish to argue in due course.

j. Even if the exceptional course of staying the proceedings is not followed in this case the passage of time will still clearly affect the cases with which the PPC are concerned. The longer the delay between alleged misconduct and any misconduct hearing the less likely in many cases it will be for the allegations to be proved to the required standard. Over time witnesses' memories fade and it may become impossible to be precise about a piece of evidence which depends on memory alone, for example the precise words and meaning of a conversation which took place many

years before. There are already examples of witnesses dying in the intervening period (in the case of Devine) and it may be the case that allegations which could have been proved in 2002 will falter in any hearing in or after 2009. In my view the PPC should look at the evidence in each case. Where the allegation rests on memory of a specific piece of evidence alone the panel should in my view take into account the realistic chance of that allegation being proved to the required standard (that is it is more probable than not that the allegation is true) should the case be referred.

In any other case, the prospect of establishing misconduct likely to lead to removal/a case to answer in respect of impairment of fitness to practise by reason of misconduct (test to be applied to depend on whether the case is to be dealt with under the old or new rules)?

1. This is a difficult question to answer given that I have not been sent the papers in respect of any of the cases in question. I have only the schedule prepared by Miss Strickland giving only basic information about each case. There are clearly a large number of cases which do not form the subject of any complaint made to the NMC at this point in time. These are cases which currently fall into the police category 2 and those in category 3 other than the case of Mrs Devine.

2. I have advised that if there are to be any investigations into cases against nurses other than those named in cases currently before the NMC they should be dealt with under the new rules. The test will therefore be whether or not there is a case to answer in each case.

3. I have not seen any evidence or summary in relation to these cases. Clearly if the question of misconduct is to be considered there will need to be an analysis of the evidence in each case to determine the strength of the evidence and whether a case to answer exists. I am happy to further advise if those instructing wish me to look at the evidence in these cases.

[redacted] **The management of the existing allegations in light of the forthcoming inquest and GMC proceedings thereafter.**

1. In my view the cases adjourned by the PPC in September 2002 and the additional 2 complaints made in 2002 should be placed before the PPC as soon as possible. The cases were originally adjourned pending the outcome of the police investigation. That is now complete although legal proceedings are still to take place in relation to some of the cases in the form of the inquests and GMC hearing.

2. Placing the cases before the PPC will enable the panel to decide on the best course at this stage. It seems to me that the possible courses are these:

    a. The PPC could decide to further adjourn all of the cases until the conclusion of the inquests and GMC hearings. This would be the appropriate course if the panel decided that all of the cases were so closely linked that it wished to deal with all matters together once those hearings have taken place and evidence has been heard in relation to them.

b. The PPC could decide to look at the cases individually and form a view in relation to them. Miss Strickland has advised, and I agree with her reasoning, that there is insufficient evidence to proceed against nurses in relation to 3 of the cases currently before the NMC. The PPC could decide to close the cases in relation to nurses named in these 3 complaints at this stage.

c. If the second course were adopted it leaves the cases of Wilkie and Devine which are both in a different category. The PPC could decide to deal with those cases now. If the panel are of the view that these could not amount to misconduct which would lead to removal then it could close the case. Otherwise in my view it would be prudent to await the outcome of the GMC proceedings. Any possible charges are likely to relate to failure to challenge/report inappropriate prescribing. If inappropriate prescribing cannot be proved against Dr Barton in these cases there can be no NMC case. If it is proved then an important part of the NMC case can be proved.

d. It would clearly be prudent to have a lawyer attend from the NMC at the inquests and GMC hearings in order that decisions can quickly be made as to any allegations that may arise from the evidence given at these. If any case is further postponed by the PPC until the conclusion of those hearings again a decision should be quickly made as to whether the evidence given at them strengthens or weakens the case against any named nurse.

The question of a legal assessor.

It seems likely that the allegations adjourned by the PPC in 2002 and the 2 additional cases not yet placed before them will be referred to the panel in the very near future for their consideration. Given the history of these cases, their complexity when looked at against the background as a whole and the likely legal issues to arise at this early stage, I am firmly of the view that a legal assessor should be instructed by the NMC to assist the panel.

Are the PPC entitled to consider a potential abuse of process argument based on delay in considering whether to refer any case?

1. Although in my view it is not certain that any abuse of process argument would succeed in this case, the fact that it could be mounted is something which the PPC could take into account at this stage when deciding whether to refer any case to the Conduct Committee. When considering the PPC's powers in this regard it is perhaps useful to compare the position of the PPC to that of magistrates in cases that are triable either way or are indictable only where there is a suggestion that an abuse of process argument may be made.

2. That magistrates have the power to consider abuse of process arguments in cases that are triable either way and where the defendant is to be committed/sent to the Crown Court for trial is well established in case law. **[R v Telford Justices ex parte Badham [1991] 93 Cr.App.R 171, R v Horseferry Road Magistrates Court ex parte Bennett [1994] 98 Cr.App.R 114]**. Where the issue is raised at the stage at which the magistrates are contemplating the transfer of the case to the Crown Court, the magistrates should

however refuse to transfer the case on the basis of delay only in very clear cases where it is established that a fair trial could not take place. Where it is not clear the magistrates should send the case to the Crown Court and allow the judge there to consider whether any steps can be taken to enable the accused to have a fair trial. It should be remembered that a stay should be the exception rather than the norm and it is for the defence to show that they will suffer real prejudice by reason of the delay. In many hearings where the defence are disadvantaged by the delay a fair trial can take place with the tribunal of fact taking into account any problems that face the defence in this regard in their favour.

3. Even in cases where the magistrates are required to send cases to the Crown Court "forthwith" under Section 51(1) of the Crime and Disorder Act 1998, they are still entitled under certain circumstances to stay the proceedings as an abuse of process. [**R (Salubi) v Bow Street Magistrates Court [2002] 1 WLR 3073**]. However the Divisional Court also stated that complex or novel points should be left to the Crown or High Court and consideration should be paid to the fact that abuse of process applications can be made immediately after the case arrives at the Crown Court.

4. In my view the PPC is in a comparable position to that of magistrates and can therefore take account of whether a case amounts to an abuse of process when deciding whether to refer the case to the Conduct Committee. However the panel should refuse to refer for this reason only if there is a very clear case that the nurse in question could not receive a fair hearing because of the delay. Otherwise the fact that such an application may be made should form no part of their decision and the matter should be left to be raised before the Conduct Committee.

5. The course that the PPC should adopt in their deliberations is as follows:

    a. The PPC must first consider whether there is a real prospect of the allegation being proved. In undertaking this task the panel should consider the strength of the evidence and in particular whether the delay is likely to have a substantial impact on the ability to prove the allegation. For example if the allegation is of something said 10 years ago where the content of the conversation is disputed, there are no witnesses to the conversation and there is no record of it the panel could properly consider how likely it is for the Conduct Committee to be able to resolve the issue. If the panel forms the view there is a real prospect of the allegation being proved against a registrant then it must decide whether there is a real prospect the committee might decide to remove her name from the register as a result. If the answer to either question is no then the PPC should not refer the case.

    b. If the answer to both questions is yes then the PPC is entitled to consider the question of whether the delay in this case has created such prejudice that the proceedings would amount to an abuse of process. In my opinion the PPC should be slow to reach such a view for the following reasons:

        i. The fact that there may be a successful abuse argument would not in itself be a reason to refuse to refer the case.

        ii. Staying the case is the exception rather than the norm. Even where there has been considerable delay the panel (or any tribunal) should be slow to stay the proceedings.

iii. For an abuse of process argument to succeed there has to be real prejudice caused to the registrant by reason of the delay. The answer to that is likely to depend on a number of factors, for example:

- On what evidence could have been available but which is now lost;
- On whether there are documents in existence from which the registrant could refresh her memory;
- On whether the registrant has made witness statements for other hearings and has therefore a document from which she can refresh her memory;
- On whether the registrant is to give evidence in other hearings;
- On whether the change in the standard of proof for hearings after 3rd November 2008 can in fact amount to prejudice sufficient for a case to be stayed for abuse of process.

There are numerous factors which could be of relevance to this issue.

iv. The PPC is unlikely to have answers to all of these questions or to be able to make a decision as to whether or not any prejudice from which the registrant may be found to suffer is so great that it cannot be rectified by the hearing itself.

v. In addition the PPC, sitting in private, will not have had the benefit of hearing argument on both sides to assist in any decision.

vi. It is for these reasons that the PPC cannot refuse to refer on grounds that proceedings would be an abuse of process unless it is clearly established that a fair hearing cannot take place. It is only if the PPC came to the view that a fair hearing could not take place that the possible question of abuse of process should form any part of their decision at this stage. If they are not of that view then the question of a possible abuse argument is irrelevant and can be left to the Conduct Committee who will be in possession of all of the facts.

The drafting of a guidance note to assist the PPC in the steps that need to be taken in reaching the decision whether to refer any case.

I enclose a guidance note for the assistance of the PPC when considering the 5 cases put before them for their consideration.

Conclusion

1. I am of the view that any proceedings brought against the named nurses in the cases currently before the PPC and the additional 2 cases should be dealt with under the old rules. Any new allegations against these nurses arising from the inquests or other proceedings

about their conduct in the same time period at the Gosport War Memorial Hospital should also be dealt with under the old rules.

2. Any allegations which may arise against other named nurses either as a result of paperwork sent to the NMC by the police in the course of their investigation or because of evidence heard at the inquests or GMC hearings should be dealt with under the new rules.

3. Having considered the case summaries and reasoning of Miss Strickland I am in agreement that there is little prospect of proving misconduct leading to removal of the named nurses in the allegations made in the cases of Page, Carby and Middleton. This is also true of some of the allegations made against nurses in the Wilkie and Devine cases. There is a possible case of failure to challenge/report inappropriate prescribing in these 2 cases. As the case of Devine forms part of the inquests and both are the subject of the GMC inquiry into the prescribing of Dr Barton the PPC could properly decide to postpone any decision until after the conclusion of these hearings. If, however, the PPC is of the view that, even if proved, an isolated example of this behaviour on the part of a named nurse is unlikely to lead to her removal from the register it could close the cases at this stage.

4. Given the delay in this case if a case is referred to the Conduct Committee the defence are likely to argue that a named nurse cannot face a fair hearing and that the proceedings should be stayed for abuse of process. On the information I have I am not of the view that such an argument will inevitably succeed. The NMC have acted entirely properly in postponing disciplinary proceedings pending the outcome of investigations by the police and the subsequent inquests and GMC proceedings. However the level of prejudice faced by each registrant is likely to be in part dependent on the medical notes and statements available from the investigations and their value in assisting the nurses in their recollection of events and practices. The existence of such documents certainly has the potential to mitigate the effects of the delay in bringing the proceedings. Plainly any nurse who has sufficient recollection to give evidence at the inquest or GMC hearing would have difficulty arguing that the delay has materially affected her recollection of events. The registrants may be able to argue that they have suffered prejudice by reason of the change in the standard of proof for hearings which take place after 3rd November 2008.

5. The PPC are entitled to form a view as to whether an abuse of process argument is likely to succeed should the case be referred to the Conduct Committee. They should refuse to refer a case only where it clearly falls into the exceptional category of cases where the nurse is so prejudiced by reason of the delay that no fair hearing is possible.

6. A legal assessor should be appointed to assist the PPC with their task.

7. If I can be of any further assistance please do not hesitate to contact me.

9-12 Bell Yard
London WC2A 2JR

Johannah Cutts QC
9th February 2009

Clare Strickland

From: Clare Strickland
Sent: 27 January 2009 10:27
To: 'JOHANNAH CUTTS'
Subject: FW: TRIM: RE: TRIM: RE: Gosport War Memorial Hospital
TRIM Dataset: TL
TRIM Record Number: 301296
TRIM Record URI: 313962

Hello Jo, hope you are well, and that you are enjoying the new year.

I'm sorry not to have been in touch for so long, but it's been a busy time.

I have received information from the coroner that the inquest into the Gosport Hospital deaths will start on 18 March 2009. Accordingly, we need to press on with our proceedings as soon as possible, so please can you let us have your advice as soon as possible?

Regards

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

From: Clare Strickland
Sent: 17 November 2008 09:02
To: 'JOHANNAH CUTTS'
Subject: RE: TRIM: RE: Gosport War Memorial Hospital

That will be fine - thanks.

Enjoy your busy time!

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

From: JOHANNAH CUTTS [mailt Code A
Sent: 14 November 2008 13:28
To: Clare Strickland
Subject: RE: TRIM: RE: Gosport War Memorial Hospital

Hi Clare,

I have received the additional papers today although not looked at them yet. I will do my best to get the advice to you asap but am afraid that after a period of calm next week heralds the beginning of

the storm. I am at a JSB seminar tomorrow, lecturing at a JSB seminar in Warwick on Monday morning and then starting a serious child abuse trial (defending) at Maidstone on Monday afternoon. That is set down for 3 weeks. I think the best I can say is that you will have the advice by the beginning of December. Is that ok? If you need it before I will make every effort to get it to you.

Hope all well

Jo

--- On **Thu, 13/11/08, Clare Strickland** <Code A

From: Clare Strickland Code A
Subject: RE: TRIM: RE: Gosport War Memorial Hospital
To: "JOHANNAH CUTTS" Code A
Date: Thursday, 13 November, 2008, 11:50 AM

Hi Jo

I have finally managed to get everything finished and so have sent your further instructions to chambers. Please let me know if you have any questions arising from them, or if there is anything you want to discuss. We don't have a fixed timescale at this end. My best estimate is that we will have a PPC meeting scheduled early in the new year. It would be really helpful if you could let me have a time estimate for completion of your work.

All the best.

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

From: Clare Strickland
Sent: 10 October 2008 13:01
To: 'JOHANNAH CUTTS'
Subject: TRIM: RE: Gosport War Memorial Hospital

Hi Jo - sorry for not getting back to you sooner. I got all the extra information we need. We've agreed here that we will try to go back to a PPC for possible closure as soon as possible. Before that, I need to adapt my memo into a summary report for the PPC, and prepare the bundles. I have been booked solid with hearings, so haven't been able to do that at the moment, but am aiming to get it done by the end of the month. Once I have the report, I will pass it to you so that you know exactly what information the PPC will be given, and at that stage, you can prepare your advice. Sorry if the timetabling is not great now that your other case has moved, but I don't think it'll take too much of your time once you do get started.

I'll be in touch again asap.

T Code A

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team

020 7462 5861

From: JOHANNAH CUTTS [mailto:johannahcutts@btinternet.com]
Sent: 10 October 2008 11:04
To: Clare.Strickland[Code A]
Subject: Gosport War Memorial Hospital

Hi Clare,

I hope all is well with you.

I have been thinking about our case. I have had a case moved into November and have some time to concentrate upon it. I know you were going to obtain some information before I put together the advice and just wondered how that was coming along. No worries if it is not yet all to hand. I suppose I could use these sunny days to walk the dogs and have a pub lunch - such hardship!!

No seriously if we are ready I could get the advice to you by the end of next week. I am working from home and my mobile usefully doesn't work here so if you need to contact me do call on Code A

Code A

Private & Confidential
Clerks to Joanna Cutts QC
9-12 Bell Yard
London
WC2A 2JR

Code A
clare.strickland@nmc-uk.org
Code A

15 November 2008

Dear Sirs

Instructions to counsel: in the matter of the Nursing and Midwifery Council and the Gosport War Memorial Hospital

Please find enclosed further instructions for Miss Cutts QC in this matter. Please do not hesitate to contact me if you have any questions.

Yours faithfully

Clare Strickland
Senior lawyer (Hearings)

In the matter of:

Nursing and Midwifery Council (NMC)

Gosport War Memorial Hospital

FURTHER INSTRUCTIONS TO COUNSEL

Since our consultation on 8 September 2008, we have obtained the following further material:

- Information from the GMC (see Clare Strickland's filenote of telephone call to Juliet St Bernard 9.9.08, attached)
- Information from the coroner (see Clare Strickland's filenote of telephone call on 9.9.08 to Mr Bradley, HM Coroner dealing with the inquest, attached)
- UKCC Code of Professional Conduct 1992 (in force during the relevant period, attached)
- Guidance to the Preliminary Proceedings Committee (PPC) of the Nursing and Midwifery Council (prepared by Ward Hadaway, attached)

It is of particular note that the inquest will not take place until March 2009. In these circumstances, we are of the view that an earlier consideration of the matter by the PPC would be appropriate, and we will take steps to arrange this.

Accordingly, I have prepared a report to the PPC, a copy of which is attached along with the proposed bundle index. This report provides a summary of the factual background, and analysis of the allegations and material received to date.

Counsel is asked to advise whether the NMC should instruct a legal assessor to attend the PPC meeting and advise the panel.

Counsel is also asked to prepare a guidance note to the PPC, similar in terms and format to the Ward Hadaway report referred to above (which will not be put before the PPC). In particular, the following points should be dealt with:

- At paragraph 4 of the Ward Hadaway guidance note, there is reference to the criminal standard of proof. By virtue of a recent change in the law, the standard of proof to be applied at all NMC hearings from 3 November 2008 is the civil standard;
- Counsel is asked to address the issue of the passage of time in this case. Counsel should advise what regard, if any, the PPC may have to potential abuse of process arguments based on delay when making its decision at this stage.

- If counsel advises that the PPC may have regard to potential abuse of process arguments based on delay, she is asked to advise if the change to the standard of proof is a relevant factor in such arguments, and if so, what effect it will have on the likelihood of an abuse argument succeeding.

- Counsel should also address the effect of the passage of time generally on the panel's considerations at this stage.

Given that the bulk of the guidance note will be similar in terms to the Ward Hadaway guidance note, we consider that the research and drafting of this guidance note should take no more than 10 hours.

Please do not hesitate to contact Clare Strickland on Code A or clare.stricklanc Code A if there is anything you wish to discuss.

Clare Strickland

From: Clare Strickland
Sent: 10 October 2008 13:01
To: 'JOHANNAH CUTTS'
Subject: TRIM: RE: Gosport War Memorial Hospital
TRIM Dataset: TL
TRIM Record Number: 261691
TRIM Record URI: 273010

Hi Jo - sorry for not getting back to you sooner. I got all the extra information we need. We've agreed here that we will try to go back to a PPC for possible closure as soon as possible. Before that, I need to adapt my memo into a summary report for the PPC, and prepare the bundles. I have been booked solid with hearings, so haven't been able to do that at the moment, but am aiming to get it done by the end of the month. Once I have the report, I will pass it to you so that you know exactly what information the PPC will be given, and at that stage, you can prepare your advice. Sorry if the timetabling is not great now that your other case has moved, but I don't think it'll take too much of your time once you do get started.

I'll be in touch again asap.

Take care, and enjoy yourself!

Clare

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

From: JOHANNAH CUTTS [Code A]
Sent: 10 October 2008 11:
To: Clare.Strickland Code A
Subject: Gosport War Memorial Hospital

Hi Clare,

I hope all is well with you.

I have been thinking about our case. I have had a case moved into November and have some time to concentrate upon it. I know you were going to obtain some information before I put together the advice and just wondered how that was coming along. No worries if it is not yet all to hand. I suppose I could use these sunny days to walk the dogs and have a pub lunch - such hardship!!

No seriously if we are ready I could get the advice to you by the end of next week. I am working from home and my mobile usefully doesn't work here so if you need to contact me do call on 01460 30053.

Much love

Jo

Clare Strickland

From: Clare Strickland
Sent: 09 September 2008 09:32
To: 'jcutts Code A
Cc: Code A
Subject: NMC investigation - Gosport War Memorial Hospital

Dear Jo

Thank you for meeting Code A and me yesterday. I think it was very useful to have a general discussion around some of the issues.

At the end of our discussions, we agreed the following:

- I will obtain a copy of the NMC Code of Conduct that was in force between 1996 and 2000.
- I will contact the coroner's office to find out when the inquest is scheduled for, which nurse witnesses the coroner intends to call, and which, if any, are represented. I will also find out whether it is to be a jury inquest.
- I will contact the GMC to obtain further information from them about their proceedings against Dr Barton. In particular, I will ask what initiated the GMC investigation into Dr Barton, whether they are proceeding against Dr Barton under their old or new rules, and whether the criminal or civil standard will apply at their hearing. I will also ask whether, generally, they have been involved in/are aware of any case law relating to challenges to cases proceeding under old or new rules.
- The NMC will inform registrants against whom there is a live allegation (i.e. those whose cases were adjourned in 2002/those whose allegations were never put to PPC) that the NMC has received allegations against them.
- Subject to the information we receive from my enquiries, we are likely to put the live cases back to a PPC so that they can consider whether to close now, or whether to wait for the outcome of the inquest/GMC hearing. We will give further consideration as to whether the registrants will be informed about the PPC meeting and given the opportunity to make representations (1993 Rule 8). We will also consider whether the PPC could/should have a legal assessor to assist them.
- The papers we put before the PPC will include a case summary (based on my memo of April 2007) and advice from Jo. The advice will concentrate on the approach that the PPC should take in considering whether to close or adjourn the cases, what considerations they can/cannot take into account (including issues of abuse of process), advice on the test to be applied (1993 Rule 9, "may lead to removal"), and advice on drafting reasons.

With regard to the issue of old rules/new rules, we are in general agreement that existing/live complaints about named nurses must be dealt with under the old rules. Having reflected on our discussion, I fully accept Jo's point that the issue can only be determined by reference to individual nurses. My view now is that, if the PPC does not close the cases against the named nurses, and any new allegations about those nurses come to light as a result of the inquest/GMC proceedings, all matters can be dealt with together under the old rules. Any allegations against any other nurses that come to light as a result of the inquest/GMC proceedings should be dealt with under the new rules.

Jo, I will be in touch again once I have the results of my enquiries.

I hope this summary is accurate and useful - please let me know if I have missed anything, or there is anything anyone would like to add.

Regards

Clare

Clare Strickland

Code A

Nursing & Midwifery Council
23 Portland Place
London W1B 1PZ
www.nmc-uk.org

020 7580 3917 (fax)
020 7637 7181 (switchboard)

Clare Strickland

From:	Clare Strickland
Sent:	22 August 2008 13:52
To:	'rsyrett Code A
Cc:	Code A
Subject:	TRIM: Instructions to Johannah Cutts QC
Attachments:	Gosport instructions to counsel Code A 20080814.DOC; Gosport memo - Code A - 20.4.07.DOC; Gosport memo Code A 20080516.DOC
&Catalog On Send:	-1
Container URI:	35474
Delete After:	0
Show Dialog:	-1
TRIM Dataset:	TL
TRIM Record Number:	240857
TRIM Record Type URI:	7
TRIM Record URI:	251591

Dear Rachel

Thank you for your assistance in this matter. As discussed, I attach a copy of our instructions to Miss Cutts, along with two of the attachments, which will provide most of the background information.

I have arranged for a hard copy of the instructions, together with all of the attachments, to be posted to you.

Thank you for confirming that the hourly rate will be £300 per hour, and that Miss Cutts is available for a conference on 8 September 2008 at 6pm. My colleague Code A and I will be attending. Please contact our Code A if that date is not suitable for any reason.

Regards

Clare Strickland
Senior lawyer (hearings)
In-house legal team
Code A

Nursing & Midwifery Council
23 Portland Place
London W1B 1PZ
www.nmc-uk.org

020 7580 3917 (fax)
020 7637 7181 (switchboard)

Private & Confidential
Clerks to Joanna Cutts QC
9-12 Bell Yard
London
WC2A 2JR

Code A

clare.strickland Code A

22 August 2008

Nursing & Midwifery Council

Dear Sirs

Instructions to counsel

Further to my telephone conversations with Rachel Syrett, please find enclosed instructions to Miss Cutts QC.

Yours faithfully

Code A

Clare Strickland
Senior lawyer (Hearings)

IN THE MATTER OF:

NURSING AND MIDWIFERY COUNCIL ("NMC")

GOSPORT WAR MEMORIAL HOSPITAL

INSTRUCTIONS TO COUNSEL
TO PROVIDE OPINION

The NMC is the statutory body charged with maintaining a register of those entitled to practise as nurses and midwives, and taking action in respect of allegations of misconduct/impairment of fitness to practise against registrants.

In respect of all allegations received by the NMC prior to 1 August 2004, the NMC's fitness to practise procedures were governed by the Nurses, Midwives and Health Visitors Act 1997 and the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 Approval Order 1993 (SI 1993:893). Together, these are known as "the old rules".

The procedures for all allegations received on or after 1 August 2004 are governed by the Nursing and Midwifery Order 2001 (SI 2002:253) and the Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004:1761). These are known as "the new rules".

The transition from the old rules to the new rules was governed by the Nursing and Midwifery Order 2001 (Transitional Provisions) Order of Council 2004 (SI 2004:1762).

The full background to the matters upon which Counsel is asked to provide [his/her] opinion is set out in the internal memorandum of Clare Strickland, in-house lawyer, dated 20 April 2007, and the attachments thereto. We do not propose to repeat that background here.

Further information is in the internal memorandum of Clare Strickland dated 16 May 2008, and the letter from Sarah Ellson of Field Fisher Waterhouse LLP dated 26 June 2008.

Counsel is instructed by the NMC's in-house legal team to provide [his/her] opinion on the following issues:

1. Whether any issues of misconduct arising from police files concerning patient deaths where the NMC has not received a complaint about named nurses should be dealt with under the old or new rules?

2. The prospects of establishing misconduct likely to lead to removal in any case against any registrant against whom the NMC has already received an allegation (to include consideration of successfully rebutting any abuse of process argument)?

3. In any other case, the prospects of establishing misconduct likely to lead to removal/a case to answer in respect of impairment of fitness to practise by reason of misconduct (test to be applied to depend on whether case dealt with under old or new rules)?

4. The management of the existing allegations in light of the forthcoming inquest and GMC proceedings thereafter.

Please contact Clare Strickland, senior hearings lawyer, on Code A mail Code A or Code A Code A if there are any questions.

Enclosures

1. Nurses, Midwives and Health Visitors Act 1997
2. Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 Approval Order 1993
3. Nursing and Midwifery Order 2001
4. Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004
5. Nursing and Midwifery Order 2001 (Transitional Provisions) Order of Council 2004
6. NMC internal memorandum Clare Strickland 20 April 2007 and attachments
7. NMC internal memorandum Clare Strickland 16 May 2008
8. Letter from Sarah Ellson, Field Fisher Waterhouse LLP, 26 June 2008

NMC File Note

Subject: Gosport

Date: 23.4.09

Author: Clare Strickland

Systems review with Code A

Casetracker:

12053 Memorial Hospital Nurses at Gosport

Code A in

Nothing on Code A (all spelling variations checked)

PROFCON:

12010 – complainants Reeves and Page

12011 complainants Reeves and Page

12012 Code A

12013

11978 complainant Jackson – closed 27.8.02

12053 Memorial Hospital Nurses at Gosport

(All correspondence post- 24.9.02 is under this case number)

WISER:

Beed Code A — Effective registration to 2010 – no FTP flag

Hamblin Code A — Effective registration to 08/2009 – no FTP flag

Shaw Code A — Effective registration to 03/2010 – no FTP flag

Debra Barker Code A — Effective registration to 11/2009 – no FTP flag

Elizabeth Jane Bell Code A	Effective registration to 04/2010 – no FTP flag
Couchman Code A	Lapsed 08/2008
Joice Code A	Effective registration to 07/2009 – no FTP flag
Neville Code A	Effective registration to 03/2010 – no FTP flag

FITNESS TO PRACTISE DATABASE:

No records corresponding to any of the above case numbers or registrant names

GOSPORT

REVIEW OF EVIDENCE – DEVINE

NMC FILES (folder 4)

Reeves letter of complaint 6.6.02

Formal complaint against Sr Code A re: care received by mother Mrs Devine at GWMH in November 1999 (d. 21.11.99).

Refers to independent review and evidence given by nurses at it – complaints made:

- *In Sr Code A statement to independent review, stated that mother woke and dressed herself at 5.30am and was agitated, and that mother later pushed two nurses – family had never seen mother agitated, and mother was too frail to push anyone*
- *Sr Code A applied fentanyl patch one day – next day, another nurse (LB) gave 50mg chlorpromazine – fentanyl patch not removed*
- *Less than one hour later, administered morphine syringe driver 40mg morphine and 40mg midazolam – fentanyl patch not removed until 12.30pm, 3 hours after syringe driver started*
- *8.15am Code A telephoned sister-in-law to say mother confused, sister-in-law said brother coming to visit 1pm – Sr Hamblin said no need to come before then – but by 1pm, unconscious and no one could speak to her again*
- *Sr Code A made unprofessional comment (in notes?) about tension between Mrs Reeves and brother/sister-in-law*
- *Even though mother deteriorating, staff continued to bathe her and wash her hair excessively, apparently because she asked for it*
- *Incorrect statement in notes 3.11.99 that Mrs Devine could not climb stairs*
- *Sr Code A sent home clothes provided by family because they were considered "too good" for stay in hospital*
- *Relative asked to take Mrs Devine to hospital restaurant and was refused without explanation, causing upset to Mrs Devine*
- *Kidney infection diagnosed and antibiotics started, but not written up in notes*
- Code A *never explained medication, and on arrival at hospital following sudden deterioration, said she could not explain because she had just come on duty*
- *In Freda Shaw's statement to the independent review, she said she spoke to Mrs Reeves and asked if Mrs Reeves understood what was happening, and*

that Mrs Reeves said "I do and I'm going to sit with my mother" – denied by Mrs Devine

Mrs Reeves' letter of complaint makes no mention of any specific allegations against Code A

NMC letter to Mrs Reeves 2.7.02

Requesting:

- Copy of independent review
- Consent to approach GWMH for registration details/copies of investigatory notes/medical records/witness statements/other documentary evidence

NMC letter to Mrs Reeves 12.8.02

Informing her that PPC will consider on 27.8.02

NMC letter to Mrs Reeves 27.9.02

Informing her that the PPC adjourned pending CPS investigation

Fareham and Gosport NHT PCT letter to NMC 11.10.02

Letter from operational director asking for details of allegations against Code A Code A as PCT had not previously been aware of referral

NB: no response to this letter, and no chaser to Mrs Reeve, so we have never received further material from the PCT, in particular the independent review report

POLICE FILES

Volume 1 main file

Dr Wilcock's comments on the statement of Dr Barton

- Dr Barton's job description states that she was to provide 24hr medical cover – therefore her suggestion that she adopted a practise of "pro-active prescribing" (i.e. prescribing a full range of pain killers to cover times when medical attention is not available) cannot be justified as a matter of necessity – 24hr medical cover should always have been available. This prescribing practice could be seen as a way of reducing the need for GPs to visit GWMH patients out of hours.

- Dr Barton says her prescriptions were reviewed on a regular basis by the consultants, none of whom ever informed her that her prescribing was inappropriate. Dr Wilcock suggests that the consultants should be asked to comment on this.

- Dr Barton relies on the increasing workload, and her additional work as a GP, to explain her failure to keep up to date medical notes – notwithstanding this, it was her duty to keep the notes up to date.

Operation Rochester investigation overview 1998 – 2006

Contains a full summary of the police investigations

Summary of evidence – Elsie Devine

Contains a police summary of the evidence in this case

Dr Wilcock's report on Elsie Devine

Contains Dr Wilcock's report 10.12.04 and his comments on Dr Barton's statement 22.12.04

Dr Wilcock concludes that the medical care given to Mrs Devine at GWMH was suboptimal. In particular, he notes that:

- *"There is no entry in the medical notes that explains the reason for prescribing the morphine, as required, on the day of transfer, or the fentanyl transcdermal patch on the 18th November 1999. Pain had not been recorded as a problem in the notes, nor had she received any other kind of analgesic, e.g. paracetamol or codeine. Without clear and accurate information in the notes that justified the use of a fentanyl transdermal patch, it is difficult to endorse this prescribing action that results in the use of an above average dose of a strong opioid as a first line analgesic in a frail elderly patient."*

- *"Although the use of chlorpromazine could b justified, the dose of 50mg was double that recommended for a frail elderly patient by the BNF and in this regard excessive to Mrs Devine's needs."*

- *"There was no opportunity given to assess the long-term effect of this dose (of chlorpromazine); it is possible that Mrs Devine's thoughts and behaviours would have improved as the peak effects of the chlorpromazine wore off and she became less drowsy. Instead, within one hour a syringe driver was commenced with diamorphine and midazolam. The diamorphine is referred to as an "analgesic" in the medical notes but there is no indication or assessment of what pain this is referred for."*

- *Dr Wilcock sets out the reasons why prescribing drugs as a range, particularly a wide range, is generally discouraged, and states "Doctors, based upon an assessment of the clinical condition and needs of the patient usually decide on and prescribe any change in medication. It is not usual in my experience for such decisions to be left for nurses to make alone."*

(This seems to be to be a key issue – what are the misconduct implications for nurses in this position?)

- *Dr Wilcock is clear that:*

    - *Use of the fentanyl patch was not appropriate (too strong for the patient, less flexible than morphine solution in dose titration)*

    - *There was an inadequate assessment and documentation of Mrs Devine's marked deterioration*

- *If midazolam was deemed necessary, it would have been more appropriate to give small doses of by intermittent subcutaneous injection as required – to go straight to a syringe driver could only be justified if it was considered without reasonable doubt that Mrs Devine was experiencing agitated confusion as a terminal event and was actively dying*

- *In the absence of pain, shortness of breath or cough, there is no justification for use of diamorphine in a syringe driver*

Police record of interview with Dr Barton re: Elsie Devine 4.11.04

Preprepared statement (general and specific to Elsie Devine) read, then no comment to questions

In her prepared statement, Dr Barton says that she prescribed fentanyl following discussion with the team, because Mrs Devine was in obvious discomfort and refusing to take medication.

On 19.11.99, found Mrs Devine very agitated and aggressive and would not allow anyone near her to administer her normal medication – therefore decided to discontinue fentanyl and move to syringe driver. As she had already received opiates via fentanyl and been resistant, starting dose was 40mg diamorphine over 24 hours – prescribed at 9.25am with sole intention of relieving distress.

Written statements of Jane Barton

As per police interviews

Job description and offer letter 28.4.88U

Independent review panel report 10.8.01

From this record, it would appear that Mrs Reeves was particularly concerned that staff at the hospital had not contacted her directly about Mrs Devine's deterioration – she was named as next of kin, and the telephone number for Hammersmith Hospital (where Mrs Reeve was with her seriously-ill husband) was included in the paperwork. Instead, the staff called Mrs Reeve's sister-in-law – Code A says this was because Mr Devine had asked her to call him first, as his sister had enough on her plate – Code A accepts she should have documented Mr Devine's instructions. Sr Hamblin says staff sensed some tention between Mr Devine and Mrs Reeve (linked to Mr Devine's wife), and had not realised until 19.11.99 that Mrs Reeve was not being kept in the picture.

The review panel concluded that there was inadequate communication between staff and Mrs Reeve, but that the clinical response to her care was appropriate.

In addition, there are two other reports:

- Report of Bridie Castle, clinical services manager, BHB Community Healthcare Trust, giving conclusions following the independent review

- Report of Dr White, consultant physician, department of medicine for the elderly, stating that, having heard from Dr Barton, Sr Hamblin and SN Shaw, the drugs and doses given we acceptable in the clinical situation

Volume 2 witness list and statements

There are a large number of witness statements, although none from Mr Devine (who died in June 2000) or his wife. Significant statements are from:

Ann Reeves 9.6.04

In October 1999, there was tension between Mrs Reeves and her sister-in-law following a suggestion by the sister-in-law that Mrs Devine would have to go into a nursing home.

Mrs Reeves visited her mother at GWMH on 28.10.99, 11.11.99, 19.11.99 (remained in the area and visited on and off until returning to Hammersmith 21.11.99).

Limited personal observation of events

Code A v 12.6.03, 6.8.04

Gives account of events and explains note

Code A n 30.6.04, 10.9.04

States that the member of staff thrown into a bookcase by Mrs Devine on the morning of 19.11.99 was Code A

Code A njected the chlorpromazine – Code A had phoned Dr Barton at the surgery to ask for advice, and Dr Barton advised chlorpromazine

Code A "specialed" Mrs Devine on the morning of 19.11.99 i.e. stayed with her the whole time

Syringe driver started 9.25am – fentanyl patch removed – either Code A Code A t spoke to Dr Barton about starting the syringe driver – Dr Barton advised syringe driver because chlorpromazine had no effect

Code A confirms signed prescription chart stating that she had put up the syringe driver and administered the diamorphine at 9.25am on 19.11.99.

Code A confirms continuation sheet of prescription shows that she administered the fentanyl patch on 18.11.99

Dr Reid 10.9.04, 26.11.04

Consultant responsible for Mrs Devine – gives a statement explaining his notes of his contacts with Mrs Devine on 25.10.99, 1.11.99, 15.11.99

Generally supportive of the medical notes and treatment given:

- but not appropriate to prescribe oramorph PRN as no pain noted at that stage (21.10.99) – however, oramorph never administered
- small doses of diamorphine injected over 24 hours may have been more appropriate than fentanyl patch, but multiple injections may have increased distress

- 40mg diamorphine is a high starting dose – 20-30mg would be more prudent
- 50mgs chlorpromazine at upper limit of dosage range – would expect to see effect within 3 – 6 hours
- Of some concern that midazolam started before chlorpromazine may have reached maximum effect, but midazolam was being administered slowly over 24 hours – may have led to some over-sedation in first few hours of syringe driver
- No note explaining reason for high start doses of diamorphine and midazolam

Reports comment by Mrs Reeves – had she been able to deal with Dr Reid at the time she would not have had to make a complaint

Code A

Jan 96 – May 98, worked on Dryad Ward as an HCA – worked as EN from May 1998. Code A was manager (ward sister/clinical manager)

Received training on how to set up syringe driver 1999 – would be set up by two qualified nurses, only on doctor's instruction

Only recollection of Mrs Devine is coming on duty one morning (can't remember date) at 7.30am to find Mrs Devine very aggressive and presenting risk to herself and others – dragged Code A down the corridor – got Mrs Devine into a chair – she dug her nails into EN Bell's hand.

Code A

Oct 99, 3 teams on Dryad Ward

Syringe drivers used all the time – would change and maintain drivers, but only in the presence of another member of staff – received training in use of syringe drivers

Remembers one morning came on duty and Mrs Devine agitated – pulled S Code A down the corridor – got her into chair – someone gave her an injection to calm her down

Anita Tubbritt 25.10.04

Employed on Dryad Ward as senior staff nurse (worked nights)

No recollection of Mrs Devine, having examined the notes, no involvement in her care

From notes, can see s/c diamorphine given 3 times:

19.11.99 Code A (days)
20.11.99 E[redacted] (nights), witnessed by Anita Tubbritt
21.11.99 E Code A (nights), witnessed by Anita Tubbritt

Code A

Staff nurse on Dryad Ward

Remembers Mrs Devine

Early one morning, witnessed Mrs Devine pushing Code A - Mrs Devine Code A Barrett – also present were Code A – Dr Barton came to do early morning round – saw what was happening and prescribed sedative – L Code A gave the injection

Further evidence file

Statement Code A 2.2.03

General background information on use of syringe drivers

Code A

Night nurse – no recollection of Mrs Devine, confirms entries in nursing notes

Gave diamorphine/midazalom via syringe driver 20.11.99 and 21.11.99 (both times witnesses by Anita Tubbritt)

File of additional evidence

Report of Dr Black (geriatrician)

Lack of documentation causes problem in determining whether care optimal.

Drug management at GWMH sub-optimal:

- No apparent justification for PRN oramorph on admission
- No explanation for logic of fentanyl patch
- Fentanyl patch only removed 3 hrs after s/c diamorphine started
- Starting doses of diamorphone and midazolam higher than conventional guidance

However:

- Patient terminally ill
- Good palliation of symptoms

Although care sub-optimal, cannot prove it was criminal or negligent

Report of Dr Dudley (nephrologist)

Beyond all reasonable doubt, Mrs Devine was dying from amyloidosis, progressive renal failure and dementia – simple measures may have improved or stabilised her condition for a few days, but further deterioration culminating in death was inevitable.

Summary for use in report

In June 2002, Mrs Reeves wrote to the NMC to lodge a formal complaint against Code A *in*

respect of the care received by her mother Elsie Devine at GWMH between admission in October 1999 and her mother's death on 21 November 1999.

Mrs Reeves referred to an independent review carried out by the hospital following her complaint to the hospital. Code A *gave evidence at that review.*

Mrs Reeves' complaints may be summarised as follows:

- Code A *suggested that Mrs Devine was agitated on the morning of 19 November 1999, but none of the family had ever seen her agitated.*
- Code A *applied a fentanyl patch one day, and the next day, another nurse (LB) gave 50mg chlorpromazine without removing the fentanyl patch first.*
- *At 8.15am,* Code A *telephoned Mrs Reeves' sister-in-law (and not Mrs Reeves, who was named as the next of kin), to say that Mrs Devine was confused. She did not suggest that there was any urgency, but by 1pm, when Mrs Reeves' brother attended the hospital, Mrs Devine was unconscious and no one could speak to her again.*
- Code A *made an unprofessional comment about tension between Mrs Reeves and her sister-in-law.*
- *Staff bathed and washed Mrs Devine's hair excessively, apparently because she asked for it.*
- *There was an incorrect statement in the notes on 3.11.99 that Mrs Devine could not climb stairs.*
- *Sister Hamblin sent home clothes that had been provided by the family because they were considered "too good" for a hospital stay (they were dry clean only).*
- *A relative asked to take Mrs Devine to the hospital restaurant and was refused without good reason.*
- *A kidney infection was diagnosed and antibiotics started, but this was not written up in the notes.*
- *When Mrs Reeves arrived at the hospital following her mother's sudden deterioration,* Code A *did not explain the medication and said she could not explain what had happened because she had only just come on duty.*

The letter contains no specific allegations about Code A

In July 2002,the NMC wrote to Mrs Reeves requesting a copy of the independent review report, and consent to approach the GWMH for documents and evidence relating to Mrs Devine's care. The NMC wrote to Mrs Reeves again in August 2002 to inform her that her complaint would be considered by the PPC on 27 August 2002, and in September to inform her that the PPC had adjourned the case pending the outcome of the criminal investigation.

In October 2002, the Fareham and Gosport NHT PCT wrote to the NMC asking for details of the allegations against Code A *as the PCT had not previously been aware of this referral. There is no indication on the file that the NMC responded to this letter.*

The police have provided voluminous material relating to this case, as it was one of the 10 cases investigated in full. From this material, it is possible to establish the following:

Mrs Devine was born on Code A *After the death of her husband in 1979, she lived in her daughter Ann Reeves' house. From January 1999, her health deteriorated. In February 1999, it was suspected that she was suffering from myeloma, but following tests, an expert advised in May 1999 that there was insufficient evidence to support a myeloma diagnosis.*

In June 1999, Mrs Reeves' husband was diagnosed as suffering from leukaemia. In October and November 1999, he was receiving treatment, including a bone marrow transplant, at the Hammersmith Hospital. As a result, Mrs Reeves was unable to care for her mother at home.

On 9 October 1999, Mrs Devine saw her GP complaining of pain when urinating. A suspected kidney infection was diagnosed and she was admitted to Queen Alexandra Hospital for treatment. She was fit to leave by mid-October, but because of Mrs Reeves' circumstances, arrangements were made for her to be transferred to GWMH and she was admitted on 21 October 1999.

On the day of admission, she was seen by Dr Barton. The only analgesic prescribed was PRN oramorph (10mg/5ml). No reason for this was given in the notes. In fact, oramorph was never administered during Mrs Devine's admission.

On 25 October and 1 November 1999, other doctors noted that Mrs Devine was physically independent and continent but needed supervision with washing and dressing. She was confused and disorientated and wandered during the day.

On 11 November 1999, she was prescribed PRN thioridazine, an anti-psychotic. There is no corresponding entry in the notes to explain why. She was also prescribed trimethoprim for a presumed urinary tract infection, but an entry in the notes on 15 November 1999 showed that the urine specimen had not yielded any growth.

The thioridazine was first administered on 15 November 1999, when Mrs Devine was reported as being very aggressive and restless at times. It was also administered on 16 November 1999. On that day, Dr Reid the consultant asked for a referral to be made to Dr Luznat, a psychiatrist, as a result of Mrs Devine's worsening confusion, and also noted that renal function was deteriorating. Also, Mrs Devine creatine level had increased from 187 to 360micromol/L between 22 October and 16 November 1999.

She was seen on 18 November 1999 by Dr Taylor, who assessed her mental state and agreed that it had deteriorated. Mrs Devine was placed on the waiting list for Mulberry Ward as a result.

On 18 November 1999, a fentanyl patch was applied (25micrograms per hour) but there is no explanation for this in the medical or nursing notes. A prescription chart continuation sheet shows that it was prescribed by Dr Barton and administered by Gill Hamblin at 9.15am.

On 19 November 1999, there are records of a marked deterioration, and statements from nurses who came on duty that morning to the effect that Mrs Devine was agitated and physicall aggressive towards them. Code A *&* Code A *give largely consistent accounts. It is agreed tha* Code A Code A *gave an injection of 50mg chlorpromazine at Dr Barton's direction, but it is not agreed whether Dr Barton was present or gave the instruction by telephone. The chlorpromazine was given at 8.30am. Mrs Devine was then "specialed" by two of the nurses.*

There is an undated prescription by Dr Barton for 40-80mg diamorphine and 20 – 80mg midazolam, to be administered sub-cutaneously via syringe driver. On 19 November 1999, Code A *started the syringe driver with 40mg diamorphine and 40mg midazolam. Dr Barton's note reads:*

> *"Marked deterioration overnight*
> *Confused aggressive*
> *Creatinine 360*
> *Fentanyl patch commenced yesterday*
> *Today further deterioration in general condition*
> *Needs SC analgesia with midazolam*
> *Son seen and aware of condition and diagnosis*
> *Please make comfortable*
> *I am happy for nursing staff to certify death*

Gill Hamblin's nursing note for 19.11.99 reads:

> *Marked deterioration over past 24 hours. Extremely aggressive this am refusing all help from staff. Chlorpromazine 50mg given IM at 08.30 – taken 2 staff to special. Syringe driver commenced at 09.25 with diamorphine 40mg and midazolam 40mg. Fentanyl patch removed. Mr Devine – son seen by Dr Barton at 13.00 and situation explained to him. He will contact his sister Mrs Reeves and inform her of Elsie's poor condition.*

Dr Barton has been interviewed by the police and made prepared statements, then answered "no comment" to all questions asked.

The material has been examined by a number of experts, whose conclusions are as follows:

- *Dr Wilcock, palliative medicine expert:*
  - *Use of the fentanyl patch was not appropriate (too strong for the patient, less flexible than morphine solution in dose titration)*
  - *There was an inadequate assessment and documentation of Mrs Devine's marked deterioration*
  - *If midazolam was deemed necessary, it would have been more appropriate to give small doses of by intermittent subcutaneous injection as required – to go straight to a syringe driver could only be justified if it was considered without reasonable doubt that Mrs Devine was experiencing agitated confusion as a terminal event and was actively dying*

- *In the absence of pain, shortness of breath or cough, there is no justification for use of diamorphine in a syringe driver*

- *Dr Black, geriatrician*
  - *No apparent justification for PRN oramorph on admission*
  - *No explanation for use of fentanyl patch*
  - *Fentanyl patch only removed 3 hrs after s/c diamorphine started*
  - *Starting doses of diamorphone and midazolam higher than conventional guidance*
  - *However, the patient was terminally ill and the drugs given provided good palliation of symptoms*

- *Dr Dudley, nephrologists*
  - *Beyond all reasonable doubt, Mrs Devine was dying from amyloidosis, progressive renal failure and dementia*
  - *Simple measures may have improved or stabilised her condition for a few days, but further deterioration culminating in death was inevitable*

The police files also contain a copy of the independent review panel report dated 10 August 2001, which concluded that there was inadequate communication between the hospital staff and Mrs Reeves. Code A gave evidence that Mrs Reeves' brother, Mr Devine, gave instructions that Mrs Reeves should not be troubled because she was at the hospital in London with her husband, who was very ill. Sister Code A accepted that this should have been documented, and that greater care should have been taken to ensure that Mrs Reeves was kept informed. The panel concluded that Mrs Devine's medical management was appropriate.

Dr Reid, the consultant responsible for Mrs Devine's care, has made a police statement. Generally, he is supportive of the medical notes and treatment given, but has some reservations:

- *In his view, it was not appropriate to prescribe oramorph PRN on admission, as no pain had been noted at that stage. However, oramorph was never administered;*
- *Ssmall doses of diamorphine injected over 24 hours may have been more appropriate than the fentanyl patch, but this would have involved multiple injections, which may have increased distress;*
- *40mg diamorphine in the syringe driver was a high starting dose. 20-30mg would have been more prudent;*
- *50mg chlorpromazine is at the upper limit of dosage range. He would expect to see the effect within 3 – 6 hours. Therefore it is of some concern that midazolam was started before the chlorpromazine may have reached maximum effect. However, the midazolam was being administered slowly over 24 hours.*

- *It is undesirable that there is no note explaining the reason for high start doses of diamorphine and midazolam*

Dr Reid also states that he established a good rapport with Mrs Reeves while she was pursuing her complaints with the hospital, and reports that she told him tbag had she been able to deal him at the time of her mother's illness and death, she would never have made a complaint.

It should be noted that there are no police statements from Mrs Reeves' brother, Mr Devine, as sadly, he has died. It is clear from Mrs Reeves' statement to the police that she had argued with her sister-in-law about Mrs Devine's care, and as a result there was tension between some of the family members.

Devine – conclusions

In my view, there is no realistic prospect of proving that any of the nurses was guilty of misconduct in the way in which they communicated with Mrs Reeves about what was happening. Given Mrs Reeves' difficult personal circumstances, and the nurses' account that her brother had instructed that she should not be troubled, a panel is likely to conclude that it was not misconduct for them to communicate with Mrs Reeves' brother and sister-in-law. Any attempt to pursue an allegation of this sort would be bound to fail because Mr Devine is dead and could not give evidence, and prior to his death, he never made any statement contradicting what the nurses say about his instruction.

In my view, Code A *s comment at the independent review about tension between Mrs Reeves and her sister-in-law does not amount to misconduct. Sister* Code A *s comment was made when she was giving evidence (not in patient notes) and was fair and accurate.*

Further, I do not consider that Sister Hamblin's refusal to accept the clothes originally sent for Mrs Devine to be misconduct. They were dry-clean only, and in my view it was reasonable for Sister Code A *to ask for more appropriate clothing.*

In my view, there could be grounds for criticising the nurse [redacted] who gave the chlorpromazine without removing the fentanyl patch (it was not removed until 3 hours later). However, Ms Barrett is not the subject of a complaint from Mrs Reeves. Further, a panel may conclude that there is no realistic prospect of this amounting to misconduct likely to lead to removal.

I do not consider that Mrs Reeves' account of Staff Nurse Code A *comments is capable of supporting a charge of misconduct that is likely to lead to removal. Her account is disputed and in my view there is little prospect of it being proved beyond reasonable doubt, and even if it was, a panel is unlikely to find misconduct in all the circumstances.*

The other complaints made by Mrs Reeves are non-specific and do not amount to allegations of misconduct against named nurses that are likely to lead to removal.

Therefore, the only potential allegation that could be pursued is the general allegation of failure to challenge inappropriate prescribing. Among the experts (including Dr Reid, Mrs Devine's consultant), there seems to be general agreement that there were defects in Dr Barton's prescribing.

Accordingly, this case raises similar issues to those outlined in relation to Wilkie (see above).

GOSPORT

REVIEW OF EVIDENCE – MIDDLETON

NMC FILES (folder 4)

Bulbeck letter of complaint 19.6.02

Complaint re: care received at GWMH 29.5.01 – 16.8.01

Suffered stroke 10.5.01 – stablized at Haslar Hospital and transferred to GWMH for rehabilitation

On one visit, found mother sitting up with meal and call bell too far away for her to reach and no cutlery

Given too much fluid despite being on a drip and having a catheter, and as a result, suffered congestive cardiac failure 4.7.01

Transferred back to Haslar for PEG to be installed

On one visit, found mother sitting in chair with sick bowl in front of her, another full bowl by her, choking, covered in sweat, unable to call for help because bell out of reach – called nurse, who called doctor and carried out x-ray showing blocked bowel

Made to wait 45 minutes for a bed pain

When Mrs Middleton told a nurse she was worried about smelling because of catheter, the nurse said "don't worry all old ladies smell"

Often found mother in bare feet/legs without blankets

Worried about drugs given as she behaved very strangely some days

Some nurses uncaring and had unprofessional attitude to patients

Some nurses failed to carry out doctors' orders

NMC letter to PCT 3.7.02

Enclosing Mrs Bulbeck's letter of complaint

Bulbeck letter 12.8.02

Complainant confirmed that she cannot name individual nurses responsible for the matters complained of

Bulbeck letter 2.9.02

Names Code A as responsible for appalling care in light of his role as clinical manager

PCT letter 14.10.02

Carried out investigation into Mrs Bulbeck's complaint – enclosed investigation report and letter to Mrs Bulbeck – no individual nurses named, some general deficiencies identified

POLICE FILES

Officer's report 9.1.03 (police review file 4)

Interview with Mrs Middleton – account consistent with letter of complaint to NMC

Expert conclusions

Ferner	A1 - optimal care given, death by natural causes
Lawson	A1 - doses of analgesia appropriate, died of natural causes
Naysmith	A1 – abdominal pain, aspiration pneumonia and very frail (on continuous oxygen) started on oral diamorphine PRN, then moved to continuous syringe driver when pain more severe – very reasonable treatment. Breakthrough pain, so diamorphine dose increased, also midazolam because agitated and distressed

(NB Irene Waters' notes incomplete)

Summary for report

In June 2002, Mrs Bulbeck wrote to the NMC to complain about the general level of care her mother Mrs Middleton received at the Gosport War Memorial Hospital from initial admission on 29 May 2001 to August 2001, when she was transferred to another hospital shortly before her death.

Mrs Bulbeck gave a number of examples of her concerns:

- *On one visit, she found her mother sitting up with her meal and call bell too far away for her to reach and no cutlery;*
- *Her mother had a "fluid overload" despite being on a drip and having a catheter, and as a result of this, suffered congestive cardiac failure on 4 July 2001;*
- *On another visit, she arrived to find her mother sitting in chair with a bowl in front of her and another bowl full of vomit by her. Her mother was being sick and choking. She was covered in sweat, and was unable to call for help because bell out of reach. Mrs Bulbeck called a nurse, who in turn called doctor. The doctor carried out an x-ray showing blocked bowel;*
- *Mrs Middleton had to wait 45 minutes for a bedpan;*
- *When Mrs Middleton told a nurse that she was worried about smelling because of catheter, the nurse said "don't worry all old ladies smell";*

- *Mrs Bulbeck often found her mother sitting up in a chair, with bare feet/legs and no blankets;*

- *Mrs Bulbeck was worried about the drugs her mother was given because she "behaved very strangely some days";*

- *Some of the nurses were uncaring and had an unprofessional attitude to the patients;*

- *Some of the nurses failed to carry out doctors' orders.*

Mrs Bulbeck was asked if she could provide further detail, but confirmed that she was unable to name individual nurses. She could only name Code A *the clinical manager, as having responsibility for her mother's care.*

The NMC forwarded a copy of Mrs Bulbeck's letter of complaint to the Fareham and Gosport NHS PCT. The PCT commissioned an investigation and provided the NMC with a copy of the investigation report, and its letter to Mrs Bulbeck. Some generic issues were identified, but none of these were attributed to named nurses.

As part of the second police investigation, this case was reviewed by the panel of experts. Their conclusions were as follows:

- *Irene Waters (Nurse)*

  No opinion expressed about the quality of nursing care (although her notes are incomplete).

- *Robin Ferner (pharmacologist)*

  Mrs Middleton received optimal care and died from natural causes.

- *Peter Lawson (geriatrician)*

  Mrs Middleton was given appropriate doses of analgesia and died from natural causes.

- *Anne Naysmith (palliative care expert)*

  Mrs Naysmith had abdominal pain and aspiration pneumonia, and was very frail (on continuous oxygen). She was started on oral diamorphine PRN, then moved to continuous administration via a syringe driver when the pain became more severe. This was very reasonable treatment. Mrs Middleton had breakthrough pain, so the dose of diamorphine was increased. She was also prescribed midazolam because she became agitated and distressed.

Middleton – conclusions

Given the expert conclusions, it is clear that there is no prospect of establishing a case based on failure to challenge inappropriate prescribed.

Mrs Bulbeck has made allegations about specific incidents, but is unable to name the nurses involved and has not provided any dates. Accordingly, there is no prospect of proving allegations relating to any particular incident against any named nurse.

The only nurse she has named is Code A *, on the basis that he was responsible for poor care because he was the clinical manager. To establish this, we would have to prove poor care, in addition to proving that* Code A *was manager, was culpable. Given the material we have received to date, and the passage of time, the PPC may take the view that there is no realistic prospect of proving this.*

GOSPORT

REVIEW OF EVIDENCE – WILKIE

NMC FILES

Ford report NMC file 1

Conclusions:

- No diagnosis made to explain reported deterioration around 15.8.98;
- No clear evidence of pain
- No explanation in nursing or medical notes as to why commenced on diamorphine and hyoscine – other oral analgesics could have been tried first
- Undated prescription for variable doses of diamorphine, hyoscine and midazolam was poor practice and potentially hazardous
- Inadequate medical and nursing and records
- Drugs administered may have hastened death, but she may have died at that time anyway

Letter of complaint from M Jackson (pp E Yeats) 1.6.02 NMC file 2

Mother transferred from QAH to GWMH for rehabilitation. After transfer to GWMH, mother appeared increasingly sleepy, weak, and unwell – could not stand unaided. Called into Code A office a few days after transfer and told that she was dying and nothing could be done to help her. Told PB did not want mother to suffer.

PB recorded in medical notes that I had agreed to syringe driver and active treatment not appropriate – this is false.

Note in records to say mother dying comes from Code A – no corresponding note from medical staff.

20.8.98 – mother appeared to be in pain. Told nursing staff, who were dismissive. Asked twice for help and waiting 1 hour for Code A

PB did not examine or carry out pain assessment – said would arrange pain relief that would make her sleepy.

Left hospital 13.55 – nothing had been done to alleviate discomfort.

Nursing notes falsely record syringe driver started 13.50.

Daughter attended - PB said "your mother seems to think that your grandmother is in pain"

Returned to hospital 8pm – mother on diamorphine and unconscious.

Why was mother placed on syringe driver with diamorphine when only that afternoon, nursing staff were unaware she was in pain?

Why was diamorphine given in 30mg doses, not 5 – 10 mgs.

Why was no other pain relief tried before diamorphine?

Why was no pain assessment carried out?

Late pm 21.8.9, persuaded to go home by nursing staff who said they'd call if any change. Returned short while later – PB said she had just died. Obvious she had died earlier.

Records falsely state daughter and granddaughter present at death.

Medical records contain mix-ups:

- *Note states mother given oramorph, then crossed out (mix up with notes of Gladys Richards)*
- *Time of death on file given as 18.30 and 21.20 (time Gladys Richards died) (Nurse Sylvia Roberts wrote the notes)*
- *Notes lacking in detail re: fluid intake/urinary output*
- *21.8.98, blood in catheter bag (witnesses by daughter and granddaughter) not noted*

Acknowledgement letter 12.8.02 NMC file 2

Letter from [Code A] to Mrs Jackson ref: PRE/19/[Code A]11978 – case to go to PPC 27.8.02

Contact fax 13.9.02 NMC file 3

Fax from Mrs Jackson to say all correspondence should be addressed to Emily Yeats

Update letters 27.9.02 NMC file 4

Letter from [Code A] to Mrs Jackson ref: PRE/DEC/20/[Code A]12053 and Emily Yeats ref: PRE/DEC/20/[Code A]12053 to inform of PPC's decision to adjourn pending outcome of CPS investigations

Records NMC file 4

Nursing notes 6.8.98 – 21.8.98

17.8.98 am – condition has generally deteriorated over the weekend. 7.45pm Daughter seen – aware that mum's condition is worsening, agrees active treatment not appropriate, & to use of syringe driver if Mrs Wilkie is in pain – signed [Code A]

21.8.98 12.55 Condition deteriorating during morning. Daughter and granddaughter's visited + stayed. Patient comfortable and pain free – signed [Code A]

21.8.98 18.30 Death confirmed at 18.30 family present – signature illegible

Medical notes 4.8.98 – 21.8.98

10.8.98 assessment note by Dr Lord

21.8.98 Marked deterioration over last few days. SC analgesia commenced yesterday family aware and happy – signed by Dr Barton

21.8.98 18.30 – pulse and breathing ?? no heart sounds pupils fixed death confirmed family present for cremation – signed by Code A *C Nurse*

Prescription record 31.7.98 – Undated (21.8.98)

Fluoextine, co-danthramer, zopiclone, lactulose, promazine, augmentin charts for 31.7.98 – 19.8.98

Undated prescription s/c diamorphine 20 – 200mg, hyoscine 200 – 800mg, midazolam 20 – 80mg Dr Barton

Administrations: 20.8.98 13.50 30mg diamorphine, 20mg midazolam (initialled), 21.8.98 30mg diamorphine, 20mg midazolam (initialled)

POLICE FILES

Officer's report 29.4.04 police file review file 2

Visit to Marilyn Jackson (d), Emily Yeats (gd) and Lisa Payne (gd).

Family have compared their notes, as provided to them by LHA, with notes held by police. Noted police records had a page missing between p88 and 89 (clinical records end 2.8.98) (*cf notes on NMC file, we have clinical notes 4.8.98 – 21.8.98).*

Admitted to GWMH for 4/6 week assessment of condition and rehabilitation - mobile and able to feed self – by weekend, like "an empty shell", had to be moved by hoist, bed bound.

17.8.98 – tel call from hospital asking her to come in – spoke to PB – Mrs Jackson concerned as did not want mother to suffer any pain.

20.8.98 – mother sleepy and appeared to be in discomfort – mother said she was in pain – approached Code A and asked her to check on mother.

Waited an hour and no nurse came

Went and fetched PB – he said "we'll give your mum something for the pain but it will make her sleepy"

Left hospital 2pm – rang daughter and asked her to go to hospital and check

Lisa Payne went to hospital – asked about grandmother and was told "your mother seems to think she's in pain" – grandmother sleeping peacefully

20.00, Mrs Jackson went to hospital – mother unconscious – stayed overnight – night staff very nice, arranged bed

21.8.98 am – mother's catheter bag full of blood

Tea time – PB told Mrs J to get some rest – assured her he'd notify of change in condition – family left and returned 18.30 – PB said "she's heard your voice she's just gone"

Mrs Wilkie looked yellow and waxy – not as if she had just died

Concerns:

- *Speed with which went from being well/walking to comatose*
- *No one spoke to family re: pain relief*
- *Not aware syringe driver in use*
- *No warning or communication about severity of condition*
- *Query time diamorphine given*
- *P88 Dr Lord wrote DNR – family not consulted*
- *Dispute PB's entry 17.8.98*
- *P140 13.8.98 – error in record, refers to medication error (Gladys Richards)*
- *19.8.98 entry re: death (Gladys Richards)*
- *No fluid input/output charts*
- *Cause of death pneumonia – never informed about this*
- *Not seen by doctor 10.8.98 – 21.8.98*
- *17.8.98 – who decided active treatment not appropriate?*
- *20.8.98 – who checked for pain?*

Expert conclusions

Ferner:	Unclear cause of death/treatment sub-optimal or negligent – high dose of diamorphine from start
Lawson:	No grading – believes missing drug chart/notes – insufficient detail in notes available
Naysmith:	Unclear cause of death/sub-optimal treatment – missing medical records for final admission and a second drug chart - late stage dementia, became v dependant following UTI requiring IV antibiotics – may have died of dementia in GWMH whatever management – only relevant drug chart seen for 20/21.8.98 – nursing notes suggest syringe driver may have been initiated 17.8.98, when permission given, but no other evidence of this – no evidence to judge whether deterioration alluded to 17.8.98 due to medical problems or secondary to opioid treatment – sub-optimal based on inadequacy of medical notes – high starting dose of diamorphine

Summary for report

Evidence in the case of Wilkie

On 1 June 2002, Mrs Wilkie's daughter Mrs Jackson wrote to the NMC to complain about the care given to her mother prior to her mother's death in August 1998. She made a number of general points, but I have summarised below those could perhaps be attributed to individual named nurses.

She noted that her mother was transferred from Queen Alexandra Hospital to GWMH for rehabilitation – on admission, she could walk and feed herself with assistance. After transfer, her mother appeared increasingly sleepy, weak and unwell, and could not stand unaided. After a few days, she received a call telling her to go to the hospital and spoke to Philip Bede in the office. He told her that her mother was dying

and nothing could be done for her. Mrs Jackson told Mr Bede that she did not want her mother to suffer.

On 20.8.98, Mrs Jackson considered that her mother was in pain, and told nursing staff, who were dismissive. She had to ask for help twice, and wait one hour, until Code A *attended and said that he would arrange pain relief which would make Mrs Wilkie sleepy. When Mrs Jackson left the hospital at 13.55, nothing had been done to alleviate her mother's discomfort. When Mrs Jackson returned to visit at 20.00, her mother was unconscious.*

On 21.8.98, Mrs Wilkie's catheter bag contained blood. Late in the afternoon of 21.8.98, the nursing staff persuaded Mrs Jackson to go and take some rest. She only agreed when they assured her that they would call her if anything happened. When she returned to the ward at 18.30, Code A *said that Mrs Wilkie has just died, and had heard their voices before she went. From her mother's appearance, Mrs Jackson believes that her mother had not only just died.*

Having reviewed her mother's records, Mrs Wilkie has the following complaints:

- *On 17.8.98,* Code A *made an entry in the nursing notes "Condition has generally deteriorated over the weekend Daughter seen – aware that mums condition is worsening, agrees active treatment not appropriate and to use of syringe driver if Mrs Wilkie is in pain". Mrs Jackson denies that her conversation with* Code A *was as recorded. She states that she did not agree that active treatment was not appropriate, and that there was no discussion about a syringe driver. She maintains that she was never told about the syringe driver.*

- *Nobody carried out a pain assessment a) when Mrs Jackson complained about her mother's pain on 17.8.98 or b) before starting the s/c diamorpine on 20.8.98.*

- *The drug administration record states that the syringe driver was started at 13.50. Mrs Jackson maintains that she did not leave the hospital until 13.55, and the syringe driver had not been started when she left.*

- *The nursing records falsely state that Mrs Wilkie's family were with her when she died.*

- *There are errors in the nursing records. On a nursing care plan there are two incorrect entries:*

    - *13.8.98, entry scored through, reads "oramorph 10mgs given at 21.00 as distressed. Settled and slept. Written in error as outside Gladys Richards room!"*

    - *21.8.98 "condition remained poorly pronounced dead @ 21.20 hrs by S/N Sylvia Roberts ?? ?? relatives (2 daughters) present". Elsewhere in the nursing notes, it is recorded that Mrs Wilkie died at 18.30, which is around the time when Mrs Jackson returned to the ward.*

  These entries are initially/signed, but I cannot identify the authors.

- *There is no mention in the notes about the blood in the catheter bag on 21.8.98.*

- *Why was her mother given diamorphine, and why was she started on such a high dose? The prescription chart, written by Dr Barton, was undated. She prescribed as a regular daily review (not PRN) diamorphine 20-200mg/24hr, hyoscine 200-800mg/24hr and midazolam 20-80mg/24hr, all to be administered subcutaneously.*

This case has been reviewed by a number of experts instructed by the police. The first of these was Professor Ford, who reported in December 2001. His conclusions were:

- *The initial assessment and plan as noted by Dr Lord on 10.8.98 was reasonable.*

- *No diagnosis was made to explain the deterioration Mrs Wilkie is reported to have experienced around 15.8.98, and there was no recorded medical assessment.*

- *There is no clear evidence of pain or explanation of why Mrs Wilkie was started on the syringe driver.*

- *Oral analgesics could and should have been tried before starting the syringe driver.*

- *The undated prescription was poor practice and potentially very hazardous, as Mrs Wilkie was a frail elderly underweight patient with dementia.*

- *The medical and nursing records are inadequate.*

- *The use of the syringe driver may have hastened death, but Mrs Wilkie was a frail dependant lady with dementia who was at high risk of developing pneumonia even if she had not been administered sedative and opiate drugs.*

As part of the second police investigation, this case was reviewed by the panel of experts. Their conclusions were:

- *Irene Waters (nurse)*

  No opinion expressed about the quality of nursing care.

- *Robin Ferner (pharmacologist)*

  Noted that there was a high dose of diamorphine from the outset. Concluded that treatment was sub-optimal or negligent, but unclear as to cause of death.

- *Peter Lawson (geriatrician)*

  Unable to assess cause of death and standard of care as medical notes and a section of the drug chart were not available from the police.

- *Anne Naysmith (palliative care expert)*

Noted that medical notes and a second drug chart appeared to be missing from the material provided by the police, but concluded that the cause of death was unclear and treatment sub-optimal. This conclusion was based on the inadequacy of the medical notes. The patient was in late-stage dementia and had become very dependent following a UTI requiring IV antibiotics. She may have died of dementia in GWMH whatever management had taken place.

Wilkie – conclusion

In my view, there is at least one potential allegation of misconduct that could be put to Code A *and it relates to his disputed note on 17.8.98. Mrs Jackson accepts that there was a conversation about her mother's pain, but denies that she agreed active treatment was inappropriate or that a syringe driver should be used. Accordingly, she alleges that M* Code A *falsified the note of their conversation.*

There are clear evidential issues with this allegation:

- *It would appear that the only people present during the conversation were Mrs Jackson and* Code A
- *Mrs Jackson accepts that she was concerned that her mother should not suffer pain;*
- *The passage of time will make it difficult to prove to the required standard exactly what was said during a conversation almost 10 years ago.*

Of the other possible allegations, my views are as follows:

- *The failure to carry out a pain assessment on 17.8.98 is difficult to attribute to a named nurse, but could potentially form the basis of an allegation against Mr Bede, as he was the person who eventually dealt with Mrs Jackson's concerns;*
- *I do not consider that Mrs Jackson's allegation about the start time of the syringe driver on 20.8.98 is capable of proof or that, if proved, would be likely to lead to the removal of the nurse responsible. The most that could be proved would be a 5-10 minutes discrepancy between the time Mrs Jackson says she left the ward and the time the syringe driver is recorded as starting;*
- *Whilst it may be possible to prove that the notes incorrectly record the time of death, and that the family was present at death, and the PPC may consider that this is unlikely to lead to removal;*
- *It would be possible to prove that the notes contain an incorrect entry dated 13.8.98 that was then scored through and corrected, but the PPC may consider that this is unlikely to lead to removal;*
- *We could prove that there was no entry in the notes on 21.8.98 that the patient's catheter bag contained blood. However, we would then have to prove that a the catheter bag did contain blood, that an individual named nurse did or should have noticed this, and that the individual named nurse failed to record this in the notes. In my view, this is not possible;*

- *Finally, there is the wider concern about the alleged poor prescribing, the administration of high starting doses, and the failure of the nurse(s) to challenge. Potential evidential issues relating to these concerns are as follows:*

    - *The identity of the nurse who started the syringe driver is not clear, but his/her initials appear on the prescription records and so it is possible that he/she could be identified.*

    - *We could seek an independent expert to review the material we have and give an opinion on the prescription and whether a nurse should have challenged it/administered medication on the strength of it as per the prescription record. However, I note that two of the experts instructed by the police comment on the apparent absence of a drug chart and the inadequacy of the records. This may make it very difficult for us to prove a positive case.*

    - *We are not in a position to make an allegation of inadequate record keeping against any named nurse(s), as we have no information about who was responsible for the records, who was on duty, etc.*

    - *One possible course would be to liaise with the GMC and establish whether they are looking into this patient and proposing to take action in respect of the prescription. If they are, we may wish to wait until GMC action is concluded, and then follow their findings. However, there has already been a substantial passage of time since the incident. Alternatively, we may ask the GMC if we can adopt or share any evidence they obtain during the course of any investigation.*

NMC File Note

Subject: Gosport

Date: 19.3.07

Reference: Code A

Review of final set of material provided by police. Prepared table of cases. Each file contains a number of statements from nurses involved in the care of the patient. The only files where family members expressed criticisms of named nurses were as follows:

- Cunningham – the family suggest that Code A was part of a conspiracy to practice euthanasia
- Devine – there are particular mentions of Code A and another nurse from another hospital

Checked original 80 police cases for references to named nurses. The only expressions of dissatisfaction with named nurses were as follows:

- Carby – police memo notes that the family commented on Code A They did not like her manner and formed the impression that she did not like their father who was a "big man".
- Queree – police memo notes that Mrs Queree's daughter found Sheila Rogers "particularly unpleasant" and nicknamed her "Jackboot Annie", as Ms Rogers said that visitors were not allowed before 2pm.
- Wilkie – the police memo records that on 20.8.98, the family asked Code A to check on Mrs Wilkie as they believed she was in pain, but Code A did not come so they spoke to Code A On 21.8.98, Code A sent them to get rest and promised he'd call them if anything happened. When they arrived back on the ward, he told them Mrs Wilkie had just died. However, the family thought she looked "yellow and waxy", and that she had not only just died.
- Richards (this case was closed by the PPC) – Code A is criticised in family member statements for not recognising that Mrs Richards was lying awkwardly following a fall.
- Middleton – the police memo records that Mrs Middleton had concerns that patient food and drink was being left out of reach, and that she raised this with the ward managers Code A and Pat Wilkins.

Next tasks are as follows:

- Prepare summaries of evidence in outstanding old rules cases, i.e.
    - Wilkie
    - Devine
    - Middleton
- Prepare a full report on work done to date and next steps

Code A

Code A

Code A

Code A

Code A

Code A

FILE

PATIENT	ADMISSION	DEATH/DISCHARGE	NAMED NURSES	NAMED DOCTORS	EXPERT'S CONCLUSION	NMC COMPLAINT?
1 Abbatt	29.5.90	30.5.90	S/N Bro? (IW)	Dr A? (IW)	B2/A2/B2	No
2 Amey	14.11.90	20.12.90	None	None	A2/B/B2	No
3 Batty	Sep-90	2.1.94	None	Dr Barton, Dr Lord, Dr Beasley (IW)	B2/B2/C2	No
4 Brickwood	3.2.98	12.6.98	S/N Giffin (IW) Code A (family)	None	B2/B2/A2	No
5 Chivers	11.5.99	20.6.99	S/N F? and Nurse B?	Dr Reid (IW) Dr Brooks, Dr Barton & Dr Briggs (RF) Dr Barton (family)	A2/B2/B2	No
6 Dicks	28.12.98	22.3.99	SN Basher (IW)	Dr Barton, Dr Lord (IW) Dr Barton (family)	B2/A2/A2	No
7 Hall	5.7.93	6.8.93	Sister Jones (IW)	Dr Walters, Dr Lord (IW)	A2/B3/A2	No
8 Lee	14.4.98	27.5.98	SR Code A and S/N	Dr Barton (IW) Dr Barton (family)	None/B2/B3	No
9 Carby	26.4.99	27.4.99	S/N Joyce and S/N N S F (Code A	Dr Barton (IW) Dr Barton and Dr Lord (family)	A2/A2/A2	Yes
10 [illegible]						No
11 Hadley	5.10.99	10.10.99	S/N Pe? (IW)	Dr Pennells, Dr Shenton, Dr Yeo, Dr Chilvers (IW) Dr Bee Wee (RF)	A2/B2/A2	No
12 Hobday	24.7.98	11.9.98	S/N Roberts (IW)	Dr Barton and Dr Lord (IW)	A2/A2/A2	No
13 Page	27.2.98	3.3.98	S/N Dorrington (IW)	Dr Lord (family)	A2/A2/A2	Yes
14 Parr	31.12.98	29.1.99	Code A	Dr Barton (family)	A1/A2/A2	No

15	Code A	11.11.98	3.12.98	'Massive' nurse (family)	Dr Reid and Dr Lord (IW)	A2/A2/B2	No
16	Queree	29.7.94	10.10.94	Sister Jones (IW) Sheila Rogers (family)	Dr Bealey and Dr Brand (IW) Dr Barton (family)	A2/A2/A2	No
17	Reeve	11.11.96	14.4.97	S/N Bre?, SSN Ray, S/N Markham (IW) Nurse Ashridge (family)	Dr Barton, Dr Gibb, Dr Viewer (IW) Dr Barton (family)	A2/A2/B1	No
18	Ripley	?	? (still alive)			A2	No
19	Taylor	3.10.96	20.10.96	SSN Tubbritt and S/N Nelson	Dr Barton and Dr Lord (IW)	B2/A2/B2	No

HLG 2

	PATIENT	ADMISSION	DEATH/DISCHARGE	NAMED NURSES	NAMED DOCTORS	EXPERT'S CONCLUSION	NMC COMPLAINT?
20	E Aubrey	12.6.95	15.6.96	S/N Treadore & S/N Tubb? (IW)	Dr Barton & Dr Lord (AN & family)	B1/B1 or B2/C3	No
21	H Aubrey	1.6.99	2.6.99	None	Dr Barton & Dr Lord (family)/Dr Bee Wee (PL)	B3/B3/B3	No
						3	No
23	Ramsey	1.6.01	27.11.01 (alive)	None	None	A1/A2 or A1/A2	No
24	Rogers	30.1.97	4.2.97	RGN Dorrington (IW)	Dr Barton (family)/Dr Barton (IW)/Dr Lord (AN)	A1/A2/A1	No
25	Tiller	4.12.95	13.12.95	Code A (family)	Dr Barton (IW)	A2/B2/A2	No
26	Wilkie	6.8.98	21.8.98	Code A (family)	Dr Barton/Dr Lord (family) Dr Peters (IW)	B2 or B3/no grade/B2	Yes
27	Corke	22.7.99	14.8.99	None	Dr Beale (IW)	No grade/A1 or no grade/A2	No
2				Code A	Dr Banks/Dr Munroe/Dr Page (IW)/Dr Barton	2/A1/A1	No
29	Stanford	23.11.93	27.11.93	Sister Goldsmith (IW)	Dr Barton (family)/Dr Barton (IW)	B2/B2 or B3/A2	No
30	Willis	9.4.97	16.2.99	S/N Marjoram (IW)	Dr Barton (family)/Dr Lord & Dr Barton (IW)	B2/A2/A2	No
31	Burt	10.2.99	22.3.99	Hallman (IW)	None	B1/A1 or A2/A2	No
32	Miller	31.3.99	8.4.99	None (AN criticises nursing re: lack of clarity over co-codamol)	Dr Barton (family)	B2/A2/A2	No
33	Leek	6.8.98	18.12.98	None	Dr Barton (family)/Dr Barton & Dr Lord (IW)	B2/B2/A1	No
34	Skeens	20.10.95	29.10.95	Marden (IW)	Dr Lord & Dr Barton (IW)	B2/A2/A2	No
35	Marshall	29.12.95	7.1.96		Dr Barton (family)/Dr Knapman & Dr Barton (IW)	B2/B2/A2	No
36	Brown	Continuing	8.10.97	Sister Code A & S/N Code A (IW)	Dr Barton (IW)	B3/B2/A2	No
37	Dumbleton	25.5.93	12.6.93	None	Dr Barton (family)/Dr Barton & Dr Lord (IW)	No grade/A3/A1	No
38	Harrington	8.6.93	21.7.93	S/N Joines (IW)	Dr Barton & Dr Lord (IW)	B2/A2/A1	No
39	Clements	6.2.95	12.2.95	S/N Tubbritt (IW)	Dr Barton & Dr Tandy (IW)	B2/B2/A2	No
40	Smith	30.3.99	6.4.99	None	None	No grade/A1/A1	No
41	Donaghue	16.5.91	3.8.91	Sister Goldsmith, S/N Gore, S/N Brooke (IW)	Dr Shawcross, Dr Sutton, Dr Pennels (IW)	B2/A1 or A2/A1	No
42	Benson	21.8.95	8.2.97	S/N Wilkin & S Code A (IW)	Dr Lord (family) Dr Lord, Dr Benton, Dr Knapman, Dr Brigg, Dr Beesley (IW)	B3/A2/A2	No
43	O Cresdee	3.4.90	2.6.90	None	None	No grade/No grade/A2	No
44	Hurnell	14.5.99	18.5.99	None	None	A2/A2/A2	No
45	Horn	5.11.99	12.11.99	None	None	B2/B2/B3	No
46	Askew	7.5.98	10.5.98	Hallmann & Theadas	None	B2/B2/B3	No
47	Horn	26.3.98	6.5.98	S/N P Shaw and Code A	Dr Lord & Dr Barton (family) Dr Banks (IW)	B2/B2/B3	No

FILE 3.

PATIENT	ADMISSION	DEATH/DISCHARGE	NAMED NURSES	NAMED DOCTORS	EXPERT'S CONCLUSION	NMC COMPLAINT?
49 Cousins	10.7.00	25.8.00	SS/N Tubbritt (?)	Dr Wilson, Dr Khawaja, Dr Beasley(?)	1A(unanimous)	No
50 Taylor	21.1.00	14.2.00	None	Dr Barton, Dr Knapman, Dr Bee Wee, Dr Lord(?)	2B/2A/2A/2A	No
51 Town	9.5.96	28.11.96	SS/N Tubbritt (?)	Dr Hajiartoris, Dr Lord, Dr Bark, Dr Peters, Dr Brookes (?)	2A/2A/1A/2A	No
52 Lee	7.5.96	9.5.96	None	Dr Barton (AN)	2B/2B	No
53 Hill	6.11.98	15.11.98	None	Dr Lord, Dr Peters (AN)	2A/2A	No
54 Stevens	20.5.99	22.5.99	SS/N Tubbritt (?) Code A (family) S/N Griffin (?), Bi...amily) + others described in statement re:	Dr Barton (family)	2B/2A/2B/1A	No
55 Richards	17.8.98	22.8.98	hospital records	Dr Barton (?/family) + others described in statement re: hospital records	2A/2A/1A/2A	No
56 Graham	16.8.00	14.9.00	Bede (family)	Dr Lord (?)	1A/1A/1A/	No

FILE 4.

	PATIENT	ADMISSIO	DEATH/DI	NAMED NURSES	NAMED DOCTORS	EXPERT'S CONCLUSION	NMC COMPLAINT?
57	Attree	26.7.96	24.8.96	S/N Ray, S/N Jarman (IW)	Dr Barton, Dr Banks (family)	A1/A1/A2	No
58	Cresdee,R	17.6.96	7.7.96	S/N Jarman, SEN Nelson (IW)	Dr Asbridge (family)	A1/A1/A2	No
59	Hooper	12.9.00	9.10.00	None	Dr Wilson, Dr Sankon, Dr Banks, Dr Wilson (IW) Dr Reid (AN) Dr Barton (family)	A1/A1/A1	No
60	Martin	6.1.98	8.1.98	None	Dr Knapna, Dr Barton (IW)	B2/A1/A1	No
61	Brennan	10.1.98	1.7.98	None	Dr Lord, Dr Barton	A2/A1/A1	No
62	Wellstead	7.4.98	13.5.98	None	Dr Childs, Dr North, Dr Taylor (IW)	B1/A1/?	No
63	Chilvers	?	19.8.90	Code A ubbritt (summary)	None	None - inadequate info	No
				Code A			No
65	Hall	1.6.99	19.6.99	None	Dr Bee Wee (RF)	A1/A1/A1	No
66	Williamson,J	29.8.00	18.9.00	S/N Nelson (IW)	Dr Lord, Dr Knapman (IW)	A1/A1/A1	No
67	Hillier	23.5.95	1.8.95	Sr Broughton (IW)	Dr Lusznat, Dr Collins (IW)	B1/A1/A1	No
							No
69	Baker	7.11.90	9.11.90	None	Dr Peters (IW)	A1/A1/A1	No
70	Clarke	5.6.00	17.6.00	None	Dr Burgess (IW), Dr Harrison (family)	A1/A1/A1	No
71	German	28.11.98	3.12.98	S/N Dorrington (IW)	Dr Traynor (family)	A1/A1/A1	No
72	Ellis	23.6.99	5.7.99	SSN Farrell (IW)	Dr Lord, Dr Barton (IW)	A1/A2/A1	No
73	Williamson,I	3.8.00	1.9.00	S/N Neville (IW)	Dr Lord, Dr Palmer (IW)	A2/A1/A1	No
74	Middleton	15.8.01	2.9.01	Bede, Wilkins (family)	None	A1/A1/A1	Yes (NCTA PPC)
75	Walsh	9.6.94	14.6.94	None	Dr Erskine, Dr Cosham (IW)	A1/A1/A1	No
76	Midford	8.7.99	20.7.99	None	Dr Pennells, Dr Banks (IW)	A1/A1/A1	No

Gosport summaries – note file 5 contains only duplicates of file 1

FILE 6.

	PATIENT	ADMISSIO	DEATH/DI	NAMED NURSES	NAMED DOCTORS	EXPERT'S CONCLUSION	NMC COMPLAINT?
77	Windsor	27.4.00	7.5.00	None	Dr Knapman, Dr Green (police report)	A3/A3/A1	No
78	Houghton	31.1.94	6.2.94	Sister Goldsmith (IW)	Dr Barton, Dr Peters (IW)	A3/B3/A2	No
79	Jarman	27.10.99	10.11.99	Code A Pearce (IW)	Dr Barton (family)	A1/A3/A2	No
80	Carter	8.11.03	24.12.93	Sr Jones (IW)	Dr Barton (IW)	A1/A3/A4	No

	PATIENT	ADMISSION	DEATH/DISCHARGE	NAMED NURSES	NAMED DOCTORS	EXPERT'S CONCLUSION	NMC COMPLAINT?
81	Cunningham	21.9.98	26.9.98	Hamblin (family); statements from various nurses	Dr Barton; Dr Lord (family)	See file - Willcock and Black	No
82	Lavender	22.2.96	6.3.96	Statements from various nurses	Dr Barton	See file - Willcock and Black	No
83	Wilson	14.10.98	18.10.98	Statements from various nurses	Dr Barton/Dr Knapman	See file - Willcock, Black, Baker, Marshall	No
84	Packman	23.8.99	3.9.99	Statements from various nurses	Barton/Reid	See file - Willcock and Black	No
85	Gregory	3.9.99	22.11.99	Statements from various nurses	Barton/Reid	See file - Willcock and Black	No
86	Service	3.6.97	5.6.97	Statements from various nurses	Barton	See file - Willcock, Black, Petch	No
87	Spurgin	23.6.99	12.4.9	Statements from various nurses	Barton/Reid	See file - Willcock, Black and Redferm	No
88	Devine	21.10.99	21.11.99	Shaw, Hamblin, Bean (QAH) (family), statements from various nurses	Barton/Reid	See file - Willcock	Yes
				Statements from Code A		See file - Willcock and	No
90	Lake	17.8.98	21.8.98	Statements from various nurses	Barton	See file - Wilcock	No

STATUTORY INSTRUMENTS

1993 No. 893

NURSES, MIDWIVES AND HEALTH VISITORS

The Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 Approval Order 1993

Made - - - - *22nd March 1993*

Coming into force *1st April 1993*

LONDON: HMSO

£5.60 net

STATUTORY INSTRUMENTS

1993 No. 893

NURSES, MIDWIVES AND HEALTH VISITORS

The Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 Approval Order 1993

Made - - - - *22nd March 1993*

Coming into force *1st April 1993*

The Lord Chancellor and the Lord Advocate, in exercise of their powers under section 22(4) of the Nurses, Midwives and Health Visitors Act 1979 (a), and as respects proceedings in England and Wales and in Scotland, respectively, hereby approve the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 made by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting and set out in the Schedule hereto.

This Order may be cited as the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 Approval Order 1993 and shall come into force on 1st April 1993.

Dated 22nd March 1993

Mackay of Clashfern, C.

Lord Advocate's Chambers
Dated 22nd March 1993

Rodger of Earlsferry
Lord Advocate

(a) 1979 c.36.

THE SCHEDULE

THE NURSES , MIDWIVES AND HEALTH VISITORS
(PROFESSIONAL CONDUCT) RULES 1993
made by
THE UNITED KINGDOM CENTRAL COUNCIL FOR NURSING,
MIDWIFERY AND HEALTH VISITING
under
THE NURSES, MIDWIVES AND HEALTH VISITORS ACT 1979 AND
THE NURSES, MIDWIVES AND HEALTH VISITORS ACT 1992

ARRANGEMENT OF RULES

Rule No.

PART III

PART IV

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting, in exercise of the powers conferred on it by sections 12 and 12A of the Nurses, Midwives and Health Visitors Act 1979 (a), hereby makes the following rules:

PART I

Citation and interpretation

1.—(1) These rules may be cited as the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993.

(2) For the purposes of these rules the following expressions have the meanings hereby respectively assigned to them except where the context otherwise requires–

(a) "the Act" means the Nurses, Midwives and Health Visitors Act 1979;

(b) "applicant" means a former practitioner who has been removed from the register, or whose registration has been suspended, and who is making an application for her name to be restored to the register, or for the termination of such suspension;

(c) "complainant" means a body or person by whom a complaint has been made to the Council alleging that a practitioner has been guilty of misconduct or that her fitness to practise is seriously impaired by reason of her physical or mental condition;

(d) "the Conduct Committee" means the Professional Conduct Committee of the Council constituted under rule 12;

(e) "the Council" means the United Kingdom Central Council for Nursing, Midwifery and Health Visiting;

(f) "the Council's officer" means any employee of the Council serving the Preliminary Proceedings Committee, the Conduct Committee, the professional screeners or the Health Committee;

(g) "the Vice-President" means the Vice-President of the Council;

(h) "the Health Committee" means the Health Committee of the Council constituted under rule 29;

(i) "legal assessor" means a person appointed to be a legal assessor under the provisions of paragraph 3(1) of Schedule 3 to the Act;

(j) "medical examiners" means the persons referred to in the Second Schedule to these rules;

(k) "misconduct" means conduct unworthy of a registered nurse, midwife or health visitor, as the case may be, and includes obtaining registration by fraud;

(l) "Notice of Inquiry" means the notice referred to in rule 13(1);

(m) "Notice of Proceedings" means the notice referred to in rule 9(1)(a);

(n) "Notice of Referral" means the notice referred to in rule 35(1);

(a) Section 12 was amended by sections 7 and 8 of the Nurses, Midwives and Health Visitors Act 1992 (c.16) and section 12A was inserted by section 9 of that Act.

(o) "parties to the proceedings" means the respondent, applicant and/or solicitor collectively or such of them as are involved in a particular case;

(p) "practitioner" means any person whose name is on the register of nurses, midwives and health visitors;

(q) "the Preliminary Proceedings Committee" means the Preliminary Proceedings Committee constituted by the Council under rule 7;

(r) "the President" means the President of the Council;

(s) "professional screeners" means the professional screeners selected by the Council under rule 30(2);

(t) "the register" means the professional register maintained by the Council under section 10(1) of the Act, and any part or parts thereof as determined in the Nurses, Midwives and Health Visitors (Parts of the Register) Order 1983(a), and "registration" shall be construed accordingly.

(u) "Registrar" means the person for the time being appointed as Registrar and Chief Executive of the Council and includes any person duly authorised to act and acting on her behalf;

(v) "respondent" means any practitioner who is alleged to be liable to be removed from the register, have her registration suspended or have a caution issued as to her future conduct;

(w) "the solicitor" means the solicitor appointed by the Council for any purpose under these rules.

Removal from, and restoration to, the register

2.—(1) The circumstances in which a practitioner may be removed from the register are–

(a) that she has been guilty of misconduct; or

(b) that her fitness to practise is seriously impaired by reason of her physical or mental condition.

(2) The means by which a practitioner may be removed from the register in the circumstances of paragraph (1)(a) are that, in accordance with Parts I and II of these rules, the question of misconduct has been investigated and referred to the Conduct Committee and, in accordance with Part II of these rules, misconduct has been proved to the Conduct Committee's satisfaction and the Conduct Committee has directed the removal.

(3) The means by which a practitioner may be removed in the circumstances of paragraph (1)(b) are that, in accordance with these rules, the question of unfitness to practise has been investigated and referred to the Health Committee which has determined the practitioner's fitness to practise to be seriously impaired by reason of her physical or mental condition and has directed the removal.

(4) A person who has been removed from the register by the means specified in paragraph (2) may be restored in accordance with rule 22(1), or by the direction of the Conduct Committee on an application made and determined in accordance with rule 22.

(5) A person who has been removed from the register by the means specified in paragraph (3) may be restored in accordance with rule 49(1) or by the direction of the Health Committee on an application made and determined in accordance with rule 49.

Suspension from the register

3.—(1) The circumstances in which a practitioner may be suspended are–

(a) that her fitness to practise is seriously impaired by reason of her physical or mental condition; or

(b) that it appears necessary to do so as an interim measure–

(i) for the protection of the public; or

(ii) in the practitioner's interests.

(a) *See* S.I. 1983/667.

(2) The means by which a practitioner's registration may be suspended in the circumstances of paragraph (1)(a) are that, in accordance with Part III of these rules, the question of fitness to practise has been investigated and referred to the Health Committee which has determined the practitioner's fitness to practise to be seriously impaired by reason of her physical or mental condition and has directed the suspension.

(3) The means by which a practitioner's registration may be suspended in the circumstances of paragraph (1)(b) are that, in accordance with Part IV of these rules, the Preliminary Proceedings Committee, Conduct Committee or Health Committee has determined and directed that interim suspension is necessary for the protection of the public or in the interests of the practitioner.

(4) The suspension of a person's registration by the means specified in paragraph (2) may be terminated in accordance with rule 49(1) or by the direction of the Health Committee on an application made and determined in accordance with rule 49.

(5) The suspension of a person's registration by the means specified in paragraph (3) may be terminated in accordance with the provisions of rule 59.

Caution as to future conduct

4.—(1) The circumstances in which a practitioner may be cautioned as to her future conduct are that she has been guilty of misconduct.

(2) The means by which a practitioner may be cautioned as to her future conduct are that, in accordance with Part I of these rules, the Preliminary Proceedings Committee has considered the question of misconduct, a Notice of Proceedings has been sent to the practitioner, and–

(a) the Preliminary Proceedings Committee has received the practitioner's admission of the facts and misconduct, has made a finding of misconduct and has determined it appropriate to issue a caution; or

(b) the Preliminary Proceedings Committee has referred the case to the Conduct Committee which has made a finding of misconduct and the Conduct Committee has determined it appropriate to issue a caution.

Removal, alteration and restoration of entries

5. Without prejudice to her more general power to remove or alter entries in the register which would otherwise be inaccurate, the Registrar shall remove, alter and restore entries whenever so directed by the Preliminary Proceedings Committee, the Conduct Committee or the Health Committee in accordance with these rules.

Consideration of allegations of misconduct

6. The Council shall consider allegations of misconduct by practitioners referred to it with a view to proceedings for such practitioners to be removed from the register.

Preliminary Proceedings Committee

7.—(1) A Preliminary Proceedings Committee shall be constituted by, and shall include members of, the Council, in order to–

(a) carry out investigation of cases of alleged misconduct;

(b) determine whether or not to refer a case of alleged misconduct to–

(i) the Conduct Committee with a view to removal of a practitioner from the register, or

(ii) the professional screeners, with a view to consideration of a practitioner's fitness to practise;

(c) determine whether a practitioner is guilty of misconduct and, if so, whether it is appropriate to issue a caution as to her future conduct.

(2) The Vice-President shall be the chairman of the Preliminary Proceedings Committee.

(3) The Council shall appoint 2 of its members to be deputy chairmen of the Preliminary Proceedings Committee and each may act as chairman of the Preliminary Proceedings Committee at the Vice-President's request or in her absence.

(4) If neither the Vice-President, nor any of the deputy chairmen is available, the members of the Preliminary Proceedings Committee present at the relevant meeting, shall select one of their number, who shall be a member of the Council, to act as chairman.

(5) The Preliminary Proceedings Committee shall be quorate if at least 3 members of the Council constitute a majority of those considering a particular case.

(6) The members of the Preliminary Proceedings Committee considering a particular case shall be selected with due regard to the professional field in which the practitioner under consideration works or has worked.

(7) The Preliminary Proceedings Committee shall meet in private.

(8) It shall not be necessary for the Preliminary Proceedings Committee when meeting to consider a particular case to be composed of the same members who considered that case on any previous occasion.

Initial consideration of allegations of misconduct

8.—(1) After an allegation of misconduct which the Council's officer considers may lead to removal from the register is received by the Council, the Registrar shall send, in writing, to the practitioner concerned–

(a) a summary of the allegations;

(b) notice that the Preliminary Proceedings Committee will in due course consider the matter; and

(c) confirmation that, if a Notice of Proceedings is issued by the Preliminary Proceedings Committee under rule 9(1)(a), the practitioner will be invited to respond in writing to the Notice, but that if the practitioner wishes to submit a preliminary response to the summary of allegations, such response will be made available to the Preliminary Proceedings Committee, provided that it is received by the Council in time to do so.

(2) The Council shall, if it considers it appropriate, conduct, through the solicitor or otherwise, an investigation before the matter is first considered by the Preliminary Proceedings Committee and if such an investigation indicates that the practitioner may be removed from the register, the Registrar shall send to the practitioner copies of statements obtained during the investigation, together with any other documents considered appropriate which are in the Council's possession, and again notify the practitioner that she is entitled to submit a preliminary response for consideration by the Preliminary Proceedings Committee at its meeting.

(3) At any stage in its consideration of allegations made against a practitioner the Preliminary Proceedings Committee may–

(a) decline to proceed with the matter;

(b) require further investigations to be conducted;

(c) adjourn consideration of the matter;

(d) refer the matter to the professional screeners;

(e) take the advice of the solicitor and may instruct him to obtain such documents, proofs of evidence and other evidence in respect of the allegations as he considers necessary;

(f) require, in the case of a complainant who is not acting in a public capacity, that the complaint be verified by way of a statutory declaration.

(4) Any statutory declaration which may be required from a complainant who is not acting in a public capacity shall state the address and description of the complainant and the grounds for her belief in the truth of any fact declared which is not within her personal knowledge.

Commencement of proceedings

9.—(1) The Preliminary Proceedings Committee shall consider allegations of misconduct and shall, subject to any determination under rule 8(3), and where it considers that the allegations may lead to removal from the register, direct the Registrar to send to the practitioner–

(a) a Notice of Proceedings;

(b) copies of statements obtained by the Council during investigation of the allegations and any other documents the Preliminary Proceedings Committee considers appropriate which are in the Council's possession, unless such documents have already been sent to the practitioner under rule 8(2) or otherwise;

(c) a request that the practitioner respond, in writing, to the Notice of Proceedings.

(2) The documents referred to in paragraph (1) shall be sent by the recorded delivery service to the registered address of the practitioner contained in the register or, if the Registrar has reason to believe that that address is not her present address, then to any later address which may be known to the Registrar.

(3) Where a Notice of Proceedings has been sent to a practitioner the Preliminary Proceedings Committee shall consider any written response by the practitioner and, subject to any determination under rule 8(3), shall–

(a) refer to the Conduct Committee a case which it considers justifies a hearing before the Conduct Committee with a view to removal from the register;

(b) if it considers that the practitioner's fitness to practise may be seriously impaired, by reason of her physical or mental condition, refer a case to the professional screeners;

(c) if not referring a case to the Conduct Committee or professional screeners, and provided that the practitioner has admitted the facts alleged in the Notice of Proceedings, and that such facts constitute misconduct, determine whether the practitioner has been guilty of misconduct and, if so, whether it is appropriate to issue a caution as to the practitioner's future conduct.

(4) Where the Preliminary Proceedings Committee has decided it is appropriate to issue a caution under paragraph (3)(c) it shall direct the Registrar to do so.

(5) Where the Preliminary Proceedings Committee has decided not to refer a case to the Conduct Committee under paragraph (3)(a), the Registrar shall so inform the complainant and the respondent but no person shall have any right of access to any documents relating to the case, nor shall the Committee be required to state reasons for, or review, its decision.

Referral by professional screeners to Preliminary Proceedings Committee

10. Where a case which has been referred to the professional screeners by the Preliminary Proceedings Committee or the President pursuant to rule 8(3)(d) or rule 14(2) respectively, is referred back to the Preliminary Proceedings Committee, the Preliminary Proceedings Committee shall resume its consideration of the case in accordance with Part I of these rules.

Voting

11.—(1) Any question put to the vote of the Preliminary Proceedings Committee shall be put in the form of a motion. The chairman shall call on all members present to vote for or against the motion by raising their hands and shall declare that the motion appears to have been carried or not carried, as the case may be.

(2) Where the result so declared is challenged by any member, the chairman shall require the Council's officer to call each member's name in turn, and the members shall declare themselves for or against the motion, the chairman voting last. The chairman shall then declare the number of members who have voted for, and the number who have voted against, the motion and whether the motion has been carried or not carried.

(3) Where on any motion at a meeting of the Preliminary Proceedings Committee the votes are equal, the motion shall be deemed to have been resolved in favour of the practitioner under consideration.

(2) No member of the Preliminary Proceedings Committee present when any question is put to a vote may abstain from voting.

PART II

Professional Conduct Committee

12.—(1) A Conduct Committee shall be constituted by, and shall include members of, the Council, in order to determine whether–

(a) a practitioner shall be removed from the register, whether or not for a specified period, for reasons falling within rule 2(1)(a);

(b) a practitioner shall be cautioned as to her future conduct, for reasons falling within rule 2(1)(a);

(c) a person who has been removed from the register may be restored to it;

(d) an entry in the register may be altered.

(2) The Conduct Committee shall be quorate if at least three members of the Council constitute a majority of those considering a particular case.

(3) The Conduct Committee hearing any particular case or cases shall be chosen with due regard to the professional fields in which the practitioner or person under consideration works or has worked.

(4) The President of the Council shall be the chairman of the Conduct Committee.

(5) The Council shall appoint a panel of not more than 9 persons from whom a deputy chairman may be chosen who shall then take the chair in the absence of the chairman, or at her request.

(6) If neither the chairman nor any one of the deputy chairmen is available, the members of the Conduct Committee present at the relevant meeting shall select one of their number, who shall be a member of the Council, to act as chairman.

(7) Any person who has participated in the consideration of a case as a member of the Preliminary Proceedings Committee or as a professional screener shall not be permitted to be a member of the Conduct Committee dealing with that case.

Notice of Inquiry before the Conduct Committee

13.—(1) Where a case has been referred by the Preliminary Proceedings Committee or the Health Committee to the Conduct Committee, the Registrar shall send to the respondent a Notice of Inquiry in writing in the form set out in the First Schedule to these rules, specifying the nature and particulars of the charge against her, and informing her of the date, time and place of the meeting of the Conduct Committee which will constitute the hearing of the inquiry. The Notice of Inquiry shall be sent by the recorded delivery service to the registered address of the respondent contained in the register or, if the Registrar has reason to believe that that address is not her present address, then to any later address which may be known to the Registrar, and shall be posted so as to allow at least 28 days to elapse between the day on which the Notice of Inquiry is posted and the date fixed for the hearing, unless the practitioner agrees otherwise.

(2) The Notice of Inquiry which is sent to the respondent pursuant to paragraph (1) shall not include any charge inconsistent with the substance of such allegations as were set out in the Notice of Proceedings.

(3) The Registrar shall send a copy of the Notice of Inquiry to the Complainant.

(4) Upon the application of a party to the proceedings to be dealt with by the Conduct Committee, the Registrar shall send to that party copies of any statutory declarations, explanation, admission or other similar statement or communication sent to the Council by either the complainant or the respondent with respect to the proceedings.

(5) The respondent may appear in person or be represented at the hearing by counsel or a solicitor, or by any officer of a representative organisation. or by any other person of her choice.

(6) The Council shall prosecute proceedings which have been referred to the Conduct Committee.

Postponement or cancellation of hearing

14.—(1) The President, of her own motion or upon the application of a party to the proceedings, may postpone the hearing of an inquiry or may refer the matter back to the Preliminary Proceedings Committee for further consideration as to whether a hearing should take place.

(2) The President may, at any time before the hearing of an inquiry by the Conduct Committee begins, refer the case to the professional screeners. On such referral the Conduct Committee shall take no further steps in relation to the inquiry, pending a decision by the professional screeners and, if appropriate, the Health Committee.

(3) Where before the hearing begins it appears to the chairman of the Conduct Committee, or at any stage during the hearing it appears to the Conduct Committee, that a Notice of Inquiry is defective, she or it shall cause the Notice to be amended unless it appears that the required amendment cannot be made without injustice, or if she or it considers that the circumstances in which an amendment is made so require, she or it may direct that the hearing shall be postponed or shall not take place.

(4) The Registrar shall, as soon as practicable, inform all parties to whom a Notice of Inquiry has been sent of any decision to postpone or cancel the hearing specifying, in the case of a postponement, the further date fixed for the hearing.

Opening of inquiry and reading of the charge

15.—(1) Where the respondent does not appear the chairman of the Conduct Committee shall call upon the solicitor to satisfy the Conduct Committee that the Notice of Inquiry has been received by the respondent. If it does not appear to have been so received the Conduct Committee may nevertheless proceed with the hearing, if it is satisfied that all reasonable efforts in accordance with these rules have been made to serve the Notice of Inquiry on the respondent.

(2) The charge shall be read in public and in the presence of the parties to the proceedings by the Council's officer. If the respondent does not appear but the Conduct Committee nevertheless decides that the hearing shall proceed the charge shall be read in her absence.

(3) As soon as the charge has been read the respondent may, if she so desires, object to the charge, or to any part or parts of it, on a point of law, and any other party to the proceedings may reply to any such objection. If any such objection is upheld, no further proceedings shall be taken on that charge or on that part of the charge to which the objection relates.

Misconduct: procedure to be followed where conviction is alleged

16.—(1) In cases arising out of a complaint alleging misconduct from which it appears that a practitioner has been convicted of a criminal offence, but excluding any cases which fall within section 1C(1) of the Powers of Criminal Courts Act 1973(a) or section 8(1) of the Probation Act (Northern Ireland) 1950(b), the following order of proceedings shall be observed concerning proof of the conviction alleged in the charge–

(a) the solicitor shall adduce evidence of each conviction;

(b) where a person has been convicted by or before a Court in England, Wales or Northern Ireland or before a Court-martial, a certificate that she has been so convicted granted by a competent officer of the Court or Court-martial shall be conclusive evidence of the conviction for the purposes of these rules unless the person is able to prove beyond reasonable doubt that she is not the person referred to in the certificate of conviction or that the offence referred to in the certificate of conviction was not that of which she was convicted;

(c) where a person has been convicted by or before a Court in Scotland, an extract conviction shall be conclusive evidence of the conviction for the purpose of these rules unless the person is able to prove beyond reasonable doubt that she is not the person referred to in the extract conviction or that the offence referred to in the extract conviction was not that of which she was convicted;

(a) 1973 c.62: section 1C was inserted by the Criminal Justice Act 1991 (c.53), section 8(3)(a) and Schedule 1.
(b) 1950 c.7 (NI).

(d) if no evidence is adduced concerning any particlar conviction, the chairman of the Conduct Committee shall thereupon announce that that conviction has not been proved;

(e) if the respondent appears, the chairman shall ask her concerning each conviction of which evidence is adduced whether she admits that she was so convicted and if she does so admit the chairman shall thereupon announce that the conviction has been proved.

(2) If, where the respondent appears, she does not admit that she was so convicted she may then adduce evidence concerning any conviction which she had not admitted, but only on the question of whether she was the person convicted as alleged or whether the offence referred to was not that of which she was convicted, and may address the Conduct Committee on that question; provided that only one address may be made under this paragraph and, where the respondent adduces evidence, that address may be made either before that evidence is begun or after it is concluded.

(3) Where evidence is adduced under paragraph (2), the solicitor may adduce evidence to rebut such evidence.

(4) Except where the respondent has admitted that she was convicted as alleged the Conduct Committee shall next consider every conviction of which evidence has been adduced and shall determine whether or not it has been proved; and the chairman shall announce the determination in such terms as the Conduct Committee shall have approved.

(5) After the Conduct Committee has determined that any conviction has been proved the validity of that conviction shall not be questioned, either by the Conduct Committee or by any party to the inquiry.

(6) Proof of conviction shall be conclusive evidence, for the purpose of these rules, of the commission by the respondent of the offence of which she was convicted.

(7) Proof of conviction alone shall not constitute misconduct; misconduct shall be a matter for the Conduct Committee to determine in accordance with these rules.

(8) At the conclusion of the proceedings under paragraphs (1) to (4) the chairman shall invite the solicitor to address the Conduct Committee as to the circumstances leading to the conviction or convictions and the solicitor may adduce evidence as to those circumstances. The respondent may then address the Conduct Committee as to the circumstances and may adduce evidence. The solicitor shall have a right of reply and may adduce evidence limited to those matters raised by the respondent.

Misconduct: procedure to be followed regarding other allegations

17.—(1) In cases arising out of a complaint from which it appears that a question arises as to whether a respondent has been guilty of misconduct the following order of proceedings shall be observed in respect of proof of the charge or charges—

(a) if the respondent appears the chairman shall ask her whether she admits the facts alleged in the charge or charges and if she does so admit them the chairman shall thereupon announce that the facts have been proved;

(b) if the respondent does not appear and has not admitted in writing to the Conduct Committee after receiving the notice of inquiry the facts alleged in the charge or charges, or if she appears and does not admit all the facts alleged, the solicitor shall open the case and adduce evidence of the facts alleged;

(c) if the respondent does not appear but has admitted in writing to the Conduct Committee after receiving the notice of inquiry the facts alleged in the charge or charges the chairman shall announce that the facts have been proved, the chairman shall then invite the solicitor to address the Conduct Committee as to the circumstances leading up to those facts in the charge or charges and the solicitor may call evidence;

(d) if no evidence is adduced concerning any particular charge on which there has been no admission of the facts alleged, the Conduct Committee, subject to its right in such a case to order the adjournment of the inquiry, shall record, and the chairman shall announce the finding that the respondent is not guilty of misconduct in respect of the matters to which that charge relates.

(2) Where the respondent appears and has admitted the facts the following further order of proceedings shall be followed–

(a) the solicitor shall address the Conduct Committee as to the circumstances leading up to the facts in the charge or charges and may call evidence;

(b) the respondent or her representative shall have a right of reply and may call evidence in connection therewith;

(c) the solicitor shall have a futher right of reply and may adduce evidence limited to those matters raised by the respondent;

(d) any witness called may be cross-examined and re-examined.

(3) Where the respondent appears but does not admit the facts the following order of proceedings shall be observed–

(a) the solicitor shall present the case against the respondent and the respondent shall have the right to cross-examine any person giving evidence against her and the solicitor may re-examine;

(b) at the close of the case against her the respondent may, if she so desires, make either or both of the following submissions relating to any charge concerning which evidence has been adduced, namely–

(i) that no sufficient evidence has been adduced upon which the Conduct Committee could find that the facts alleged in that charge have been proved;

(ii) that the facts alleged in the charge are not such as to constitute misconduct;

and where either or both of such submissions is made, any other party may reply thereto;

(c) if a submission is made under sub-paragraph (b), the Conduct Committee shall, in camera, consider and determine whether it should be upheld; if the Conduct Committee determines to uphold the submission, it shall record, and the chairman shall announce the finding that, in relation to the matters to which that charge relates, the respondent is not guilty of misconduct;

(d) where such submissions are heard and are rejected by the Conduct Committee or where no submission has been made under sub-paragraph (b), the respondent may adduce evidence in answer to any charge concerning which evidence has been adduced and, whether she adduces evidence or not, may address the Conduct Committee; except with the leave of the Conduct Committee only one address may be made under this sub-paragraph which, where the respondent adduces evidence, may be made either before that evidence is begun or after it is concluded; at the close of the case for the respondent, the solicitor may with the leave of the Conduct Committee adduce evidence to rebut any evidence adduced by the respondent, and if he does so the respondent may make a further address limited to the rebutting evidence;

(e) the solicitor may with the leave of the Conduct Committee address the Conduct Committee by way of reply to the respondent's case;

(f) without prejudice to sub-paragraph (e), if the respondent has made a submission to the Conduct Committee on a point of law any other party has a right to reply limited to that submission.

(4) On the conclusion of the proceedings under paragraph (3), the Conduct Committee shall consider and determine, in camera, in respect of each charge which remains outstanding which, if any, of the allegations have been proved to its satisfaction.

(5) If under paragraph (4) the Conduct Committee determines in respect of any charge, either that none of the allegations in the charge has been proved to its satisfaction, or that such facts as have been so proved would be insufficient to support a finding of misconduct, the Conduct Committee shall record a finding that the respondent is not guilty of misconduct in respect of the matters to which that charge relates. The chairman shall announce the findings in public and declare that the respondent is not guilty of misconduct in respect of the matters to which the charge relates.

Procedure upon proof of the facts in cases of alleged misconduct

18.—(1) Where in a case of alleged misconduct the Conduct Committee has found the facts or any of them alleged in any charge to have been proved to its satisfaction the following procedure shall be observed–

(a) if the respondent appears, the chairman shall ask her whether on the basis of the facts which have been proved she admits the charge of misconduct; if she does admit misconduct the Conduct Committee shall nevertheless proceed to make a determination under paragraph (2); if she does not admit misconduct, the respondent either directly or through her representative may adduce both evidence and argument as to why the facts do not constitute misconduct; the solicitor may reply to the respondent or her representative and with the leave of the Conduct Committee may adduce further evidence and the respondent shall have a right of reply to any matters raised by the solicitor but may not adduce further evidence;

(b) if the respondent does not appear and has not admitted in writing the charge of misconduct, the Conduct Committee may call upon the solicitor to present any further information or evidence in respect of that charge.

(2) The Conduct Committee shall then forthwith consider and determine whether in relation to the facts found proved as aforesaid the respondent is guilty of misconduct. If it determines that she is not guilty of misconduct in relation to some or any of such facts it shall record a finding to that effect and the chairman shall announce it in public.

(3) If the Conduct Committee determines that the respondent is guilty of misconduct in relation to all or any of such facts the chairman shall invite the solicitor to address the Conduct Committee and to provide evidence as to the previous history of the respondent. The respondent or her representative may cross-examine any person giving evidence at this stage of the proceedings and the solicitor may then re-examine that person. The chairman shall then invite the respondent or her representative to address the Conduct Committee by way of mitigation and the respondent or her representative, as the case may be, may adduce evidence as to her previous history and as to character. The solicitor may cross-examine any person giving evidence at this stage of the proceedings and the respondent or her representative may re-examine that person.

(4) Except where the respondent has been found guilty of misconduct on all charges the Conduct Committee shall next consider and determine, in camera, whether it should postpone judgment.

(5) If the Conduct Committee determines to postpone judgment, it shall also determine the month and year in which the hearing will resume, and the chairman of the Conduct Committee shall announce in public the determination in such terms and with such recommendations as the Conduct Committee shall have approved.

(6) If the Conduct Committee determines not to postpone judgment, it shall determine whether by reason of the misconduct of the respondent the Registrar shall be directed to remove the respondent from the register (whether or not for a specified period) or whether it is appropriate to issue a caution as to the respondent's future conduct. The chairman shall then announce the determination in public in such terms and with such recommendations as the Conduct Committee shall have approved.

(7) Where the Conduct Committee has determined not to postpone judgment and not to direct that the respondent be removed from the register, or that she be cautioned, the Conduct Committee shall determine to conclude the case without taking any further action on the respondent's proven misconduct. The chairman shall then announce the determination in public in such terms as the Conduct Committee shall have approved.

(8)(a) The Registrar shall forthwith send a letter to the respondent by the recorded delivery service informing her of the decision of the Conduct Committee and state any registration fee which may be due where the Conduct Committee has determined not to remove the respondent from the register.

(b) In those cases where judgment has been postponed the letter shall set out any recommendations made by the Conduct Committee including the requirement for any registration fee that may be due.

(c) In those cases where the respondent has been removed from the register the letter shall set out any recommendations made by the Conduct Committee. In such a case the letter shall also require that she should return to the Registrar within 21 days any document or insignia issued by the Council or its predecessor which indicates registration status and warn her of her liability to proceedings under section 14(1)(b) of the Act if she holds herself out to be a practitioner in a part of the register from which her name has been removed. With the letter shall be sent a form to be signed by the respondent and returned to the Registrar, acknowledging the receipt of the Council's decision and confirming that the contents of the letter are understood.

(d) In those cases where the Conduct Committee has determined that it is appropriate to issue a caution the letter shall record that caution.

(e) The Registrar, in the case of the removal of the respondent from the register, shall delete her name from the register in accordance with the Conduct Committee's determination.

Procedures in cases relating both to alleged misconduct and to other matters

19. Where in any misconduct case it is alleged against the respondent that misconduct is evidenced by conviction and also by other matters the Conduct Committee shall proceed first under rule 17 as regards the other matters and then under rule 16 as regards the conviction.

Procedure on postponement of judgment

20.—(1) Where under any of the foregoing provisions of these rules the judgment of the Conduct Committee in any case stands postponed, the following rules of procedure shall apply–

(a) not later than 8 weeks before the day fixed for the resumption of the proceedings the Registrar shall send to the respondent at the address given by the respondent at the earlier hearing, or to any subsequent address notified by the respondent, a notice sent by the recorded delivery service specifying the day and place at which the proceedings are to be resumed and invite the respondent to appear thereat with or without representation as she chooses;

(b) additionally, the notice shall remind the respondent of the recommendations, if any, made by the Conduct Committee at the earlier hearing, and confirmed or notified to her by subsequent letter, and shall invite the respondent to furnish to the Registrar the names and addresses of at least two suitable persons with knowledge of the facts found against her who are able and willing to give evidence as to the nature of her employment since the adjourned hearing, and such other evidence as the Conduct Committee may reasonably require; such names and addresses shall be submitted to the Conduct Committee not less than 4 weeks before the date of the hearing;

(c) a copy of the notice shall be sent to the complainant, if any, and she may in turn, if she so desires, send to the Registrar a statement or statutory declaration concerning any matter relating to the conduct of the respondent since the previous hearing provided that the statement or statutory declaration is made from her own knowledge;

(d) not less than 4 weeks before the date fixed for the resumption of the proceedings a notice shall be sent to both the respondent and the complainant stating the time at which the hearing will be resumed;

(e) at the meeting at which the proceedings are resumed the chairman shall first invite the Council's officer, or if the Conduct Committee so requires the solicitor, to inform the Conduct Committee, which shall meet in public, of the facts established at the original hearing, and of any recommendations of the Conduct Committee at the time; the Conduct Committee shall then consider any reports or references and any further oral or documentary evidence in relation to the case, or to the conduct of the respondent since the hearing at which the finding of misconduct was made, and shall hear any other evidence in mitigation or aggravation; the Conduct Committee shall allow the respondent to address the Conduct Committee either directly or through a representative, and may question the respondent;

(f) the Conduct Committee shall then consider and determine, in camera, whether it should further postpone its judgment on the charges on which its judgment was previously postponed; if the Conduct Committee determines further to postpone judgment, the judgment of the Conduct Committee shall stand postponed until such future meeting of the Conduct Committee as it may determine; the chairman shall announce the determination in public in such terms as the Conduct Committee shall have approved;

(g) if the Conduct Committee determines that judgment shall not be further postponed, it shall resolve the matter in accordance with rule 18(6).

(2) Prior to the commencement of any resumed proceedings if a new allegation of misconduct against the respondent has been received by the Council, the respondent shall be invited to admit, in writing, the facts in respect of the new allegation and that they constitute misconduct, and to agree that the Conduct Committee may, in such circumstances, apply rule 18(6) simultaneously to both matters.

(3) Nothing in paragraph (2) shall prevent the Conduct Committee from concluding any resumed proceedings as though no new allegation of misconduct had been received, or from postponing, or further postponing judgment in respect of one or both matters.

(4) If the respondent does not make the admissions referred to in paragraph (2) the new allegation of misconduct shall be considered in accordance with Part I and, if appropriate, Parts II, III and IV of these rules.

(5) It shall not be necessary for the Conduct Committee when meeting to consider a case on which judgment had earlier been postponed, to be composed of the same members who constituted the Conduct Committee at the original hearing. The validity of any resumed hearings shall not be called into question on these grounds.

Procedure where there is more than one respondent

21. Nothing in this Part of these rules shall prevent one inquiry being held into charges against two or more respondents where the Conduct Committee considers the circumstances justify the procedure; and where such an inquiry is held the foregoing rules shall apply with the necessary adaptations and subject to any directions given by the Conduct Committee on the advice of the legal assessor as to the order in which proceedings shall be taken under any of those rules by or in relation to the several respondents. Any of the rights ensured to a respondent under these rules shall be exercised separately by each of the respondents who may desire to invoke any of these rights.

Restoration to the register

22.—(1) Where a person has, for a specified period, been removed from the register in the circumstances set out in rule 2(1)(a), she shall be restored to the register on the expiry of the period so specified.

(2) Where a person has, for an unspecified period, been removed from the register in the circumstances set out in rule 2(1)(a), any application for restoration to any or all parts of the register for which she possesses a qualification shall be made in writing addressed to the Registrar and signed by the applicant, stating the grounds on which the application is made.

(3) The applicant shall then be sent a letter by the Registrar to–

(a) outline the application procedure;

(b) remind the applicant of any recommendations made by the Conduct Committee at the time of removal;

(c) enclose a form on which the applicant must state the necessary personal details and the names and addresses of two or more persons with knowledge of the facts found against her able and willing to identify the applicant and give evidence as to her character, and the nature of her employment since the date of the removal of her name and, where practicable, before that date;

(d) require the applicant to declare whether or not she has been convicted of a criminal offence since being removed from the register or that she is not the subject of any current criminal proceedings, but if she has been convicted of a

criminal offence or if she is currently the subject of criminal proceedings to provide details thereof including the judgment and the address of the Court at which the proceedings took place or are taking place;

(e) require her to declare whether or not she has knowingly represented herself to be a practitioner since the date of her removal from the register except in respect of any part from which she has not been removed;

(f) state the fee for restoration should the application be successful;

(g) state any registration fee which may be due.

The Conduct Committee may invite the applicant to verify, by statutory declaration, any statement made in her application.

(4) Subject to the provisions of this rule and to those of rules 23, 24 and 25, the procedure of the Conduct Committee in respect of applications for restoration to the register shall be such as the Conduct Committee may determine.

(5) As soon as practicable after the documents have been received in respect of the application a date, time and place for the consideration of the application by the Conduct Committee shall be determined and shall be notified to the applicant in a letter signed by the Registrar. The particular Conduct Committee which considers the application shall be convened with due regard to the applicant's professional qualifications and the part or parts of the register to which restoration is sought.

(6) The Conduct Committee shall not consider an application for restoration to the register in the absence of the applicant unless it shall decide that there are exceptional reasons for her inability to attend. In the latter circumstances the Conduct Committee may, unless it determines otherwise, invite the applicant's response to specific questions it wishes to raise, and may require that the written answers are provided in the form of a statutory declaration.

(7) At the meeting at which the application is considered the chairman shall first invite the Council's officer, or if the Conduct Committee so requires the solicitor, to inform the Conduct Committee, which shall meet in public, of the facts established at the hearing which resulted in removal from the register and of any recommendations of the Conduct Committee at the time.

(8) The chairman may also require the Council's officer or the solicitor to inform the Conduct Committee about any known activities of the applicant since the applicant was removed from the register.

(9) The Conduct Committee shall consider the evidence submitted in respect of the application and may question the applicant.

(10) The applicant may appear in person or be represented at the hearing by counsel or a solicitor, or by any officer of a representative organisation, or by any other person of her choice.

(11) Where the Conduct Committee decides that the applicant shall be restored to the register, and so directs the Registrar, it shall also determine the date when the restoration shall take effect and whether it should be subject to any of the limitations for which rules made under section 10(3)(c) of the Act provide. The decision of the Conduct Committee shall be announced in public.

(12) The decision of the Conduct Committee shall be signed by the Registrar and sent to the applicant by the recorded delivery service.

(13) Where the Conduct Committee has decided that the applicant shall be restored to the register then upon payment by the applicant of any restoration and registration fee, the Registrar shall cause the applicant to be restored to the register and shall issue to the applicant a full copy of the entry in the register.

Hearing and adjournment

23.—(1) The Conduct Committee may deliberate in camera at any time and for any purpose during or after a hearing.

(2) Save as aforesaid and where provided in these rules all proceedings before the Conduct Committee shall take place in the presence of all parties thereto who appear therein and shall be open to the public except as provided by paragraph (3).

(3) Where in the interests of justice it appears to the Conduct Committee that the public should be excluded from any proceedings or part thereof, the Conduct Committee may direct that the public shall be so excluded; but a direction under this paragraph shall not apply to the announcement in pursuance of any of these rules of a determination of the Conduct Committee.

(4) The Conduct Committee may adjourn its proceedings from time to time as it thinks fit.

Referral to the professional screeners

24.—(1) At any time during the hearing, but before the Conduct Committee determines whether by reason of the misconduct of the respondent the Registrar shall be directed to remove the respondent from the register or whether the respondent should be cautioned as to her future conduct, in accordance with rule 18(6), the Conduct Committee may direct that the matter shall be referred to the professional screeners who shall proceed in accordance with rule 34.

(2) Where the professional screeners or the President, under rule 34(4)(b), or the Health Committee, under rule 44(a), refer a matter back to the Conduct Committee, the Conduct Committee shall resume, or begin, as the case may be, its inquiry into the case and dispose of it.

Evidence

25.—(1) The Conduct Committee may receive oral, documentary or other evidence of any fact which appears to it relevant to the inquiry into the case before it; provided that, where a fact which it is sought to prove or the form in which any evidence is tendered is such that it would not be admissible in criminal proceedings in any Court in England or Wales, or Scottish Court where the proceedings are in Scotland, or Northern Ireland Court where the proceedings are in Northern Ireland, the Conduct Committee shall not receive evidence of that fact or in that form, unless after consultation with the legal assessor it is satisfied that it is desirable in the interests of justice to receive it having regard to the difficulty or expense of obtaining evidence which would be so admissible.

(2) Without prejudice to the generality of paragraph (1), the Conduct Committee may, if satisfied that the interests of justice will not thereby be prejudiced, admit in evidence without strict proof, copies of documents which are themselves admissible, maps, plans, photographs, certificates of conviction and sentence, certificates of birth and marriage and death, the records (including the registers) of the Council, the notes of proceedings before the Conduct Committee and before other tribunals and the records of such tribunals and the Conduct Committee may take note without strict proof of the professional qualifications, the registration, the address and the identity of the practitioner and of any other person.

(3) The Conduct Committee may accept admissions made by any party and may, in such case, dispense with proof of the matters admitted.

(4) A witness, including the respondent (if she gives evidence), shall first be examined by the person calling her and may then be cross-examined. Questions may be put to any witness by the Conduct Committee, or by the legal assessor, with the leave of the chairman. A witness may then be re-examined.

(5) The Conduct Committee may require the solicitor to call any person as a witness in any proceedings before it.

(6) No witness as to fact other than the respondent, if she gives evidence, may, prior to giving evidence, be present during the hearing before the Conduct Committee.

Voting

26.—(1) Any question put to the vote of the Conduct Committee shall be put in the form of a motion. The chairman shall call on all members present to vote for or against

the motion by raising their hands and shall declare that the motion appears to have been carried or not carried, as the case may be.

(2) Where the result so declared is challenged by any member, the chairman shall require the Council's officer to call each member's name in turn, and the members shall declare themselves for or against the motion, the chairman voting last. The chairman shall then declare the number of members who have voted for and the number who have voted against the motion and whether the motion has been carried or not carried.

(3) Where on any motion at a hearing of the Conduct Committee to remove a respondent from the register the votes are equal, the motion shall be deemed to have been resolved in favour of the respondent. For the purposes of this rule if there is an equal vote on whether to postpone judgment the chairman shall so inform the respondent and judgment shall be postponed unless the respondent objects, in which case the Conduct Committee shall further consider its judgment in camera and determine the matter in accordance with rule 18(6).

(4) Where on any motion at a hearing of the Conduct Committee to restore an applicant to the register the votes are equal, the question shall be deemed to have been resolved against the applicant.

(5) No member of the Conduct Committee present when any question is put to a vote may abstain from voting.

Communication of the Conduct Committee's decision to nurse, midwife or health visitor registration authorities outside the United Kingdom

27. Where it is evident from the Council's records that a person who has been removed from, or restored to, the register either–

(a) was admitted to the register following original registration outside the United Kingdom; or

(b) was the subject of verification of her original registration in the United Kingdom to registration authorities in any other countries,

a communication to the relevant authorities of the decision to remove the respondent from the register or restore the applicant to the register shall be sent by the Registrar.

Record of caution

28. The Council shall keep a record for 5 years of each caution issued and the record of a caution may be taken into consideration by the Preliminary Proceedings Committee and Conduct Committee in the exercise of their respective powers.

PART III

Health Committee

29.—(1) A Health Committee shall be constituted by, and comprise members of, the Council in order to determine whether, in the circumstances specified in rule 2(1)(b)–

(a) a practitioner shall be removed from the register;

(b) a practitioner's registration shall be suspended;

(c) a person who has been removed from the register may be restored to it; and

(d) the suspension of a person's registration shall be terminated.

(2) The Council shall appoint some of its members who shall be eligible and required to serve from time to time on the Health Committee, such members to be selected with due regard to the need to represent a wide range of fields of professional work.

(3) The President shall be the chairman of the Health Committee.

(4) In addition, from amongst those persons appointed under paragraph (2) the Council shall appoint a panel of six persons from whom a deputy chairman may be chosen who shall then take the chair in the absence of the chairman, or at her request.

(5) In the event of neither the chairman nor any of the six deputy chairmen being available those members who constitute the Health Committee on that occasion shall select a chairman from within their own number.

(6) The quorum of the Health Committee shall be three.

(7) Any person who has participated in the consideration of a case as a member of the Preliminary Proceedings Committee, or as a professional screener, shall not be permitted to be a member of the Health Committee dealing with that case.

Appointment of persons to conduct initial consideration of cases

30.—(1) The Council shall appoint a panel of its members to be professional screeners from whom a group of 3 shall be selected to consider any matters referred to them, due regard being had to the professional field in which the practitioner works or has worked.

(2) No case shall be considered by the Health Committee unless it has been referred by the professional screeners appointed under paragraph (1).

Information raising the question as to the fitness to practise of nurses, midwives or health visitors

31.—(1) Where information in writing is received by the Registrar about any practitioner which raises a question as to whether the fitness to practise of the practitioner is seriously impaired by reason of her physical or mental condition, the Registrar shall submit the information to the professional screeners.

(2) Anyone wishing to lay information must execute a statutory declaration which shall state–

(a) her address and designation; and

(b) the information; and

(c) her grounds for the belief in the truth of any fact declared which is not within her personal knowledge.

(3) If it appears to the professional screeners that there is no reasonable evidence to support the allegations they shall direct the Registrar so to inform the complainant and, if they consider it necessary or desirable, the practitioner. The professional screeners may, if they consider it necessary to assist them in arriving at a decision, obtain an opinion from a selected medical examiner on the information and evidence they have received.

(4) Unless it appears to the professional screeners that the matter need not proceed further they shall direct the Registrar to write by the recorded delivery service to the practitioner–

(a) notifying her that information has been received which appears to raise a question as to whether her fitness to practise has become seriously impaired by reason of her physical or mental condition and indicating the symptomatic behaviour which gives rise to that question;

(b) inviting the practitioner to agree within 14 days to submit to examination at the Council's expense by two medical examiners to be chosen by the professional screeners and to agree that such examiners should furnish to the Registrar reports on the practitioner's fitness to practise;

(c) informing the practitioner that it is also open to her to nominate other medical practitioners to examine her at her own expense and to report to the Registrar on the practitioner's fitness to practise; and

(d) inviting the practitioner to submit to the Registrar any observations or other evidence which she may wish to offer as to her own fitness to practise.

(5) All information received by the Registrar pursuant to sub-paragraphs (b), (c) and (d) of paragraph (4) shall be forwarded to the professional screeners.

(6) In the event of the two medical examiners not being able to agree on the result of their examination a third medical examiner may be appointed at the Council's expense.

(7) Before giving a direction under paragraph (4) the professional screeners may cause such enquiries to be made in relation to the matters before them as they think fit.

Examination by medical examiners

32.—(1) If the practitioner agrees to submit to medical examination in response to an invitation sent out under rule 31(4)(b) and (c) the Registrar shall make arrangements for such examination. The medical examiners shall be chosen by the professional screeners in accordance with the provisions of the Second Schedule to these rules.

(2) The Registrar shall send to the chosen medical examiners the information received by the Registrar and the professional screeners and shall ask the medical examiners to report on the fitness of the practitioner to engage in practice, and how they recommend that her case should be managed.

Action following consideration of reports of medical examiners

33.—(1) The professional screeners shall consider the reports received from the medical examiners, including any reports by medical practitioners nominated by the practitioner under rule 31(4)(c), and shall cause the Registrar to send copies of them to the practitioner.

(2)(a) If the medical examiners consider unanimously that the practitioner is not fit to practise, or is a practitioner on whose practice restrictions should be imposed, or if in the case of a difference of opinion amongst the medical examiners it appears to the professional screeners that the practitioner may not be fit to practise or may not be fit to practise without the imposition of restrictions, the professional screeners shall refer the information received together with the reports of the medical examiners to the Health Committee and may direct the solicitor to take all necessary steps to verify the evidence to be submitted to the Health Committee and to obtain any necessary documents and the attendance of witnesses;

(b) where in any case there is considered to be no sufficient evidence of illness in accordance with the foregoing rules the practitioner and complainant shall be so informed by the Registrar.

Provisions applying when a case has been referred to the professional screeners by the Preliminary Proceedings Committee, the President or the Conduct Committee

34.—(1) Where a case has been referred by the Preliminary Proceedings Committee, the President or the Conduct Committee to the professional screeners, the screeners shall direct the Registrar–

(a) to invite the practitioner to submit to examination at the Council's expense by at least two medical examiners to be chosen by the professional screeners; and

(b) to invite the practitioner to agree that such examiners should furnish to the professional screeners reports on the practitioner's fitness to practise; and

(c) to inform the practitioner that it is also open to her to nominate other medical practitioners at her own expense to examine her and to report to the professional screeners on her.

(2) In the event of the medical examiners not agreeing on their report a third medical examiner may be appointed at the Council's expense.

(3) If the practitioner agrees to submit to examination as aforesaid the Registrar shall make arrangements for such examination and any reports received to be referred to the professional screeners, together wth the information on which the Preliminary Proceedings Committee, the President or the Conduct Committee, as the case may be, decided to refer the case.

(4) The professional screeners shall consider the reports and information referred to in paragraph (3) and shall either–

(a) refer the case to the Health Committee for a determination as to whether the practitioner's fitness to practise is seriously impaired by reason of her physical or mental condition; or

(b) refer the case back to the Committee from which it was received or, in the case of referral by the President under rule 14(2), to the President who shall, subject to a determination pursuant to rule 14(1), refer the matter to the Conduct Committee.

(5) If the practitioner fails to submit to examination as provided for in rule 31(4)(b) or refuses to nominate other medical practitioners to examine her under rule 31(4)(c) the professional screeners shall decide whether or not to refer the information received to the Health Committee indicating the reason why no medical report is available.

Notice of Referral

35.—(1) Subject to rule 34, as soon as practicable after a case has been referred by the professional screeners to the Health Committee, the Registrar shall send to the practitioner a Notice of Referral which shall–

(a) indicate the grounds for the belief that her fitness to practise is seriously impaired; and

(b) state the day, time and place at which the Health Committee will meet to consider the matter.

(2) Except with the agreement of the practitioner no case shall be referred for consideration at any date earlier than twenty eight days after the date of posting the Notice of Referral.

(3) A Notice of Referral shall be delivered to the practitioner or sent by the recorded delivery service to the registered address of the practitioner contained in the register or, if the Registrar has reason to believe that that address is not her present address, then to any later address which may be known to the Registrar.

(4) When sending a Notice of Referral the Registrar shall inform the practitioner that it is open to her to be represented at the hearing and also to be accompanied by her medical adviser. The Registrar shall also invite the practitioner to state whether she proposes to attend the hearing.

(5) The Registrar shall send with any Notice of Referral a copy of these rules and copies of any reports and other information which it is proposed to present to the Health Committee, other than reports of which copies have already been sent to the practitioner under rule 33(1).

(6) When forwarding copies of the information or medical reports to the practitioner under paragraph (5) the Registrar shall ask the practitioner to state within fourteen days of the receipt of the Notice of Referral whether she will require evidence of any part of the information or of the findings and opinions contained in the reports to be given orally before the Health Committee. If the practitioner requires the presentation of oral evidence the Registrar may fix a new date for the hearing and shall issue an amended Notice of Referral in accordance with the requirements of paragraphs (2) and (3).

Postponement or cancellation of hearing

36.—(1) Notwithstanding the provisions of the foregoing rules the President, of her own motion or upon the application of a party thereto, may postpone the hearing of an inquiry or may refer the matter back to the Preliminary Proceedings Committee, the Conduct Committee or the professional screeners, as the case may be, for further consideration as to whether a hearing should take place.

(2) Where before the hearing begins it appears to the chairman of the Health Committee, or at any stage during the hearing it appears to the Health Committee, that a Notice of Referral is defective, she or it shall cause the notice to be amended unless it appears that the required amendment cannot be made without injustice, or if she or it considers that the circumstances in which an amendment is made require it, she or it may direct that the hearing shall be postponed or shall not take place.

(3) The Registrar shall as soon as practicable inform the practitioner of any decision to postone or cancel the hearing, specifying, in the case of a postponement, the further date fixed for the hearing.

Preliminary circulation of evidence

37. Before the meeting of the Health Committee the Registrar shall send to each member of the Health Committee, and to the medical examiners chosen to advise the

Health Committee on the particular case, copies of the Notice of Referral, of the information received by the Council, of any medical reports received in accordance with rules 33 and 34, and of any observations or other evidence submitted by or on behalf of the practitioner.

Conduct of inquiry

38.—(1) The Health Committee shall sit in private.

(2) At least one of the medical examiners selected by the professional screeners to examine the practitioner shall be in attendance throughout the inquiry except during those periods when the Health Committee decides to deliberate in camera.

(3) The practitioner shall be entitled to be present while her case is heard, and may also be represented by counsel or a solicitor, or by an officer of a representative organisation, or by any other person of her choice, and may be accompanied by her medical adviser.

(4) Where the practitioner is neither present nor represented the chairman of the Health Committee shall ask the Council's officer or the solicitor, if present, to satisfy the Health Committee that the Notice of Referral has been received by the practitioner. If it does not appear to have been so received the Health Committee may nevertheless proceed with the inquiry, if it is satisfied that all reasonable efforts in accordance with these rules have been made to serve the Notice of Referral on the practitioner.

Grounds for belief that the practitioner's fitness to practise is seriously impaired and calling of witnesses where notice has been given

39.—(1) At the opening of the proceedings the chairman shall draw attention to the grounds for the belief that the practitioner's fitness to practise is seriously impaired as set out in the Notice of Referral and to the documentation which has been circulated.

(2) Where in any case the practitioner has within the period indicated in rule 35(6) required that all or part of the information or reports be supported by oral evidence, the persons on whose testimony or opinions such information or reports depend shall be called as witnesses. Such witnesses may be examined by the solicitor, and may be cross-examined by or on behalf of the practitioner and may then be re-examined.

(3) Where in any case the practitioner has declined medical examination the solicitor may adduce evidence of the facts alleged and the practitioner or her representative may cross-examine any person giving evidence and the solicitor may then re-examine that person.

Calling of witnesses where no previous notice has been given

40. If, in any case where no prior notice has been given on behalf of the practitioner that all or part of the evidence shall be given orally, the practitioner or her representative indicates that she requires such evidence to be given orally, the Health Committee shall consult the legal assessor as to whether, in the interests of justice, it should adjourn the hearing in order to secure the attendance of such persons as witnesses or whether to proceed with the hearing without taking such oral evidence. If such witnesses are called they may be examined by the Health Committee or the solicitor and may be cross-examined on behalf of the practitioner and may be re-examined.

Presentation of the practitioner's case

41. At the conclusion of any oral evidence given as aforesaid the chairman shall invite the practitioner or her representative to address the Health Committee and to adduce evidence as to the practitioner's fitness to practise.

Questions

42. At any time in the proceedings questions may be put to any witness by the Health Committee and, with the leave of the chairman, by the legal assessor or the medical examiner. Whether or not witnesses are called the Health Committee may put questions to the practitioner either direct or through her representative.

Determination by Health Committee

43. At the conclusion of proceedings under the foregoing rules the Health Committee may–

(a) adjourn the case in order to obtain further medical reports or evidence as to the physical or mental condition of the practitioner or for such other purposes as may in the circumstances be appropriate; or

(b) determine that the fitness to practise of the practitioner is not seriously impaired by reason of her physical or mental condition; or

(c) postpone judgment; or

(d) determine that the fitness to practise of the practitioner is seriously impaired by reason of her physical or mental condition.

Determination that fitness is not impaired

44. If the Health Committee makes a determination under rule 43(b) it shall either–

(a) certify such opinion and instruct the Registrar to refer the matter back to the Committee from which the case was referred, or, in the case of a referral by the President, to the President who shall, subject to a determination pursuant to rule 14(1), refer the matter to the Conduct Committee; or

(b) conclude the case.

Postponement of judgment

45. If the Health Committee makes a determination under rule 43(c) it shall also determine the month and year in which the hearing will resume and shall indicate the medical evidence of the practitioner's fitness to practise which it will require at the resumed hearing.

Determination that fitness is impaired

46. If the Health Committee makes a determination under rule 43(d) it shall direct the Registrar to remove the practitioner from the register, or to suspend the practitioner's registration, whether or not for a specified period.

Announcement of determination

47. The chairman shall announce the determination or determinations of the Health Committee under the foregoing rules in such terms and with such recommendations as the Health Committee shall have approved.

Communication of decision

48.—(1) The Registrar shall forthwith communicate with the practitioner by the recorded delivery service informing her of the decision of the Health Committee and stating any registration fee which may be due where the Conduct Committee has determined not to remove the practitioner from the register.

(2) In those cases where a decision has been postponed the letter shall set out any recommendations made by the Health Committee including a requirement for the payment of any registration fee which may be due.

(3) In those cases where a person has been removed from the register, or where her registration has been suspended, the letter shall set out any recommendations made by the Health Committee. In such cases the letter shall also require that she should return to the Registrar within 21 days any document or insignia issued by the Council or its predecessor which indicates registration status and warn her of her liability to proceedings under section 14(1)(b) of the Act if she holds herself out to be a practitioner in a part of the register from which her name has been removed, or from which her registration has been suspended.

(4) With the letter shall be sent a form to be signed by the practitioner or person, as the case may be, and returned to the Registrar, acknowledging the receipt of the Council's decision and confirming that the contents of the letter are understood.

Termination of suspension and restoration to the register

49.—(1) Where removal of a person from the register or suspension of a person's registration, in the circumstances set out in rule 2(1)(b) and rule 3(1)(a) respectively, has been for a specified period, such removal or suspension shall terminate at the expiry of the period so specified.

(2) Where, in the circumstances set out in rule 2(1)(b) or rule 3(1)(a) respectively, a person has, for an unspecified period, been removed from the register, or a person's registration has, for an unspecified period, been suspended, any application for restoration to the register, or for the suspension to be terminated, shall be made in writing addressed to the Registrar and signed by the applicant stating the grounds on which the application is made.

(3) The applicant shall then be sent a letter by the Registrar to–

(a) outline the application procedure;

(b) enclose a form on which the applicant must state the necessary personal details and the name and address of a medical practitioner to whom the Council may apply for a report on the applicant's health:

(c) require the applicant to declare whether or not she has been convicted of a criminal offence since the date of her removal from the register, or suspension of her registration, or that she is not the subject of any current criminal proceedings, but if she has been convicted of a criminal offence or if she is currently the subject of criminal proceedings to provide details thereof including the judgment and the address of the Court at which the proceedings took place or are taking place;

(d) require her to declare whether or not she has knowingly represented herself to be a practitioner since the date of her removal or suspension from the register, except in respect of any part from which she was not removed or from which her registration was not suspended;

(e) state the fee (if any) for restoration should the application be successful;

(f) state any registration fee which may be due.

The Health Committee may invite the applicant to verify by statutory declaration any statement made in her application.

(4) As soon as practicable after the documents have been received in respect of the application a date, time and place for the consideration of the application by the Health Committee shall be determined and shall be notified to the applicant in a letter signed by the Registrar.

(5) The professional screeners shall direct the Registrar to invite the applicant to submit to examination at the Council's expense before the application is considered by the Health Committee, by at least two medical examiners to be chosen by the professional screeners and to agree that such examiners should furnish to the Health Committee reports on the applicant's fitness to practise.

(6) In the event of the medical examiners not agreeing on their report a third medical examiner may be appointed at the Council's expense.

(7) If the applicant agrees to submit to examination as aforesaid the Registrar shall make arrangements for such examination and any reports received shall be referred to the Health Committee. If the applicant declines to submit to a medical examination as aforesaid the Registrar shall refer the application to the Health Committee but indicating the reason why no medical report is available.

(8) The chairman may require the Council's officer to provide information about any known activities of the applicant since the applicant was removed or suspended from the register.

(9) The Health Committee shall consider the evidence submitted in respect of the application, and may question the applicant.

(10) Where the Health Committee decides that the applicant shall be restored to the register or that the suspension shall be terminated, and so directs the Registrar, it shall also determine the date when the restoration or termination shall take effect and whether

it should be subject to any of the limitations for which rules made under section 10(3)(c) of the Act provide. The decision of the Health Committee shall be announced in the presence of the applicant and/or her representative and/or her medical practitioner (as referred to in paragraph (3)(b)) if the practitioner wishes any or all of them to be present.

(11) The decision of the Health Committee shall be signed by the Registrar and conveyed to the applicant by the recorded delivery service.

(12) Where the Health Committee has decided that the applicant shall be restored to the register or that the suspension shall be terminated, then, upon the payment by the applicant of any restoration and registration fee, the Registrar shall cause the applicant to be restored to the register and shall issue to the applicant a full copy of the entry in the register.

(13) Subject to the foregoing paragraphs of this rule and the requirements of natural justice the procedure of the Health Committee shall be such as it may determine.

Notice of resumed hearing

50.—(1) Where under any of the foregoing rules the Health Committee has adjourned the case or postponed judgment, the Registrar shall not later than 4 weeks before the day fixed for the resumption of the proceedings send to the practitioner or applicant, as the case may be, a notice which shall–

(a) specify the day, time and place at which the proceedings are to be resumed and invited her to appear thereat; and

(b) if the Health Committee has so directed, invite her to submit to examination by the medical examiners chosen by the Health Committee; and

(c) if the Health Committee has so directed, invite her to furnish the names and addresses of medical practitioners or other persons to whom the Health Committee may apply for confidential information as to their knowledge of her fitness to practise since the time of the original inquiry.

(2) Paragraphs (3), (4), (5) and (6) of rule 35 shall apply to the sending of notices under this rule.

Application of rules 37 to 49

51. At any resumed hearing the procedure shall be that provided by rules 37 to 49 for the original hearing and the Health Committee may exercise any power which under those rules it could have exercised at the original hearing.

Adjournment of proceedings

52. The Health Committee may adjourn any of its proceedings or meetings from time to time as it thinks fit.

Deliberation in camera

53. Subject to the provisions of these rules, the Health Committee may deliberate in camera at any time and for any purpose during any proceedings and for such purpose may exclude the practitioner or applicant, as the case may be, her representative and her medical adviser.

Evidence

54. The Health Committee shall comply with rule 25 insofar as it is applicable.

Voting

55. The voting procedure of the Health Committee shall be governed by rule 26 insofar as it is applicable.

Postal service of documents

56. Without prejudice to any requirement of these rules as to the service of documents by registered post or the recorded delivery service. any notice authorised or required by these rules may be sent by post.

Communication of Health Committee's decision to nurse, midwife or health visitor registration authorities outside the United Kingdom

57. Where it is evident from the Council's records that a person who has been removed from, or restored to, the register or whose registration has been suspended, or whose suspension of registration has been terminated, either–

(a) was admitted to the register following original registration outside the United Kingdom; or

(b) was the subject of verification of her original registration in the United Kingdom to registration authorities in any other countries,

a communication to the relevant authorities ot the decision made in respect of the person or applicant, as the case may be, shall be sent by the Registrar.

PART IV

Interim suspension of registration

58.—(1) If, during a hearing before the Conduct Committee or the Health Committee, it appears that the hearing will not conclude in the time set aside for that purpose, and it further appears to the Committee necessary to direct the interim suspension of a practitioner's registration, the chairman shall–

(a) so inform the practitioner giving reasons for the Committee's views;

(b) give the practitioner and her representative, if any, reasonable opportunity to show cause to the Committee why she should not be made the subject of such a direction;

(c) require the Committee to determine, within the period set aside for the hearing, whether it is satisfied that a direction of interim suspension is necessary for the protection of the public or in the interests of the practitioner.

(2) Subject to the provisions of paragraph (1), if at any stage in the exercise of powers under these rules it appears necessary to do so, the Preliminary Proceedings Committee, Conduct Committee or Health Committee (referred to in this Part hereafter as "the Committee") shall, in accordance with the following paragraphs, consider whether to direct the interim suspension of a practitioner's registration.

(3) The Registrar shall, before a direction of interim suspension under paragraph (5) is given–

(a) send, by registered post, notice to the practitioner to show cause why she should not be made the subject of a direction of interim suspension pursuant to paragraph (5), at a hearing on a date which shall be specified by the Registrar and which shall not be a date earlier than 14 days from the date the notice is sent to the practitioner, unless the practitioner otherwise agrees; such notice to be sent to the practitioner's registered address or, if the Registrar has reason to believe that that address is not her present address, then to any later address which may be known to the Registrar;

(b) send to the practitioner with the notice referred to in paragraph (a), copies of any documents in the Council's possession, or any information, relevant to the question of interim suspension which the Committee will consider;

(c) inform the practitioner of her right to attend the hearing referred to in paragraph (a) and to be heard on the issue of whether a direction of interim suspension of registration should be given;

(d) inform the practitioner that she may be represented at the hearing by counsel or a solicitor, or by an officer of a representative organisation, or by any other person of her choice;

(e) convene a hearing of the Committee, to be attended by a legal assessor, to consider the question of interim suspension. whether or not such hearing takes place for any other purpose laid down in Parts I, II or III of these rules.

(4) The Committee shall, before a direction of interim suspension under paragraph (5) is given–

(a) give the practitioner, her witnesses and her representative, if present at the hearing, the opportunity to be heard in response to the documents and information referred to in paragraph 3(b);

(b) put questions to the practitioner, if considered necessary, either direct or through her representative;

(c) put questions to any witness direct, by the solicitor or, with the leave of the chairman, by the legal assessor or medical examiner, if any;

(d) require such assistance from the solicitor as may be deemed necessary;

(e) determine whether it is satisfied that a direction of interim suspension of the practitioner's registration is necessary for the protection of the public or in the interests of the practitioner.

(5) The Committee may direct the interim suspension of the practitioner's registration to have effect during such period as may be specified in the direction.

(6) After a direction has been made under paragraph (5), the Registrar shall fix a date, which shall be as soon as reasonably practicable, for such hearing, or resumed hearing, as may be required to be held, in respect of the person whose registration has been suspended, in accordance with Part II or III of these rules.

(7) During the period in which a direction of interim suspension is effective, the Committee which made the direction shall review the suspension at 3 monthly intervals, and may so review at any time, and the provisions of paragraph (4) shall apply to such review.

(8) The Committee which sits to exercise powers under this rule shall sit in private.

(9) The Committee may, at any stage when considering the question of interim suspension adjourn, or decline to proceed with, such consideration.

(10) The voting procedure of the Committee shall be governed by rule 26 insofar as it is applicable.

Termination of interim suspension

59.—(1) Where a direction made under rule 58(5) specified a period during which the suspension is to have effect, such suspension shall terminate at the expiry of the specified period.

(2) Where a direction made under rule 58(5) does not specify a period during which the suspension is to have effect, such suspension shall terminate in accordance with the following provisions–

(a) where the direction was given by the Preliminary Proceedings Committee, it shall terminate–

(i) upon the issue of a caution or the case being closed by the Preliminary Proceedings Committee:

(ii) in accordance with the following sub-paragraphs, where the case was referred to the Conduct Committee or Health Committee;

(b) where the direction was given by the Conduct Committee or was given by the Preliminary Proceedings Committee or Health Committee prior to, or at the time of, referral to the Conduct Committee, it shall terminate–

(i) upon the issue of a caution, postponement of judgment, direction of removal from the register, or the case being closed by the Conduct Committee;

(ii) in accordance with sub-paragraph (c) where the case was determined by the Health Committee on referral to it;

(c) where the direction was given by the Health Committee or was given by the Preliminary Proceedings Committee or Conduct Committee prior to, or at the time of, referral for consideration of the practitioner's fitness to practise, it shall terminate–

(i) upon the direction of removal from the register or suspension of registration under rule 46;

(ii) upon postponement of judgment under rule 45;
(iii) upon the case being closed by the Health Committee.

(3) At any stage during the exercise of its functions under these rules, the Committee may revoke a direction made under rule 58(5), whether by that, or another, Committee.

Miscellaneous

60. Save where indicated otherwise in rules 58 and 59, the Committee shall proceed in accordance with the provisions of Parts I, II and III of these rules, as required.

Transitional provision

61. The provisions of these rules and all duties and powers contained therein (including the powers provided in rules 2, 3, 4 and 5) shall as of the date of coming into force of these rules have full and immediate effect in respect of–

(a) all allegations of misconduct notified or referred to a National Board or the Council prior to such date;
(b) all investigations already commenced, being carried out or otherwise under consideration by a National Board on such date;
(c) all proceedings referred by a National Board to the Conduct Committee or the Council and then pending;
(d) all cases or proceedings before the Conduct Committee which have not been concluded by a judgment (including all cases in which the Conduct Committee has postponed judgment prior to the said date and has not thereafter resumed its consideration).

Revocation of previous rules

62. The Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1987 (a) are hereby revoked.

(a) *See* S.I. 1987/2156.

FIRST SCHEDULE (Rule 6(1))

FORM OF NOTICE

UNITED KINGDOM CENTRAL COUNCIL FOR NURSING, MIDWIFERY AND HEALTH VISITING PROFESSIONAL CONDUCT COMMITTEE
Nurses, Midwives and Health Visitors Act 1979 as amended

NOTICE OF INQUIRY

To .....

of .....

Take notice that the charge (or charges) against you, particulars of which are set forth below, has/ have been brought to the notice of the Council, and that the Professional Conduct Committee of the Council proposes to investigate such charge(s) at a meeting to be held at .....

..... at ..... am/pm on

..... the ..... 19..... and to determine whether your name should be removed from the register or any part or parts of it, or whether you should be cautioned as to your future conduct. If the meeting has to be adjourned it is open to the Professional Conduct Committee to direct the immediate suspension of your registration but this will not occur without your being given an opportunity to make representations to the Professional Conduct Committee to show cause why this is not necessary for the protection of the public or in your own interests.

PARTICULARS OF CHARGE(S)

You are hereby required to attend before the Professional Conduct Committee of the Council at the time and place mentioned above and to answer such charges bringing with you all papers and documents in your possession relevant to the matter and any persons whose evidence you wish to lay before the Professional Conduct Committee. It should be carefully noted–

> You are entitled to be represented at the hearing before the Professional Conduct Committee by counsel or a solicitor, or by an officer of a representative organisation, or by any other person of your choice, but if you propose to be so represented, you should give written notice to the Registrar of the Council at the address mentioned above at least seven days before the hearing.

A copy of the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 is enclosed.

.....
Registrar and Chief Executive of the Council

SECOND SCHEDULE (Rule 25(1))

MEDICAL EXAMINERS

1. Subject to paragraph 4 of this Schedule, medical examiners shall be chosen by the Health Committee from persons nominated by any one of the following bodies:

The Royal College of Psychiatrists	Psychiatrists
The Central Committee for Hospital Medical Services of the British Medical Association	Neurologists, Physicians and Surgeons
The General Medical Services Committee of the British Medical Association	General Practitioners and other Branches of Medicine
Royal College of General Practitioners	General Practitioners
Royal College of Physicians of London	Neurologists and Physicians
Royal College of Physicians of Edinburgh	Physicians
Royal College of Surgeons of England	Surgeons
Royal College of Physicians and Surgeons of Glasgow	Neurologists, Physicians and Surgeons
Royal College of Physicians of Ireland	Physicians
Royal College of Surgeons in Ireland	Surgeons

2. Members of the Council shall not be eligible for nomination as medical examiners.

3. The Council shall from time to time determine the minimum number of persons to be nominated in respect of each branch of medicine, the periods for which nomination shall be made, and the intervals at which lists of those nominations shall be revised and may give directions as to the nomination of persons on a geographical basis.

4. In choosing medical examiners to act in relation to particular cases, the professional screeners and the Health Committee shall have regard to the nature of the physical or mental condition which is alleged to impair the practitioner's fitness to practise.

5. (a) It shall be the duty of at least one of the medical examiners selected to examine the practitioner, whether or not the practitioner has agreed to be examined, to be present at the inquiry and to advise the Health Committe c.a the medical significance of the evidence before it.

(b) Medical examiners shall give advice on questions referred to them by the Health Committee, and shall also advise the Health Committee of their own motion if it appears to them that, but for such advice, there is a possibility of a mistake being made in judging the medical significance of such evidence (including the absence of evidence) on any particular matter relevant to the fitness to practise of the practitioner.

GIVEN under the Official Seal of the
UNITED KINGDOM CENTRAL
COUNCIL FOR NURSING,
MIDWIFERY AND HEALTH VISITING
this 18th day of March 1993

Dame Audrey Emerton
Chairman

Colin Ralph
Registrar and Chief Executive

EXPLANATORY NOTE

(This note is not part of the Order)

This Order, as respects proceedings in Great Britain, approves the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993, which are set out in the Schedule. The Order comes into force on 1st April 1993 and, in pursuance of section 22(4) of the Nurses, Midwives and Health Visitors Act 1979, the Rules come into force as respects Great Britain on that date; a further Order, made by the Lord Chief Justice of Northern Ireland, is required to bring them into force as respects Northern Ireland.

The Rules revoke and replace, with amendments, the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1987. Most of the amendments arise as a consequence of the Nurses, Midwives and Health Visitors Act 1992 which, among other matters, transferred from the National Boards to the Council the obligation to investigate allegations of misconduct; gave to the Council power to caution practitioners as to their future conduct and power to suspend practitioners' registration. Rule 7 constitutes a Preliminary Proceedings Committee ("PPC") which will investigate and give initial consideration to allegations of misconduct; a caution may be issued by this Committee after admission by a practitioner of the facts alleged and that they amount to misconduct (rule 9). The PPC will refer to the Professional Conduct Committee ("PCC") those cases which appear to justify removal from the register. The PPC may refer cases to the professional screeners for assessment of a practitioner's fitness to practise (rule 9). The power to caution is also given to the PCC (rule 12) though not to the Health Committee. The Health Committee may suspend a practitioner's registration (rule 46) though it retains the alternative power to remove the practitioner from the register (rule 29). All three Committees are granted a new power to direct the interim suspension of a practitioner's registration (rule 58) in circumstances in which it is thought necessary for the protection of the public or in the interests of the practitioner.

The PPC, the President and the PCC may refer cases of alleged misconduct to the professional screeners (rules 8, 14 and 24). The professional screeners are given a new discretion to assess the suitability of cases for consideration by the Health Committee and to return those which they deem unsuitable to the referring Committee (rule 34). The procedure to be followed where a practitioner is required to answer allegations of misconduct and matters evidenced by conviction has changed so that the PCC will first consider all other matters before addressing a conviction (rule 19). Rule 28 provides that the Council will keep for a period of five years a record of any caution issued. All practitioners the subject of consideration by the PPC will be informed, if not before the Committee's consideration, then afterwards, of the outcome (rule 9). The complainant no longer has a right to prosecute allegations before the PCC (rule 13). Where a practitioner admits misconduct the Committee considering the case will, nevertheless, be required to make a determination as to whether, in its view, the practitioner is guilty of misconduct (rule 9 and rule 18). The transitional provision (rule 61) provides that the Rules will apply to all allegations already the subject of consideration on the date the Rules become effective; all new powers given in the Rules may be exercised in relation to all such cases.

STATUTORY INSTRUMENTS

1993 No. 893

NURSES, MIDWIVES AND HEALTH VISITORS

The Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 Approval Order 1993

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STATUTORY INSTRUMENTS

1998 No. 1103

NURSES, MIDWIVES AND HEALTH VISITORS

The Nurses, Midwives and Health Visitors (Professional Conduct) (Amendment) Rules 1998 Approval Order 1998

Made - - - - -	*20th April 1998*
Coming into force - -	*18th May 1998*

The Lord Chancellor and the Lord Advocate, in exercise of their powers under section 19(5) of the Nurses, Midwives and Health Visitors Act 1997(a), and as respects proceedings in England and Wales and in Scotland, respectively, hereby approve the Nurses, Midwives and Health Visitors (Professional Conduct) (Amendment) Rules 1998 made by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting and set out in the Schedule hereto.

This Order may be cited as the Nurses, Midwives and Health Visitors (Professional Conduct) (Amendment) Rules 1998 Approval Order 1998 and shall come into force on 18th May 1998.

Irvine of Lairg, C.

Dated 8th April 1998

Hardie

Dated 20th April 1998

(a) 1997 c. 24.

SCHEDULE

The Nurses, Midwives and Health Visitors (Professional Conduct) (Amendment) Rules 1998 made by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting under the Nurses, Midwives and Health Visitors Act 1997

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting, in exercise of the powers conferred on it by section 10 of the Nurses, Midwives and Health Visitors Act 1997(a), hereby makes the following rules—

Citation, Interpretation and Transitional Provision

1.—(1) These rules may be cited as the Nurses, Midwives and Health Visitors (Professional Conduct) (Amendment) Rules 1998.

(2) For the purposes of these rules "the Professional Conduct rules" means the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993(b).

(3) These rules shall apply in respect of a person removed from the register on or after the date of the commencement of these rules and any person removed from the register for a specified period before that date shall be treated as if these rules had not come into force.

Amendment of the Professional Conduct rules

2.—(1) The Professional Conduct rules shall be amended in accordance with the following paragraphs of this rule.

(2) In rule 2—

(a) in paragraph (4) the words "in accordance with rule 22(1), or" shall be deleted: and

(b) in paragraph (5) the words "in accordance with rule 49(1) or" shall be deleted.

(3) In rule 18(4) before the word "guilty" there shall be added the word "not".

(4) In rule 22—

(a) paragraph (1) shall be deleted; and

(b) in paragraph (2) the words ", for an unspecified period," shall be deleted.

(5) In rule 49—

(a) paragraph (1) shall be deleted; and

(b) in paragraph (2) the words ", for an unspecified period," where they twice appear shall be deleted.

GIVEN under the Official Seal of the UNITED KINGDOM CENTRAL COUNCIL FOR NURSING, MIDWIFERY AND HEALTH VISITING this 16th day of March 1998.

L.S.

Mary Uprichard
President

Sue Norman
Chief Executive/Registrar

(a) 1997 c. 24.
(b) S.I. 1993/893.

EXPLANATORY NOTE

(This note is not part of the Order)

This Order, as respects proceedings in Great Britain, approves the Nurses, Midwives and Health Visitors (Professional Conduct) (Amendment) Rules 1998, which are set out in the Schedule. A further Order made by the Lord Chief Justice of Northern Ireland, is required to bring them into force as respects Northern Ireland.

The 1998 Rules amend the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 so that a person who has been removed from the register for a specified period for ill health or misconduct has to apply for restoration at the end of that period in the same way as a person who has been removed from the register for an unspecified period.

STATUTORY INSTRUMENTS

1998 No. 1103

NURSES, MIDWIVES AND HEALTH VISITORS

The Nurses, Midwives and Health Visitors (Professional Conduct) (Amendment) Rules 1998 Approval Order 1998

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STATUTORY INSTRUMENTS

2001 No. 536

NURSES, MIDWIVES AND HEALTH VISITORS, ENGLAND AND WALES

The Nurses, Midwives and Health Visitors (Professional Conduct) (Amendment) Rules 2001 Approval Order 2001

Made - - - - *23rd February 2001*

Coming into force *1st March 2001*

The Lord Chancellor, in exercise of the powers conferred upon him by section 19(5) of the Nurses, Midwives and Health Visitors Act 1997(a), and as respects proceedings in England and Wales only, hereby approves the Nurses, Midwives and Health Visitors (Professional Conduct) (Amendment) Rules 2001 made by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting and set out in the Schedule to this Order.

This Order may be cited as the Nurses, Midwives and Health Visitors (Professional Conduct) (Amendment) Rules 2001 Approval Order 2001, and shall come into force on 1st March 2001.

Dated 23rd February 2001 *Irvine of Lairg*, C.

SCHEDULE

THE NURSES, MIDWIVES AND HEALTH VISITORS (PROFESSIONAL CONDUCT) (AMENDMENT) RULES 2001

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting, in exercise of the powers conferred on it by section 10 of the Nurses, Midwives and Health Visitors Act 1997, hereby makes the following rules—

Citation and Interpretation

1.—(1) These rules may be cited as the Nurses, Midwives and Health Visitors (Professional Conduct) (Amendment) Rules 2001.

(2) For the purposes of these rules "the Professional Conduct rules" means the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993(b).

Amendment of the Professional Conduct rules

2.—(1) The Professional Conduct rules shall be amended in accordance with the following paragraphs of this rule.

(a) 1997 c. 24.
(b) S.I. 1993/893 to which there are amendments not relevant to these rules.

(2) In rule 7(5) (Preliminary Proceedings Committee) for the number "3" there shall be substituted the number "2".

(3) In rule 12(2) (Professional Conduct Committee) for the word "three" there shall be substituted the word "two".

(4) In rule 29 (Health Committee)—

(a) in paragraph (1) the word "comprise" shall be deleted and shall be replaced by the word "include";

(b) in paragraph (5)—

(i) the word "members" shall be deleted, and

(ii) after the second use of the word "chairman" there shall be added the words ", who shall be a member of the Council,";

(c) for paragraph (6) there shall be substituted the following—

"(6) The Health Committee shall be quorate if at least two members of the Council constitute a majority of those considering a particular case.".

(5) In rule 30 (Appointment of persons to conduct initial consideration of cases), in paragraph (1) the words "its members to be" shall be deleted.

GIVEN under the Official Seal
of the UNITED KINGDOM CENTRAL
COUNCIL FOR NURSING, MIDWIFERY
AND HEALTH VISITING this
1st day of February, 2001

Alison Norman
President

Sue Norman
Chief Executive/Registrar

EXPLANATORY NOTE

(This note is not part of the Order)

This Order approves, as respects proceedings in England and Wales only, the Rules set out in the Schedule. These amend the Professional Conduct Rules of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting so as to reduce from three to two the number of Council members necessary to constitute a quorum of each of the Preliminary Proceedings Committee, the Professional Conduct Committee and the Health Committee, and to increase the involvement of non-Council members in the initial consideration of some cases.

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GOSPORT WAR MEMORIAL HOSPITAL INQUESTS

Monday 20 April 2009

The Law Courts
Winston Churchill Avenue
Portsmouth,
PO1 2DQ

BEFORE:

Mr Anthony Bradley
Coroner for North Hampshire
Assistant Deputy Coroner for South East Hampshire

Code A 9 Ors

(DAY TWENTY-ONE)

MR ALAN JENKINS QC, instructed by **, appeared on behalf of Dr Jane Barton.
MR JAMES TOWNSEND, Counsel, instructed by the Royal College of Nursing, appeared on behalf of a number of nurse witnesses.
MS BRIONY BALLARD, Counsel, instructed by **, appeared on behalf of the acute trust and the PCT.
MR TOM LEIPER, Counsel, instructed by Messrs Blake Lapthorn, Solicitors, appeared on behalf of the families of Brian Cunningham, Michael Packman, Elsie Devine and Sheila Gregory.
MR PATRICK SADD, Counsel, (instructed from 23/03/09) appeared on behalf of the Wilson family.

(Transcript of the Official Recording by T A Reed & Co Ltd
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(In the presence of the jury)

THE CORONER: Good morning and welcome back. I am going to ask you to retire again for the moment. There is the question of room availability and you may find that there will be delays coming in and going out because of alternative uses of this room. Without putting any pressure on you and without requiring you to answer the question, is there any question we might finish today? Are you close enough to a decision to give that indication? It is questionable? [Yes]

I will ask you to retire and if there is anything further you need, let the usher know.

(The jury bailiff was sworn)

(The jury further retired to consider their verdict)

THE CORONER: Ladies and gentlemen, you have a clear indication there of a long day.

(The court was adjourned)

(In the presence of the jury)

THE CORONER: What I will do is I will ask you if you have reached a verdict on each case. I will ask you if that is a unanimous verdict. I will ask you for the cause of death. I will ask you for the answers to the three questions. If there are dissenters I will ask you all to sign the inquisition but if there are dissenters to note by their names that they are dissenting from the verdict. I will give you an inquisition as we go through each one.

Code A

THE CORONER: I will give you that inquisition which I have signed. If you could each sign that, please. Any dissenters if you could just put after your name "dissenting", please. (Pause)

THE CORONER: Elsie Lavender – can we do a bit of multi-tasking?

THE FOREMAN OF THE JURY: Yes, certainly.

THE CORONER: Cause of death for Elsie?

THE FOREMAN OF THE JURY: 1(a) high cervical cord injury.

THE CORONER: Nothing else?

THE FOREMAN OF THE JURY: No.

THE CORONER: In response to the question the administration of medication contributing more than minimally or negligibly to the death of the deceased?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was the medication given for therapeutic purposes?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it given appropriately for the condition or symptoms?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Helena Service: cause of death?

THE FOREMAN OF THE JURY: Congestive cardiac failure.

THE CORONER: Anything else?

THE FOREMAN OF THE JURY: No.

THE CORONER: In response to the question: the administration of medication contribute?

THE FOREMAN OF THE JURY: No.

THE CORONER: Ruby Lake: cause of death?

THE FOREMAN OF THE JURY: 1(a) bronchial pneumonia and (2) fractured neck of femur repaired on 5/8/98.

THE CORONER: And in response to the questions: the administration of medication?

THE FOREMAN OF THE JURY: No.

THE CORONER: Arthur Cunningham: cause of death, please?

THE FOREMAN OF THE JURY: 1(a) bronchial pneumonia; 1(b) sacral ulcer and (2) Parkinson's disease.

THE CORONER: In response to the questions: the medication contributing to the death?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it given for therapeutic purposes?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it appropriate for the condition?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Robert Wilson: cause of death, please?

THE FOREMAN OF THE JURY: 1(a) congestive cardiac failure and (2) alcoholic cirrhosis.

THE CORONER: Given as a (2)?

THE FOREMAN OF THE JURY: As a (2).

THE CORONER: The medication – did it contribute minimally or negligibly to death?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it given for therapeutic purposes?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it appropriate for the condition?

THE FOREMAN OF THE JURY: No.

THE CORONER: Enid Spurgeon: cause of death, please?

THE FOREMAN OF THE JURY: 1(a) infected wound and 1(b) fractured right hip repaired 20/3/99.

THE CORONER: Medication: did it contribute to death?

THE FOREMAN OF THE JURY: No.

THE CORONER: Geoffrey Packman: cause of death?

THE FOREMAN OF THE JURY: 1(a) gastrointestinal haemorrhage.

THE CORONER: Anything else?

THE FOREMAN OF THE JURY: No.

THE CORONER: On the question of medication, did it contribute?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it given for therapeutic purposes?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it appropriate for the condition and symptoms?

THE FOREMAN OF THE JURY: No.

THE CORONER: Elise Devine: cause of death?

THE FOREMAN OF THE JURY: 1(a) chronic renal failure; 1(b) ameloidosis and 1(c) IgA paraproteinaemia.

THE CORONER: In response to the question medication contributing to the death?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it given for therapeutic purposes?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it appropriate for the condition and symptoms?

THE FOREMAN OF THE JURY: No.

THE CORONER: Finally, Sheila Gregory: cause of death, please?

THE FOREMAN OF THE JURY: 1(a) pulmonary embolus and (2) fractured neck of femur.

THE CORONER: In response to the questions did the medication contribute?

THE FOREMAN OF THE JURY: No.

THE CORONER: Thank you. Ladies and gentlemen, can I say that you have my undying admiration. To unscramble all that was quite extraordinary. I am sorry it was presented to you in that way but I could not think of any other way of putting ten together and taking generic evidence and the personal evidence and the expert evidence in one lump, as it were, but you have done a sterling job. Thank you very much indeed. You really have served us very well. I will formally discharge you and I sincerely hope that you never have to do a job like this again. It is the only time I have ever done one like this and it is the only time that I have had to face those issues. I do not think I will do one again either. Thank you for what you have done, I am very grateful.

That completes the proceedings. Unless there is anything anyone wants to say, I will formally conclude. Ladies and gentlemen, thank you very much indeed. My sympathy to the family members; I am sure it has been very difficult for you to sit through this but I am glad you have and I hope you have achieved something.

(The inquest was concluded)

Code of Professional Conduct

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

23 Portland Place, London W1N 4JT
Telephone 0171 637 7181 Facsimile 0171 436 2924

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

June 1992

Code of Professional Conduct for the Nurse, Midwife and Health Visitor

Third Edition
June 1992

Each registered nurse, midwife and health visitor shall act, at all times, in such a manner as to:

- **safeguard and promote the interests of individual patients and clients;**
- **serve the interests of society;**
- **justify public trust and confidence and**
- **uphold and enhance the good standing and reputation of the professions.**

As a registered nurse, midwife or health visitor, you are personally accountable for your practice and, in the exercise of your professional accountability, must:

1 act always in such a manner as to promote and safeguard the interests and well-being of patients and clients;

2 ensure that no action or omission on your part, or within your sphere of responsibility, is detrimental to the interests, condition or safety of patients and clients;

3 maintain and improve your professional knowledge and competence;

4 acknowledge any limitations in your knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner;

5 work in an open and co-operative manner with patients, clients and their families, foster their independence and recognise and respect their involvement in the planning and delivery of care;

6 work in a collaborative and co-operative manner with health care professionals and others involved in providing care, and recognise and respect their particular contributions within the care team;

7 recognise and respect the uniqueness and dignity of each patient and client, and respond to their need for care, irrespective of their ethnic origin, religious beliefs, personal attributes, the nature of their health problems or any other factor;

8 report to an appropriate person or authority, at the earliest possible time, any conscientious objection which may be relevant to your professional practice;

9 avoid any abuse of your privileged relationship with patients and clients and of the privileged access allowed to their person, property, residence or workplace;

10 protect all confidential information concerning patients and clients obtained in the course of professional practice and make disclosures only with consent, where required by the order of a court or where you can justify disclosure in the wider public interest;

11 report to an appropriate person or authority, having regard to the physical, psychological and social effects on patients and clients, any circumstances in the environment of care which could jeopardise standards of practice;

12 report to an appropriate person or authority any circumstances in which safe and appropriate care for patients and clients cannot be provided;

13 report to an appropriate person or authority where it appears that the health or safety of colleagues is at risk, as such circumstances may compromise standards of practice and care;

14 assist professional colleagues, in the context of your own knowledge, experience and sphere of responsibility, to develop their professional competence

and assist others in the care team, including informal carers, to contribute safely and to a degree appropriate to their roles;

15 refuse any gift, favour or hospitality from patients or clients currently in your care which might be interpreted as seeking to exert influence to obtain preferential consideration and

16 ensure that your registration status is not used in the promotion of commercial products or services, declare any financial or other interests in relevant organisations providing such goods or services and ensure that your professional judgement is not influenced by any commercial considerations.

Notice to all Registered Nurses, Midwives and Health Visitors

This Code of Professional Conduct for the Nurse, Midwife and Health Visitor is issued to all registered nurses, midwives and health visitors by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. The Council is the regulatory body responsible for the standards of these professions and it requires members of the professions to practise and conduct themselves within the standards and framework provided by the Code.

The Council's Code is kept under review and any recommendations for change and improvement would be welcomed and should be addressed to the:

Chief Executive/Registrar
United Kingdom Central Council
for Nursing, Midwifery and Health Visiting
23 Portland Place
London
W1N 4JT

IN THE MATTER OF:

NURSING AND MIDWIFERY COUNCIL ("NMC")

GOSPORT WAR MEMORIAL HOSPITAL

GUIDANCE TO THE PELIMINARY PROCEEDINGS COMMITTEEOF THE NURSING AND MIDWIFERY COUNCIL OPERATING UNDER THE NURSES MIDWIVES AND HEALTH VISITORS (PROFESSIONAL CONDUCT) RULES 1993

In relation to these cases of alleged misconduct (cases relating to patients Page, Carby, Middleton, Wilkie and Devine) which are to be determined in accordance with the 1993 Rules, the Preliminary Proceedings Committee ("PPC") should follow the guidelines set out below.

1. Where there is more than one practitioner facing allegations, each practitioner must be considered separately.

2. The PPC must consider separately each allegation made against a practitioner.

3. In relation to each allegation the PPC must:

    a. Review the allegation which is made.

    b. Review the evidence which is available in relation to the allegation and any response to the allegation which has been submitted by or on behalf of the practitioner concerned.

    c. Bear in mind that:

        i. The PPC has a limited filtering role and is considering the case in private on documents alone.

ii. Public confidence and the legitimate expectation of complainants require that allegations will be publicly investigated by the Conduct Committee in the absence of some special and sufficient reason.

iii. It is rarely if ever the PPC's role to resolve conflicts of evidence, issues of admissibility, weight or inference, or to anticipate potential defences that might be run – that is the function of the Conduct Committee.

iv. Any doubt as to whether a complaint should go forward is to be resolved in favour of the investigation proceeding.

v. The PPC should be particularly slow in halting a complaint against a practitioner who continues to practise.

vi. The PPC should exercise the utmost caution before declining to forward a complaint based on a finding made by another medically qualified body, for example, another regulator, or a coroner or a judicial inquiry after it has heard oral evidence in public.

vii. The PPC may at any stage:

- require further investigation to be conducted;
- adjourn consideration of the matter;
- refer the matter to the professional screeners;
- take the advice of the NMC's solicitor and may instruct him to obtain such documents, proofs of evidence and other evidence in respect of the allegations as he considers necessary; and/or
- require, in the case of a complainant who is not acting in a public capacity, that the complaint be verified by way of a statutory declaration.

d. With the factors set out in paragraph (iii) above in mind, the PPC must decide the main matter: whether there is any question raised which is capable of resulting in a finding of misconduct bearing in mind that an allegation must be proved on the balance of probabilities, that is so the Conduct Committee is of the view that it is more probable than not that the allegation is correct.

e. In order for the PPC to answer this question they must consider whether there is a real (as opposed to fanciful) prospect of the factual element of the allegation being established. In this regard the PPC should have regard to the delay in these cases coming before it and effect of that delay on the real prospect of each allegation being established. If there is such a prospect, the PPC must consider whether there is a real (as opposed to fanciful) prospect the Conduct Committee might decide to

remove her name from the register as a result.

f. In deciding the main matter, it is not for the PPC to attempt to answer any question which is raised by the complaint: that is for the Conduct Committee, if the complaint otherwise passes muster. This means the PPC should not decide conflicts in the evidence whether factual or expert.

g. With the factors set out in paragraph (iii) above in mind, the PPC may decide whether in these cases to take into account the effects of the delay upon them and whether the delay is such that the proceedings in relation to any allegation should be stayed for abuse of process.

h. Whether proceedings are an abuse of process is generally a question for the Conduct Committee. The PPC should only refuse to refer a case on the basis of delay in highly exceptional cases where it is very clear that a fair hearing cannot take place. If it is not clear the PPC should, if satisfied of the criteria set out in 3(d) above, refer the case to the Conduct Committee and allow it to consider whether a fair hearing can take place and whether steps can be taken to enable the registrant to have a fair hearing.

i. When determining whether a case should be stayed on the ground of delay the PPC should bear in mind the following principles:

   i. even where delay is unjustifiable, a permanent stay should be the exception rather than the rule;

   ii. where there is no fault on the part of the complainant or the NMC it will be very rare for a stay to be granted;

   iii. no stay should be granted in the absence of serious prejudice to the registrant so that no fair hearing can be held;

   iv. on the issue of serious possible prejudice there is a power to regulate the admissibility of evidence and the trial process itself should ensure that all relevant factual issues arising from the delay will be placed before the Conduct Committee which can take all into account in deciding the case.

If having considered all of these factors the PCC's assessment is that a fair hearing may
be possible, a stay should not be granted.

4. If the PPC decides that it is very clear in any case that no fair hearing can be held it should refuse to refer the case to the Conduct Committee and stay the proceedings for abuse of process.

5. If the PPC decides:

   a. there is a real prospect that the factual element of the allegation could be established and that there is a genuine possibility that the Conduct Committee might find misconduct established and removal from the register to be satisfied

      and

   b. has not concluded that this is an exceptional case in which it is very clear that no fair hearing can be held

   then:

      i. it must direct the Registrar to send to the practitioner a Notice of Proceedings together with the documents referred to in Rule 9(1)(b) & (c) of the 1993 Rules, and then consider any written response and re-determine the matters set out in paragraph 3(d) above; and

      ii. if the Notice of Proceedings stage has already been completed, it must forward the allegation for hearing before the Conduct Committee.

6. If the PPC decides there is no real prospect that the factual element of the allegation could be established on the basis of the available evidence, it must consider what further investigations could (and bearing in mind the factors set out above) should be conducted before a final decision is made on the case by the PPC, and must order those investigations to be made. Subject only to this obligation, if the PPC decides at any point, that no question capable of resulting in a finding of misconduct and removal from the register arises, it may decline to proceed with the allegation.

7. If the PPC decides that there is a real prospect that the factual element of the allegation could be established before the Conduct Committee and that the Conduct Committee could consider it to amount to misconduct, but that there is no genuine possibility the Conduct Committee could consider that misconduct to justify removal from the register then:

   a. if the PPC considers that the practitioner's fitness to practice may be seriously impaired by reason of her physical or mental condition, it must refer the case to the professional screeners; and

   b. if the case is not to be referred to the professional screeners and if the practitioner has admitted the facts alleged in the Notice of Proceedings, the PPC may determine whether the practitioner has been guilty of misconduct and, if so, whether it is appropriate to issue a caution as to the practitioner's future conduct (and if so it shall direct the Registrar to issue a caution.)

8. The PPC must record brief reasons for each decision it makes.

GUIDANCE TO
THE PRELIMINARY PROCEEDINGS COMMITTEE
OF THE NURSING AND MIDWIFERY COUNCIL
OPERATING UNDER THE NURSES, MIDWIVES AND HEALTH VISITORS (PROFESSIONAL CONDUCT) RULES 1993

In relation to a case of alleged misconduct which is to be determined in accordance with the 1993 Rules, the Preliminary Proceedings Committee ("PPC") should follow the guidelines set out below.

- Where there is more than one practitioner facing allegations, each practitioner must be considered separately.

- The PPC must consider separately each allegation made against a practitioner.

- In relation to each allegation the PPC must:

1. Review the allegation which is made.

2. Review the evidence which is available in relation to the allegation and any response to the allegation which has been submitted by or on behalf of the practitioner concerned.

3. Bear in mind that:

   (1) The PPC has a limited filtering role and is considering the case in private on documents alone.

   (2) Public confidence and the legitimate expectation of complainants require that allegations will be publicly investigated by the Conduct Committee in the absence of some special and sufficient reason.

(3) It is rarely if ever the PPC's role to resolve conflicts of evidence, issues of admissibility, weight or inference, or to anticipate potential defences that might be run – that is the function of the Conduct Committee.

(4) Any doubt as to whether a complaint should go forward is to be resolved in favour of the investigation proceeding.

(5) The PPC should be particularly slow in halting a complaint against a practitioner who continues to practise.

(6) The PPC should exercise the utmost caution before declining to forward a complaint based on a finding made by another medically qualified body, for example, another regulator, or a coroner or a judicial inquiry after it has heard oral evidence in public.

(7) The PPC may at any stage:

(a) require further investigation to be conducted;

(b) adjourn consideration of the matter;

(c) refer the matter to the professional screeners;

(d) take the advice of the NMC's solicitor and may instruct him to obtain such documents, proofs of evidence and other evidence in respect of the allegations as he considers necessary; and/or,

(e) require, in the case of a complainant who is not acting in a public capacity, that the complaint be verified by way of a statutory declaration.

4. With the factors set out in paragraph 3 above in mind, the PPC must decide the main matter: whether there is any question raised which is capable of resulting

in a finding of misconduct bearing in mind that an allegation must be proved beyond reasonable doubt, that is, so the Conduct Committee is sure.

5. In order for the PPC to answer this question they must consider whether there is a real (as opposed to fanciful) prospect of the factual element of the allegation being established and, if so, whether there is a real (as opposed to fanciful) prospect the Conduct Committee might decide to remove her name from the register as a result.

6. In deciding the main matter, it is not for the PPC to attempt to answer any question which is raised by a complaint: that is for the Conduct Committee, if the complaint otherwise passes muster. This means the PPC should not decide conflicts in the evidence whether factual or expert.

- If the PPC decides there is a real prospect that the factual element of the allegation could be established and that there is a genuine possibility that the Conduct Committee might find misconduct established and removal from the register to be justified then:

  (1) it must direct the Registrar to send to the practitioner a Notice of Proceedings together with the documents referred to in Rule 9(1)(b)&(c) of the 1993 Rules, and then consider any written response and re-determine the matters set out in paragraph 4 above; and,

  (2) if the Notice of Proceedings stage has already been completed, it must forward the allegation for hearing before the Conduct Committee.

- If the PPC decides that there is no real prospect that the factual element of the allegation could be established on the basis of the available evidence, it must consider what further investigations could and (bearing in mind the factors set out above) should be conducted before a final decision is made on the case by the

PPC, and must order those investigations to be made. Subject only to this obligation, if the PPC decides, at any point, that no question capable of resulting in a finding of misconduct and removal from the register arises, it may decline to proceed with the allegation.

- If the PPC decides that there is a real prospect that the factual element of the allegation could be established before the Conduct Committee and that the Conduct Committee could consider it to amount to misconduct, but that there is no genuine possibility the Conduct Committee could consider that misconduct to justify removal from the register then:

  (1) if the PPC considers that the practitioner's fitness to practice may be seriously impaired by reason of her physical or mental condition, it must refer the case to the professional screeners; and,

  (2) if the case is not to be referred to the professional screeners and if the practitioner has admitted the facts alleged in the Notice of Proceedings, the PPC may determine whether the practitioner has been guilty of misconduct and, if so, whether it is appropriate to issue a caution as to the practitioner's future conduct (and if so it shall direct the Registrar to issue a caution).

- The PPC must record brief reasons for each decision it makes.

GUIDANCE TO THE PRELIMINARY PROCEEDINGS COMMITTEE OF THE NURSING AND MIDWIFERY COUNCIL

OPERATING UNDER THE NURSES, MIDWIVES AND HEALTH VISITORS (PROFESSIONAL CONDUCT) RULES 1993

WARD HADAWAY,
Sandgate House,
102 Quayside,
Newcastle upon Tyne,
NE1 3DX.

Ref: L(PH)DT.UKC001.1093
(WAR-56044.GUI)

Meeting of the Preliminary Proceedings Committee
at 23 Portland Place, London, W1N 4JT
on 22 October 2002
in The Dame Catherine Hall Room
at 9.00 am

Agenda

PART 1 **New cases to decide whether to:**

1. **decline to proceed with the matter**
2. **require further investigation to be conducted**
3. **adjourn consideration of the matter**
4. **refer the matter to the professional screeners**
5. **take the advice of a solicitor**
6. **require a complaint to be verified by a statutory declaration**
7. **issue a Notice of Proceedings**

1 [redacted]

Case Ref 11995
Code A
RGN (Part 1 of the register)

Summary of allegations Inappropriate Contact with a former patient

2 [redacted]

Case Ref 11394
PIN 63K0113E
RN15 (Part 15 of the register)

Summary of allegations Assualt on a patient

3 [redacted]

Case Ref 11777
Code A
EN(G) (Part 2 of the register)

Summary of allegations Under took an additional position whilst employed at Martlesham Ward, demonstrated a lack of care towards patients in your care.

4 [redacted]

Case Ref 11421

Code A
RGN (Part 1 of the register)

Summary of allegations Failed to administer medication

5 [redacted]

Case Ref 9965
Code A
RGN (Part 1 of the register)

Summary of allegations Failure to document patient notes, failed to triage patients properly

6 [redacted]

Case Ref 12219
Code A
EN(G) (Part 2 of the register)

Summary of allegations Smelt of alcohol whilst on duty

7 [redacted]

Case Ref 11898
Code A
RN12 (Part 12 of the register)

Summary of allegations Police caution for disorderly behaviour

8 [redacted]

Case Ref 9451
Code A
RGN (Part 1 of the register)

Summary of allegations Failed to give appropriate advice to patients. Disclosure of confidental information. Failure to co-opearate

9 [redacted]

Case Ref 12222
Code A
RGN (Part 1 of the register)
EN(G) (Part 2 of the register)

Summary of allegations Failure to control the feed and blood sugar of a patient. Defacing of patient records.

10 [redacted]

Case Ref 12134
Code A
RN12 (Part 12 of the register)

Summary of allegations Causing death by dangerours driving

11 [redacted]

Case Ref 11278
Code A

RN (Part 12 of the register)

Summary of allegations Falsified signatures of doctors and falsely recorded that patients had received Morphine

12 [redacted]

Case Ref 11935
Code A
RGN (Part 1 of the register)

Summary of allegations Convicted of fraud

13 [redacted]

Case Ref 11287
Code A
RMN (Part 3 of the register)

Summary of allegations Obtaining a pecunairy advantage by deception etc

14 [redacted]

Case Ref 11083
Code A
RGN (Part 1 of the register)
RM (Part 10 of the register)

Summary of allegations Failure to support colleagues, failed to carry out a CTG trace, poor record keeping etc

15a [redacted]

Case Ref 11371
Code A
RMN (Part 3 of the register)
EN(M) (Part 4 of the register)

Summary of allegations Failed to seek medical attention. Failure to keep relatives informed. Failure to register parient with GP. Failure to update careplan

15b [redacted]

Case Ref 11372
Code A
RMN (Part 3 of the register)

Summary of allegations Same as above

16 [redacted]

Case Ref 11709
Code A
RM (Part 10 of the register)

Summary of allegations Attempted to commence a blood transfusion on a patient without checking it first and delayed a syntocin infusion on a patient

PART 2 **Cases for further consideration other than where a Notice of Proceedings has been issued (i.e. the previous decision had been 2, 3, 5 or 6 in Part 1) - to decide as in Part 1.**

17 [redacted]

Case Ref 11721
Code A
RMN (Part 3 of the register)

Summary of allegations Failed to take appropriate action when a patient stopped breathing

PART 3 **Cases where a Notice of Proceedings has been issued to decide whether to:**

1 **refer the case to the Professional Conduct Committee**
2 **refer the matter to the professional screeners**
3 **issue a caution (N.B. admission of facts and misconduct required)**
4 **decline to proceed**

18 [redacted]

Case Ref 9025
Code A
RMN (Part 3 of the register)

19 [redacted]

Case Ref 10852
Code A
RGN (Part 1 of the register)

20 [redacted]

Case Ref 10969
Code A
EN(G) (Part 2 of the register)

21 [redacted]

Case Ref 11191
PIN 80I0216S
EN (Part 7 of the register)

22 [redacted]

Case Ref 10106
Code A
RGN (Part 1 of the register)

23 [redacted]

WITHDRAWN

Case Ref 11223
Code A
RGN (Part 1 of the register)

24 [redacted]

Code A
RN12 (Part 12 of the register)

25 [redacted]

Case Ref 10923
Code A
RN14 (Part 14 of the register)

26 [redacted]

(WITHDRAWN)

Case Ref 11262
Code A
RGN (Part 1 of the register)
EN(G) (Part 2 of the register)

27 [redacted]

Case Ref 11354
Code A
RN (Part 1 of the register)
RN (Part 13 of the register)

28 [redacted]

Case Ref 11139
Code A
RGN (Part 1 of the register)
RN15 (Part 15 of the register)

29 [redacted]

Case Ref 11397
Code A
RNMH (Part 5 of the register)

30 [redacted]

Case Ref 10753
Code A
RN (Part 3 of the register)
RN (Part 2 of the register)

31a [redacted]

Case Ref 8733
Code A
RGN (Part 1 of the register)

31b [redacted]

Case Ref 8734
Code A
RGN (Part 1 of the register)
EN(G) (Part 2 of the register)

PART 4 **Cases where no action would appear to be indicated - those cases where, even if the facts are proved, it is considered by the Council's Officer that they would not lead to removal.**

32	[redacted]	Case Ref 11576 UNKNOWN
33	[redacted]	Case Ref 12171 Code A RGN (Part 1 of the register)
34	[redacted]	Case Ref 11525 Code A RMN (Part 3 of the register)
35	[redacted]	Case Ref 11920 UNIDENTIFIED
36	[redacted]	Case Ref 11896 Code A RMN (Part 3 of the register)
37	[redacted]	Case Ref 11921 UNIDENTIFIED
38a	[redacted]	Case Ref 11661 Code A RN12 (Part 12 of the register)
38b	[redacted]	Case Ref 11662 Code A EN(G) (Part 2 of the register)
39	Chubbah and Others	Case Ref 11765 UNIDENTIFIED
40	[redacted]	Case Ref 11926 Code A RGN (Part 1 of the register) EN(G) (Part 2 of the register)
41	Nurse Collins	Case Ref 12176 UNIDENTIFIED
42	[redacted]	Case Ref 11831 Code A RMN (Part 3 of the register)
43	[redacted]	Case Ref 12225 UNIDENTIFIED

44	[redacted]	Case Ref 12242 Code A RGN (Part 1 of the register)
45	[redacted]	Case Ref 11646 Code A RGN (Part 1 of the register) RM (Part 10 of the register) RHV (Part 11 of the register)
46	[redacted]	Case Ref 11967 Code A RMN (Part 3 of the register) RNMH (Part 5 of the register)
47	[redacted]	Case Ref 12040 Code A RN (Part 12 of the register)
48	[redacted]	Case Ref 11495 UNIDENTIFIED
49	[redacted]	Case Ref 11824 UNKNOWN
50a	[redacted]	Case Ref 11742 Code A RGN (Part 1 of the register)
50b	[redacted]	Case Ref 11743 Code A RGN (Part 1 of the register)

PART 5 **Cases referred back to Screeners.**

Cases identified on the day of the meeting.

PART 6 **Report of the outcome of cases referred by the Preliminary Proceedings Committee to the Professional Conduct Committee.**

To follow

EXTRA CASES GOING AS ON TABLE

1A. [redacted]

Case Ref 11944
Code A
RGN (Part1 of the register)

Summary of allegation: Failed to return to duty and failed to honour contracts

1B [redacted]

Case Ref 11945
Code A
RGN (Part1 of the register)

Summary of allegation: As above

1C [redacted]

Case Ref 11946
Code A
RGN (Part 1 of the register)

Summary of allegation: As above

1D [redacted]

Case Ref 11947
Code A
RGN (Part 1 of the register)

Summary of allegation: As above

2 [redacted]

Case Ref 12105
Code A
RGN (Part 1 of the register)

Summary of allegation: Failed to honour a contract

MR/AJW
7 October 2002
Ag 22 10 02

Reasons for PPC 27 August 2002

1. [redacted]
Reason 1. The committee considered that this was a one off incident.

2. [redacted]
The committee considered that this was a one off incident that would not lead to removal from the register.

3. [redacted]
Reason 1. The committee requested that the Code of professional conduct be drawn to the practitioner's attention.

5. [redacted]
Reason 1

14. [redacted]
Reason 1. The committee considered that this was a one off incident but cautioned the practitioner that a repetition of such conduct would be viewed very seriously. The committee asked that the Code of professional conduct be drawn to the practitioner's attention.

16. [redacted]
Reason 1. The committee considered that the matter had been appropriately dealt with at local level.

23. [redacted]
Reason 1. The committee were concerned at the serious neglect of nursing care and asked that the practitioner's attention be drawn to the Code of professional conduct. She was requested to act always within its guidelines in her future practice.

27. [redacted]
Reason 1. The practitioner admitted to failings in her practice and informed the committee that she had learnt from the incident.

28. [redacted]
The committee considered that this matter could lead to removal but decided that in the circumstances it was appropriate to issue a caution as the practitioner had acknowledged that she had made a mistake and admitted to the charges.

32. [redacted]
Reason 1. The committee were concerned at the failure to provide adequate care and act appropriately following the incident and asked that the practitioner's attention be drawn to the Code of professional conduct. She was requested to consider this document and act always within its guidelines in her future practice.

34 a and b [redacted]
Reason 2

For complainant's letter
The committee asked that their sympathy be conveyed to the complainants and acknowledge the distress and anxiety that they must have felt during this difficult second pregnancy. The committee were mindful when making this decision to close the case of the difficulty of proving the case to the required standard.

35. East Glamorgan nurses
Reason 1. The committee noted that this matter had been subject to comprehensive local investigation and recommendations.

36. [redacted]
Reason 1

37. [redacted]
Reason 1. The committee noted that the matter had been subject to an investigation and that following this incident the procedures had been changed.

38. [redacted]
Reason 1. The committee did not condone the practitioner's actions and requested that the Code of professional conduct been drawn to his attention. The practitioner was asked to consider the code and act always with it in mind.

39. [redacted]
Reason 1. The committee felt that this was an employment matter that had been dealt with appropriately at local level.

40. [redacted]
The committee considered that after considering the information before it there was no evidence of misconduct on the practitioner's part.

41. [redacted]
Reason 1

42. Pilgrim Hospital nurses
The committee considered that no individual practitioner could be identified whose level of misconduct could be considered to be of such seriousness that it would warrant removal from the register.

43. [redacted]
The committee considered that there was no evidence of misconduct on which it could proceed.

THE INDEPENDENT

How dirty tricks dossier forced Oxford's female poetry professor to quit

'We demand justice': The families at the heart of Gosport's hospital scandal

Nearly 100 deaths at a hospital in Gosport have provoked an outcry from many of the patients' families, who believe the cases are suspicious. Official investigations have established little. The Independent on Sunday was the first to make arguments for a public inquiry and continues to pressurise the authorities to find out what really happened. Beyond the headlines, the relatives are struggling to uncover the whole truth behind their parents' final days... Nina Lakhani hears their stories

Sunday, 24 May 2009

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In 1991, nurses working night shifts at Gosport War Memorial Hospital in Hampshire were troubled. Over the previous few months, the number of elderly patients dying under their care had been mounting. Two nurses at the community hospital (which treats elderly patients in need of rehabilitation or sometimes terminal care, in collaboration with GPs) raised the alarm to senior hospital staff and the Royal College of Nursing. They believed the deaths started after patients were given diamorphine (a powerful painkiller) via a syringe driver (which delivers drugs via a tube and needle, and is traditionally used for very sick patients who need constant medication but find it difficult to swallow tablets). Giving these drugs, while sometimes necessary for chronic pain, can cause serious side-effects, such as difficulty breathing. These are more likely to occur in those patients not in pain: breathing can stop altogether.

Letters were written, internal meetings were held, but eventually the matter was closed by the hospital trust. A GP attached to Gosport, Dr Jane Barton, was responsible for prescribing drugs to many of the elderly patients. She continued working in the rehabilitation and terminal care wards.

The death at the hospital of 91-year-old Gladys Richards in 1998 triggered the first NHS, and two police, investigations after her daughter, Gillian Mackenzie, refused to accept she had died from natural causes. The police investigations were later found to have been incompetent and led to a third – lasting four years – into at least 92 deaths at the hospital. Thirteen were categorised as the "most serious" by an eminent team of medical experts led by Professor Robert Forrest, the forensic toxicologist who gave evidence at the Harold Shipman trial, but no charges were brought.

Eighteen years after the nurses' initial worries, on 17 March 2009, inquests into the deaths of 10 people who died at Gosport between 1996 and 1998 opened at Portsmouth Combined Court. The unprecedented concurrent inquests – to determine how, when and why the 10 patients aged between 68 and 99 had died – came after years of campaigning by relatives who believed their loved ones died in suspicious circumstances. The 10 were among almost 100 deaths at the hospital investigated by Hampshire police between 1998 and 2006, but why they were chosen for an inquest remains unclear. They were not the most straightforward cases, or the strongest, and family members point out that the mix diluted the strength of the evidence.

In April, an eight-strong jury decided diamorphine and other powerful drugs had "contributed more than minimally" to five of the deaths (including those of Robert Wilson and Arthur Cunningham). An inquest, however, has no authority to apportion blame to individuals. The verdict led to a moment of jubilation for a few, but calls for a public inquiry – a Shipman-type independent investigation into the deaths and handling of the complaints by authorities – resumed soon after.

BRIJESH PATEL

Charles Farthing's stepfather Arthur Cunningham died at Gosport. Farthing told the inquest that Arthur was 'out of this world and I thought straight away they must be killing him, because my mum had been given a syringe driver just before she died of cancer in 1989.'

The deaths at Gosport happened around the time of several scandals involving NHS doctors and nurses. In 1993, nurse Beverly Allitt was convicted of murdering four children at a Lincolnshire hospital. At least three babies died in the Bristol baby scandal between 1991 and 1995, and more than 2,000 organs were illegally harvested at Alder Hey Children's Hospital between 1988 and 1995. The GP Harold Shipman was convicted of 15 murders in 2000 but a public inquiry found evidence to say he killed at least 250 patients.

The consensus among the bereaved families who have spoken out is that there has been a cover-up about what happened at Gosport. They are unhappy with the way their complaints have been dismissed, delayed or inadequately investigated. Relatives believe the deaths were downplayed because another NHS scandal would cause public outrage and may have had political consequences.

Families of the dead have made a number of complaints against Dr Barton to the General Medical Council (GMC), but the council allowed her to work unrestricted until last year. In July 2008, they issued an interim order banning her from prescribing diamorphine and restricting her ability to prescribe the sedative drug diazepam. She will face allegations of serious professional misconduct at the GMC next month – at least seven years after police first passed on their files.

No one – apart from the Government and the GMC – has set eyes on a crucial study by Professor Richard Baker into whether the death rate at Gosport was abnormally high. Other highly critical medical opinions were withheld from the jury by the coroner at the inquests. And the Government rejected pleas from the coroner to hold a public inquiry into all of the deaths rather than inquests into just a few. The children of Arthur Cunningham, Stanley Corby, Robert Wilson and Norma Windsor, who died between 1998 and 2000, have all been advised by the authorities to "move on" and accept that their parents were old and sick – but none is prepared to. They feel let down: by the NHS, police, Crown Prosecution Service, GMC, coroner and the Government. They believe the public deserves the truth and that justice must be done, for their parents, but also for everyone else who has, or will have, an elderly relative in hospital. Because if things go wrong, horribly wrong, the truth should not be hidden – no matter how much it hurts.

Arthur Cunningham

Arthur "Brian" Cunningham could be a difficult man. In the 1940s, he had worked on the tea plantations in Sri Lanka, and his colonial attitudes rubbed many people up the wrong way. In the mid-1980s he developed Parkinson's disease, and a combination of symptoms, medication side-effects and his cantankerous personality meant that nursing-home staff could find him difficult.

However, he and his stepson, Charles Farthing (left), had always been on good terms. On the morning of 21 September 1998, Cunningham was admitted to Gosport War Memorial Hospital suffering from bed sores. "I rushed down to the War Memorial and someone on reception told me he was on Dryad Ward," says Farthing. "At that point a man, maybe a porter or cleaner, said to me, 'That's the death ward,' which seemed stupid because Brian was nowhere near death, but I didn't think too much of it."

Cunningham was sitting up in bed when his stepson arrived, alert and animated despite a "sore butt". Before Farthing left for work in London, he spoke to the nurse in charge, Sister Gill Hamblin. "She said Brian's bed sores were the worst she'd ever seen and he might not survive them, which completely astounded me. I asked to see a doctor, but no one was available."

By the time Farthing returned with his wife two days later, Cunningham was attached to a syringe driver for regular morphine and midazolam – a strong sedative – and was unconscious. He repeats now what he told the inquest, that his stepfather was "out of this world and I thought straight away they must be killing him, *because* my mum had been given a syringe driver just before she died of cancer in 1989."

He continues: "I demanded that it be removed so that I could talk to Brian and find out if this is what he wanted."

But Dr Barton, who had prescribed the drugs, said that he was dying from the "poisonous" sores. The driver remained in place. From that point, Farthing and his wife sat with Cunningham until he died on Saturday 26 September 1998, aged 79.

Over the years, Farthing has obtained dozens of documents and independent medical reports which he believes proves his stepfather's death was suspicious, but many were excluded from the inquest. "I believe they didn't like him because of his manner.

"Ever since Mr Blair stood up in the Commons and said there would never be another Shipman, we have been up against a brick wall. I've always been a law-abiding citizen, I believe in right and wrong, and that's what keeps me going: I still want justice."

Robert Wilson

"Help me son, they're killing me." These were the last words Robert Wilson (above), 74, said to his son the day before he died on Dryad Ward. His son, Iain Wilson, tried to reassure him. "No they're not, Dad, they're doing what they can to try to help you." He now believes his father was right.

Glasgow-born Robert Wilson fought in the Second World War and left the navy in 1965, already a drinker. He fractured his shoulder after falling at home in September 1998 and was admitted to Queen Alexander Hospital for almost three weeks. The doctors found alcohol-related problems with his kidneys and liver but none were considered life-threatening, so he was transferred to Gosport to recover, as his wife couldn't cope with his broken shoulder at home. He was wearing a sling, but didn't even want paracetamol for pain.

"My younger brother and I visited Dad the night before he was transferred and he was in good spirits, joking around, eating and drinking, though he wasn't looking forward to the journey as he hated being driven anywhere," says Iain Wilson. "When I visited him in Gosport two days later, he was almost comatose, on a syringe driver, and Sister Hamblin told me he would be dead within four days. At that point I nearly got thrown out for kicking up a fuss, but how I wish now I'd trusted my instincts and got him out of there."

Robert Wilson died on 18 October 1998, four days after he was admitted for rehabilitation.

The experience of looking after his dying wife six years beforehand convinced Iain Wilson that his father was treated as if he were a dying man as soon as he arrived at Gosport. But his fight for justice has led to arguments with his seven siblings over the years.

At first he felt "ecstatic" when the jury decided his dad had died because of inappropriate medication, but within days the elation was gone. "I actually feel gutted now because it feels we're back at the beginning. But I have to keep going.

"Every time I'm told 'no' by the coroner or the police or the GMC, it just makes me more determined to keep searching for the truth. I have to get justice for him."

Norma Windsor

Norma Windsor died on her 69th birthday after 10 days of "rest and recuperation" at Gosport. Windsor had a heart condition and was awaiting bypass surgery, which had been delayed by the onset of a blood disorder. She was poorly, she was tired, but there was nothing in her notes to suggest that she was dying.

At the end of April 2000, her GP, Dr Knapman (who also attended patients at Gosport), suggested a short hospital admission to give her husband time to pack for their imminent move to Sussex. Windsor balked: "You go there to die," she told her youngest daughter Sheena, but she persuaded her mother to go in for a rest, so Windsor reluctantly walked into Sultan Ward.

She went downhill rapidly. Her daughter Maggie Ward (left) says: "Within days she went from being chatty, mobile, just normal really, to being spaced out, hardly able to talk or keep her eyes open. Her skin went from being plump to totally dry." As the family complained, Windsor got sicker. "Mum kept saying to us 'You don't know what they're doing to me,' but we felt helpless."

On 4 May 2000, Dr Knapman agreed to a second opinion and Windsor was transferred to St Mary's Hospital in Portsmouth. "When we got there, one of the doctors said they'd never received a patient from another hospital in such bad condition," says Ward. Windsor died from multiple organ failure on 7 May 2000.

A hospital doctor asked them to consider an autopsy, but the family, traumatised, refused, which they regret. The medical notes they've seen are incomplete and they have no idea what medication she was given. The police dismissed their initial complaint in 2002; said Windsor's death was one of the most serious cases being investigated in 2003; and dismissed it again in 2006. Requests for an inquest have been denied.

"We feel like Mum has been forgotten," says a tearful Ward. "Things are probably OK at Gosport now but what we feel was criminal neglect robbed us of time with Mum and for that, there should be justice. We don't understand why the deaths at Gosport aren't as important as the Shipman murders."

Stan Carby

Everybody knew Stan Carby. He was a larger-than-life former naval officer, whose subsequent career as an ice-cream vendor had made him a local legend. At 65, he suffered a series of mini-strokes that landed him in the army hospital, Royal Haslar, where his bad jokes and relentless flirting earned him the nickname "Stan the man". The mini-strokes had caused some weakness and drooping of his left side, so he needed a period of rehabilitation. His weight ruled out home rehab and despite being technically too young for Gosport War Memorial Hospital, he was eventually admitted to Daedalus ward at lunchtime on 26 April 1999.

"He picked out a horse for a bet at around 3.30pm, had a cup of tea and was generally fine," says his daughter Debbie Mackay, the second eldest of five. "He was not in any pain and had been discharged from Haslar on nothing stronger than aspirin. But he was a bit agitated about staying in and his medical notes had still not arrived, so I made sure the nurses knew they should call me if he became upset or things got worse, whatever the time." The last relative left at 9pm and they all went to bed under the impression things were settled. But Mackay received a phone call the next morning telling her Stan had taken a "turn for the worse".

"Dad's eyes were shut, he was clammy, unresponsive and his breathing was heavy," says his daughter Cindy Grant (above with her brother). "We were devastated at the change; it was completely unexpected. We lifted him up to try to help him breathe, which is when I saw a tube in his back – what I now know was a syringe driver."

Around midday, the doctor came in and told the family she suspected a major stroke; she would make sure he wasn't in any pain but they would now "let nature take its course". Stan Carby took his last breath at 1pm, barely 24 hours after being admitted for rehabilitation.

The family have shown me his admission notes, written by Dr Barton, which state: "happy for nursing staff to confirm death". They also know he was given large doses of midazolam and morphine through the syringe driver, despite never complaining about pain. His medical notes from Haslar had not arrived.

Carby's death wasn't chosen for an inquest and his relatives' complaints to the GMC have led to nothing. "I want to knock on Barton's door and find out the truth," says Grant, close to tears. "Dad was taken from us and mum died in 2007 without knowing what happened. We have to see it through for her."

bad43 wrote:

INDEPENDENT MINDS

Monday, 25 May 2009 at 01:07 pm (UTC)

Member

I have no medical training or knowledge and was not a relative of either of the people described below however I was there every day during the relevant periods.

If it is correct that there are indeed excessive deaths in this hospital then it seems to me that it is one of the costs we pay of keeping the merciful killing of very seriously ill patients a subject that we cannot discuss.

I have witnessed at close hand the deaths of two people from cancer. The first was in about 1925 and the second in about 2000. Both received syringe driver delivered diamorphine for pain relief

In the first case there seemed much medical reluctance to deliver a sufficient dose to relieve the pain and the result was in my opinion awful to behold. Days and days and weeks and weeks of intermittent high levels of pain. Fifteen years later and in a different part of the country there was no reluctance to deliver the dose required to relieve the pain. My friend appeared to me to die from the results of the drugs.

I have little doubt that her life could have been prolonged if the drug dose had been reduced however it would have been a terrible life, wracked with pain.

In both cases I assume that the medical staff behaved according to their training and their best efforts to hold the interest of the patient to the fore.

It seems to me that different patients might have different desires in the way that such difficult times are managed and the thing that is lost if it is impossible to discuss deliberately choosing medical intervention to increase comfort at the expense of reduced life is the possibility of the people involved making a choice. They have to rely on the sense and sensibilities of the medical staff.

In the cases discussed in the Independent's article it appears on the face of it that perhaps the silent medical interventions have gone too far.

In the absence of discussion it is inevitable that some medical practitioners will intervene more that patients would wish and that some will intervene less.

This is the reason that we must legalise the deliberate administration of drugs in situations where they will shorten life. The alternatives are too awful to consider.

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There if the Church is not with us who are with us the devils?

farrukha wrote:

Monday, 25 May 2009 at 01:51 pm (UTC)

Bishops urge voters to shun BNP

In a rare joint public statement, the Archbishops of Canterbury and York will today plead with the public not to vote for the British National Party in next month's European elections in protest at MPs' expenses. Despite "understandable" anger, the crisis should not lead to gains for the "divisive" BNP. It would also be "tragic" if voters were to stay away from the polling booths altogether, they say

There if the Church is not with us who are with us the devils?

I thank you

Farrukh A. Mulla

Link | Reply | Thread

From The Sunday Times
May 18, 2008

Convalescent unit faces inquest into suspicious deaths

Lois Rogers

Jack Straw, the justice secretary, has ordered an inquest into 10 suspicious deaths at an old people's convalescent unit in Hampshire.

The patients were among a group of 92 who died unexpectedly after being given abnormally large doses of morphine and other drugs at the Gosport War Memorial hospital. Their relatives believe their deaths were a form of euthanasia.

Straw has demanded the coroner's investigation even though at least seven of the bodies were cremated. An inquest cannot take place in the absence of a corpse unless there are exceptional circumstances.

The justice ministry believes there is sufficient anxiety about the circumstances of the cases to require such a procedure, which, in the absence of remains, will be based only on a review of medical records and witness statements.

The allegation of "murder by euthanasia" is similar to that levelled against Harold Shipman, the GP from Greater Manchester who was Britain's biggest mass killer. He was convicted of 15 murders but is believed to have killed about 250 of his patients. Shipman committed suicide in prison in 2004.

At Gosport, relatives complained repeatedly that the victims were not sick enough to require morphine. Questions about the hospital's heavy use of the drug were also raised by the Commission for Health Improvement, the hospital watchdog.

Despite these concerns, police have been unable to gather sufficient evidence to pursue a prosecution. The two police investigations of the affair were themselves criticised for shortcomings.

The inquest into the 10 selected Gosport deaths was opened last Wednesday at Portsmouth and South East Hampshire coroner's court.

A full hearing is scheduled for this autumn. A different coroner, Andrew Bradley, from Basingstoke, will conduct the process, which is expected to be the largest inquest of its kind.

The patients whose deaths are being investigated are Code A Code A Elsie Lavender, Ruby Lake, Robert Wilson, Enid Spurgeon, Elsie Devine, Helena Service, Arthur Cunningham, Sheila Gregory and Geoffrey Packman. All 10 died between 1996 and 1999.

Ann Reeves, a beauty therapist, whose mother, Elsie Devine, 88, died in the hospital in 1999, has been one of the most vocal campaigners for the bereaved relatives. She is writing a book about the events and claims that questions had been raised as long ago as 1991 about the use of syringe drivers – automatic pumps that produce a continuous flow of morphine into a patient's body.

"My mother was getting better until she went into that place. We are in no doubt there has been a massive cover-up. We are determined not to rest until we get justice for all of these patients," she said.

Many of the other families are dismayed that their cases have not been selected for the inquest. Mike Wilson from Gosport says his 91-year-old mother, Edna Purnell, was out of bed and using a walking frame after a hip replacement operation, before she was transferred from Portsmouth's Haslar hospital for a brief period of rehabilitation at Gosport.

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they started giving her morphine. We are in no doubt that is what killed her."

Richard Baker, a professor of clinical governance at Leicester University, carried out the statistical analysis that proved the abnormal scale of the death rate among Shipman's patients. He is believed to have raised similar concerns about the death rate in Gosport.

The methods of at least two doctors and seven nurses working

Page last updated at 10:04 GMT, Wednesday, 14 May 2008 11:04 UK

Inquest into 10 hospital deaths

An inquest has been opened into the deaths of 10 patients at a Hampshire hospital in the late 1990s.

Brian Cunningham died while being treated at the hospital

The deaths at Gosport War Memorial Hospital between 1996 and 1999 were the subject of a lengthy investigation by Hampshire police.

In December 2006, the Crown Prosecution Service (CPS) said there was not enough evidence to charge anyone.

Some families claimed patients had died after sedatives like diamorphine were over-prescribed by staff.

Hampshire police conducted two investigations into the deaths, the first of which was the subject of complaints to the Independent Police Complaints Commission (IPCC).

The second investigation, which looked into the deaths of 90 patients, resulted in 10 files being passed to the CPS.

'Insufficient evidence'

But last year the Portsmouth and South East Hampshire coroner asked for the police files, and opened and anjourned the inquest into the 10 deaths on Wednesday.

Brian Cunningham, who was one of the 10 patients, went into the hospital because of bedsores and later died.

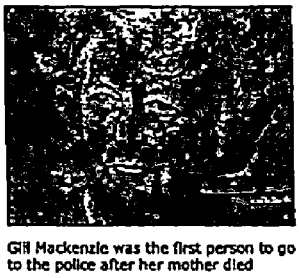
His death certificate said he died from bronchial pneumonia, but his family are convinced it was because of an overdose of morphine.

His step-son Charles Farthing said: "It's been in my mind ever since it happened, I can never forget it and there will never be closure until someone is brought to task.

"It's as simple as that, I won't rest on the issue.

"I just hope the coroner will find a correct cause of death and there will be enough evidence from the inquest for the CPS to reopen its case."

It was the death of Gill Mackenzie's 91-year-old mother Gladys Richards that prompted the first police investigation in 1998.



Gill Mackenzie was the first person to go to the police after her mother died

Gill Mackenzie said: "I didn't go to the police because my mother died, I went because I was convinced and I am still convinced that her death broke the law and that's why I went to the police.

"I didn't want it to happen to anybody else."

In December 2006, Paul Close, of the CPS, said: "I considered whether the evidence gathered by the police showed that a criminal offence had been committed, and particularly the offence of gross negligence manslaughter.

"After looking at all the evidence - including that of experts - and seeking the advice of counsel, I decided there was insufficient evidence for a realistic prospect of conviction.

"Errors alone, no matter how catastrophic the consequences may be, do not, of themselves, amount to gross negligence."

Full inquests, which are likely to take several weeks and be heard in front of a jury later this year, will take place into the deaths of: Leslie Pittock, Elsie Lavender, Ruby Lake, Robert Wilson, Enid Spurgeon,

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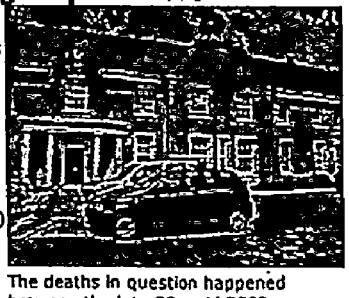
Hospital deaths charges possible

Medical staff could face prosecution over the deaths of 10 elderly patients at a Hampshire hospital.



The deaths in question happened between the late 90s and 2002

A lengthy police inquiry into 90 deaths at the Gosport War Memorial Hospital has led to 10 cases being sent to the Crown Prosecution Service (CPS).

The CPS will decide if there is enough evidence to charge anyone.

The families of the patients claim sedatives like diamorphine were over-prescribed at the hospital, leading to the deaths.

The deaths being investigated occurred between the late 1990s and 2002.

Det Supt David Williams said: "Following extensive investigation and reference to medical experts, it has been established that there has been no criminal negligence in respect of the 80 cases.

> **"This investigation has been necessarily detailed and thorough, given the complexity of issues"**
>
> Det Supt David Williams

"However, issues have been raised in respect of the standard of care in some of those cases which have been forwarded to the General Medical Council and Nursing and Midwifery Council for their attention.

"We continue to fully investigate the 10 remaining complaints made to us, which are now at an extremely advanced stage.

"This investigation has been necessarily detailed and thorough, given the complexity of issues."

Each case referred to Hampshire police has been examined by a panel of national experts in the fields of palliative care, geriatric care, general practice, nursing and forensic toxicology in association with the case investigation officers.

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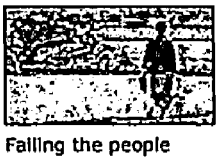

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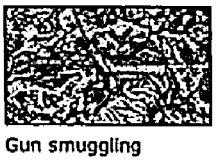

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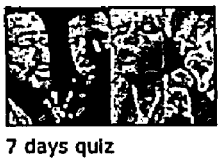

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Client: Nursing and Midwifery Council
Source: Press Association
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HOSPITAL STAFF MAY FACE CHARGES OVER PATIENT DEATHS

Medical staff could face prosecution over the deaths of 10 elderly patients at a hospital, police said today.

Detectives have spent several years probing 90 deaths at the Gosport War Memorial Hospital in Hampshire from the late 1990s until 2002.

The families of the patients claim 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.

A Hampshire Police spokeswoman said 10 files have now been sent to the Crown Prosecution Service to decide if there is enough evidence to charge people over the deaths. A decision is expected within a month.

Detectives have now released the other 80 cases under investigation and have informed all the families.

Detective Superintendent David Williams said: ``Following extensive investigation and reference to medical experts, it has been established that there has been no criminal negligence in respect of the 80 cases.

``However, issues have been raised in respect of the standard of care in some of those cases which have been forwarded to the General Medical Council and Nursing and Midwifery Council for their attention.

``We continue to fully investigate the 10 remaining complaints made to us, which are now at an extremely advanced stage, and have received considerable co-operation from the Fareham and Gosport Primary Care Trust in facilitating interviews with staff.

``This investigation has been necessarily detailed and thorough, given the complexity of issues. I feel confident that the Crown Prosecution Service has all available evidence upon which to properly consider the determination of the investigation."

The investigation, codenamed Operation Rochester, is very complex.

Each case referred to Hampshire Police has been examined by a panel of national experts in the fields of palliative care, geriatric care, general practice, nursing and forensic toxicology in association with the case investigation officers.

end
111152 JUL 06

Report to the Preliminary Proceedings Committee

Gosport Ward Memorial Hospital Nurses

Draft 3.6.04 - to be amended in light of GMC outcome.

Report from the in-house legal team [date]

Introduction

1. This report summarises the background to this case, the material received by the NMC, and the current situation.

2. The NMC has received several complaints about nurses at the Gosport War Memorial Hospital ("GWMH"), and a number of agencies have investigated concerns about clinical practice there in the late 1990s. Three wards are involved: Daedalus, Dryad, and (to a lesser extent) Sultan.

3. Those investigations began in September 1998. A patient named Mrs Richards had died on Daedalus Ward earlier that year, and her relatives made a complaint to the police. The police investigated the complaint, but in March 1999 the CPS advised that there was insufficient evidence to prosecute any member of staff for any offence.

4. The investigation was reopened in 2001. The police obtained an expert report into Mrs Richards' death from Professor Livesley. Three nurses were named in this report – [redacted] Code A In September 2001, the NMC's PPC considered the matters raised in the Livesley report about Mrs Richards, and decided to close the case.

5. At about the same time, the CPS again advised the police that there was insufficient evidence to prosecute any member of staff.

6. As a result of local media coverage, other families contacted the police with concerns about the deaths of their relatives. The police referred five cases – Richards, Cunningham, Wilkie, Wilson and Page - to another expert, Professor Ford. Professor Ford reported in December 2001 (bundle pp ?? - ??).

7. The police made the expert reports available to a number of bodies, including the Commission for Health Improvement ("CHI"), General Medical Council ("GMC") and NMC.

8. The CHI conducted an investigation into the trust's systems since 1998, and reported in July 2002. The CHI report is at pp ?? - ?? of the bundle. The CHI's key findings were as follows:

   - There were insufficient local prescribing guidelines in place covering the prescription of powerful pain relieving and sedative medicines;

   - A lack of rigorous routine review of pharmacy data led to high levels of prescribing on wards caring for older people going unquestioned;

   - The absence of adequate trust-wide supervision and appraisal systems meant that poor prescribing practice went unidentified;

- There was a lack of thorough multi-disciplinary patient assessment to determine care needs on admission;

- By the time of the report in 2002, the trust had resolved the problems by ensuring that adequate policies and guidelines were in place to govern the prescription and administration of pain relieving medicines.

9. In response to the Ford report, the NMC asked the Trust for comments. The Trust replied on 15 May 2002 with details of its response to the concerns raised (bundle pp 216 – 220). No disciplinary action was taken against any nurse.

10. Also in May 2002, Mr Page, son of Mrs Page, made a direct complaint to the NMC. He named nurses Code A (bundle p ?).

11. In June 2002, the NMC received three further complaints:

    - Mrs Jackson complained about nurse Code A in respect of her deceased mother Mrs Wilkie (bundle pp ?? - ??);

    - Mrs Reeves complained about nurses Code A in respect of her deceased mother, Mrs Devine (bundle pp ?? - ??);

    - Mrs Bulbeck complained about the general care given to her deceased mother Mrs Middleton (she subsequently named Philip Beed as being the manager with overall responsibility) (bundle pp ?? - ??).

12. In August 2002, the NMC received a further complaint from Mrs Carby against nurses Code A in respect of her deceased husband Mr Carby (bundle p ?).

13. In September 2002, the police reopened the case and began a large-scale investigation into 90 deaths at the hospital. Further details of this investigation are given below, and in the attached police summary of the investigation.

14. On 24 September 2002, the PPC considered the following cases:

    - Code A – allegation from Jackson re: Wilkie
    - Code A – allegations from Reeves re: Devine and Page re: Page
    - Code A – allegations from Reeves re: Devine and Page re: Page
    - Code A – allegation from Reeves re: Devine
    - Code A allegations from Reeves re: Devine

    The Committee was assisted by a detailed summary of the evidence from Code A Code A (bundle pp ?? - ??). These cases were adjourned pending the outcome of the police investigation.

15. There is no evidence to suggest that the PPC has considered the Carby complaint against nurses Code A or the Bulbeck complaint against Code A

Police investigation

16. In October 2004, Hampshire police provide the NMC with an update on the police investigation. The police had considered 90 patient deaths. They interviewed relatives of patients. They also commissioned a team of clinical experts: Irene Waters, a nursing expert (and at the time, an NMC panel member), Robin Ferner, a pharmacologist, Peter Lawson, a geriatrician, and Anne Naysmith, an expert in palliative care. Matthew Lohn of Field Fisher Waterhouse prepared a summary of evidence in most cases for the police.

17. The experts were instructed to review the medical records and provide an analysis of treatment. The doctors rated care given on a scale from 1 to 4, where 1 is optimal, 2 sub-optimal, 3 is negligent and 4 is intended to cause harm. They then assessed the cause of death, with A meaning natural causes, B meaning cause of death is unclear, and C meaning the cause of death is unexplained by illness. Cases were put into one of 3 categories. Cases were put into Category 1 where the experts concluded that treatment was acceptable. Category 2 cases were those where the treatment was considered to be sub-optimal, but did not present evidence of criminal activity. Category 3 cases were considered to warrant further investigation with a view to determining whether criminal activity took place.

18. By October 2004, the police had contacted all of the families of patients whose cases fell into Category 1 to notify them of their findings. The NMC was told that investigations in Category 3 cases were ongoing, and was not given the names of the patients whose cases fall into these categories.

19. It was agreed that the police would provide the NMC with all of evidence gathered in Category 2 cases. They had reached a similar agreement with the GMC. The police informed the relatives, who all consented to this course of action.

20. Throughout 2004, 2005 and 2006, the NMC received files relating to the 80 cases in Category 2. Typically, these contained the following information in respect of each case:

    - Police reports of interviews with family members (not in formal witness statement format)
    - Expert summaries
    - Summary comments by Matthew Lohn
    - Medical records

21. I have done the following work on those cases:

    - Logged each file on a spreadsheet recording all salient details
    - Reviewed the police reports of their interviews with family members
    - Reviewed the expert comments on each case

- Reviewed the summaries by Matthew Lohn

22. Except where the documents listed above drew attention to particular points, the NMC has not reviewed the medical records for each of the Category 2 patients.

23. Of the cases where relatives have made complaints to the NMC, all but one (Devine) fell into the police's Category 2, i.e. Wilkie, Page, Middleton and Carby.

24. In December 2006, the police announced the outcome of their investigation ten Category 3 cases. The Crown Prosecution Service had concluded that no further action should be taken on each of the cases (the police report is at pp 161 - 173 of the bundle).

25. In March 2007, the police delivered further files to the NMC. These included a large number of generic further statements, full records of police interviews with Dr Barton and Dr Reid (a consultant at the hospital), expert reports, and witness statements and medical records relating to each of the ten Category 3 patients. The police had obtained statements from family members and all members of staff involved in the patients' care. They had instructed two further experts: Dr Wilcock, a palliative care expert, and Dr Black, a geriatrician. Further experts had been instructed to advise on individual cases as required. Mrs Devine's case was in this group.

26. Among this material was evidence that in 1991, at least one of the nurses (Anita Tubritt) had raised concerns about the use of syringe drivers. There was correspondence between management, the unions, and the staff, and meetings took place. The outcome of this process is not clear.

27. The police reported that the coroner may decide to hold inquests into the deaths of three patients (Mrs Devine, Mrs Lavender, and Mrs Gregory), as they had been buried rather than cremated.

Coroner's inquest

28. In March and April 2009, a coroner's inquest was held into the deaths of ten patients, one of whose death is the subject of a complaint to the NMC (Mrs Devine). A transcript of the jury's narrative verdict is attached (bundle pp ?? - ??).

29. In respect of Mrs Devine, the jury concluded that:

- Her cause of death was 1(a) chronic renal failure 1(b) ameloidosis 1(c) IgA paraproteinaemia
- Medication contributed to her death
- The medication was given for therapeutic purposes
- The medication was not appropriate for her condition and symptoms.

GMC proceedings against Dr Barton

30. [The GMC is bringing proceedings under its old rules against Dr Barton. We have not seen the proposed charges, but we understand that she is charged with serious professional misconduct based on inappropriate prescribing/prescribing

that was not in the best interests of her patients. We understand that the GMC enquiry will focus on the following patients:

- Code A
- Elsie Lavender
- Eva Page
- Alice Wilkie
- Gladys Richards
- Ruby Lake
- Arthur Cunningham
- Robert Wilson
- Enid Spurgeon
- Geoffrey Packman
- Elsie Devine
- Jean Stevens

31. Relatives of Eva Page, Alice Wilkie and Elsie Devine have made complaints to the NMC.

32. The GMC hearing is scheduled to take place from 8 June 2009 – 21 August 2009.

33. The GMC intends to call a number of nurse witnesses at the hearing into Dr Barton's conduct, including most of the nurses who have been named in complaints to the NMC.]

NMC complaint cases

34. Having conducted preliminary reviews of the material available, I am able to summarise the cases as follows.

Evidence in the case of Page

35. On 17 May 2002, Mr Page wrote to the NMC to complain about nurses Hamblin, Shaw and others unnamed. His mother died at GWMH in 1998. He did not express specific concerns about nursing care, but referred to the Ford report. It appears that at the time he wrote to complain, Mr Page had not seen a copy of the Ford report.

36. On 12 June 2002, the NMC wrote to ask Mr Page to provide details of his specific concerns about the nursing care his mother received (bundle pp ?? - ??). I have not seen any further correspondence from Mr Page in the files. The NMC then wrote to him on 12 August 2002 to tell him that the PPC would consider the case (bundle pp ?? - ??), and on 27 September 2002 to inform him of the PPC's decision to adjourn the case (bundle p ?).

37. Professor Ford's only significant concern about Mrs Page's treatment is with the decision to commence subcutaneous diamorphine and midazolam on the day of her death. He considers that there was no indication in the notes that she was in pain or distress. In his view, the prescription was poor practice and potentially very hazardous. He would have expected very clear reasons for this prescription to have been recorded in the medical notes. He considers that, apart from this, the medical and nursing records were of adequate quality. He concludes:

In my opinion the majority of management and prescribing decisions made by medical and nursing staff were appropriate. The exception is the prescription of diamorphine and midazolam on the day of Mrs Page's death.

38. Professor Ford does not name any individual nurses. From the medical records, I have been unable to identify whether nurses Code A were on duty on the day of Mrs Page's death.

39. The police experts' agreed that the case fell into category A2. Robin Ferner notes that diamorphine was used for confusion rather than pain, and queries the rapid increase in dose. Peter Lawson concluded:

    Care being graded as sub-optimal is perhaps a little picky but relates to the changes in opioid and method of administration rather than the doses used.

    Anne Naysmith considers that it was not ideal palliative care, and particularly criticises the dose of Fentanyl.

40. The police record of interview with Mr Page contains no other significant evidence.

Page – conclusion

41. Although Mr Page named nurses Code A, he does not make any particular complaint about them. Professor Ford does not refer to either of them. It is not apparent from the medical records whether nurses Code A were in a position to challenge the prescription on the day of Mrs Page's death. The police experts concluded that, on balance, treatment was sub-optimal, but they do not all agree as to what was wrong with it.

42. Taking all of this together, the PPC may conclude that there is insufficient material to proceed with any allegation of misconduct against nurses Code A and Code A in connection with Mrs Page's death.

Evidence in the case of Carby

43. On 22 August 2002, Mrs Carby wrote to the NMC alleging that her husband's sudden death in 1999 was caused by the negligence of nurses Code A and Code A (bundle p ?). She did not particularise her complaint, but stated that Mr Carby's medical records contained ample evidence of nursing misconduct.

44. On 5 September 2002, the NMC passed the complaint to the Trust for its internal investigation.

45. The Trust instructed an expert, Professor Jean Hooper, to review Mr Carby's medical records. Professor Hooper's report was sent to the NMC on 15 November 2002 (bundle pp ?? - ??). She expressed concern about discrepancies as to dates and times in the nursing records, but could find no evidence in the records to indicate that the nurses were negligent in their treatment of Mr Carby.

46. In addition to Professor Hooper's report, the Trust provided the NMC with excerpts from the ward controlled drugs record book (bundle pp ?? - ??), which showed that a syringe driver was set up with 40mgs of diamorphine at 12.15pm. It was discontinued at 1.20pm on the same day, and 9.5 of the original 10mls of fluid discarded.

47. The police experts agreed that this was an A2 case. All criticised the high dose of diamorphine and midazolam, but noted that Mr Carby died within 45 minutes of the syringe driver being set up, before the drugs had time to take effect.

48. In interview with the police, Mr Carby's family criticised Nurse Joice, saying that they did not like her manner. They also suggest that after Mr Carby's death, when one of his daughters became extremely upset, an unnamed nurse suggested giving her an injection to calm her down. This has not been raised with the NMC

Carby – conclusion

49. It is possible to prove that Nurse Code A failed to record the time of her nursing notes entries on 27 April 2004. However, the PPC may conclude that this alone would not amount to misconduct.

50. There is no other evidence before the NMC of misconduct by nurses Beed, Joice and Neville in respect of their care of Mr Carby.

Evidence in the case of Middleton

51. In June 2002, Mrs Bulbeck wrote to the NMC to complain about the general level of care her mother Mrs Middleton received at the Gosport War Memorial Hospital from initial admission on 29 May 2001 to August 2001, when she was transferred to another hospital shortly before her death (bundle pp ?? - ??).

52. Mrs Bulbeck gave a number of examples of her concerns:

- On one visit, she found her mother sitting up with her meal and call bell too far away for her to reach and no cutlery;
- Her mother had a "fluid overload" despite being on a drip and having a catheter, and as a result of this, suffered congestive cardiac failure on 4 July 2001;
- On another visit, she arrived to find her mother sitting in chair with a bowl in front of her and another bowl full of vomit by her. Her mother was being sick and choking. She was covered in sweat, and was unable to call for help because bell out of reach. Mrs Bulbeck called a nurse, who in turn called doctor. The doctor carried out an x-ray, which showed that Mrs Middleton had a blocked bowel;
- Mrs Middleton had to wait 45 minutes for a bedpan;
- When Mrs Middleton told a nurse that she was worried about smelling because of catheter, the nurse said "don't worry all old ladies smell";
- Mrs Bulbeck often found her mother sitting up in a chair, with bare feet/legs and no blankets;
- Mrs Bulbeck was worried about the drugs her mother was given because she "behaved very strangely some days";

- Some of the nurses were uncaring and had an unprofessional attitude to the patients;

- Some of the nurses failed to carry out doctors' orders.

53. Mrs Bulbeck was asked if she could provide further detail, but confirmed that she was unable to name individual nurses. She could only name Philip Beed, the clinical manager, as having responsibility for her mother's care.

54. The NMC forwarded a copy of Mrs Bulbeck's letter of complaint to the trust. The trust commissioned an investigation and provided the NMC with a copy of the investigation report, and its letter to Mrs Bulbeck (bundle pp ?? - ??). Some generic issues were identified, but none of these were attributed to named nurses.

55. The police experts reached the following conclusions in this case:

- Irene Waters (Nurse)

  No opinion expressed about the quality of nursing care (although her notes are incomplete).

- Robin Ferner (pharmacologist)

  Mrs Middleton received optimal care and died from natural causes.

- Peter Lawson (geriatrician)

  Mrs Middleton was given appropriate doses of analgesia and died from natural causes.

- Anne Naysmith (palliative care expert)

  Mrs Middleton had abdominal pain and aspiration pneumonia, and was very frail (on continuous oxygen). She was started on oral diamorphine PRN, then moved to continuous administration via a syringe driver when the pain became more severe. This was very reasonable treatment. Mrs Middleton had breakthrough pain, so the dose of diamorphine was increased. She was also prescribed midazolam because she became agitated and distressed.

<u>Middleton – conclusions</u>

56. Given the expert conclusions, it is clear that there is no prospect of establishing a case based on failure to challenge inappropriate prescribing.

57. Mrs Bulbeck has made allegations about specific incidents, but is unable to name the nurses involved and has not provided any dates. Accordingly, there is no prospect of proving allegations relating to any particular incident against any named nurse.

58. The only nurse she has named is Code A on the basis that he was responsible for poor care because he was the clinical manager. To establish this, we would have to prove poor care, in addition to proving that Mr Beed, as manager, was culpable. Given the material we have received to date, and the

passage of time, the PPC may conclude that there is no realistic prospect of establishing misconduct.

Evidence in the case of Wilkie

59. On 1 June 2002, Mrs Wilkie's daughter Mrs Jackson wrote to the NMC to complain about the care given to her mother prior to her mother's death in August 1998 (bundle pp ?? - ??). She made a number of general points, but I have summarised below those could perhaps be attributed to individual named nurses.

60. She noted that her mother was transferred from Queen Alexandra Hospital to GWMH for rehabilitation – on admission, she could walk and feed herself with assistance. After transfer, her mother appeared increasingly sleepy, weak and unwell, and could not stand unaided. After a few days, she received a call telling her to go to the hospital and spoke to Code A in the office. He told her that her mother was dying and nothing could be done for her. Mrs Jackson told Mr Beed that she did not want her mother to suffer.

61. On 20 August 1998, Mrs Jackson considered that her mother was in pain, and told nursing staff, who were dismissive. She had to ask for help twice, and wait one hour, until Code A attended and said that he would arrange pain relief which would make Mrs Wilkie sleepy. When Mrs Jackson left the hospital at 13.55, nothing had been done to alleviate her mother's discomfort. When Mrs Jackson returned to visit at 20.00, her mother was unconscious.

62. On 21 August 1998, Mrs Wilkie's catheter bag contained blood. Late in the afternoon of 21 August 1998, the nursing staff persuaded Mrs Jackson to go and take some rest. She only agreed when they assured her that they would call her if anything happened. When she returned to the ward at 18.30, Philip Beed said that Mrs Wilkie has just died, and had heard their voices before she went. From her mother's appearance, Mrs Jackson believes that her mother had not only just died.

63. Having reviewed her mother's records, Mrs Wilkie has the following complaints:

- On 17 August 1998, Code A made an entry in the nursing notes "Condition has generally deteriorated over the weekend Daughter seen – aware that mums condition is worsening, agrees active treatment not appropriate and to use of syringe driver if Mrs Wilkie is in pain". Mrs Jackson denies that her conversation with Code A was as recorded. She states that she did not agree that active treatment was not appropriate, and that there was no discussion about a syringe driver. She maintains that she was never told about the syringe driver.

- Nobody carried out a pain assessment a) when Mrs Jackson complained about her mother's pain on 17 August 1998 or b) before starting the s/c diamorpine on 20 August 1998.

- The drug administration record states that the syringe driver was started at 13.50. Mrs Jackson maintains that she did not leave the hospital until 13.55, and the syringe driver had not been started when she left.

- The nursing records falsely state that Mrs Wilkie's family were with her when she died.

- There are errors in the nursing records. On a nursing care plan there are two incorrect entries:

  - 13 August 1998, entry scored through, reads "oramorph 10mgs given at 21.00 as distressed. Settled and slept. Written in error as outside Gladys Richards room!"

  - 21 August 1998 "condition remained poorly pronounced dead @ 21.20 hrs by S/N Sylvia Roberts ?? ?? relatives (2 daughters) present". Elsewhere in the nursing notes, it is recorded that Mrs Wilkie died at 18.30, which is around the time when Mrs Jackson returned to the ward.

  These entries are initialled/signed, but I cannot identify the authors.

- There is no mention in the notes about the blood in the catheter bag on 21 August 1998.

- Why was her mother given diamorphine, and why was she started on such a high dose? The prescription chart, written by Dr Barton, was undated. She prescribed as a regular daily review (not PRN) diamorphine 20-200mg/24hr, hyoscine 200-800mg/24hr and midazolam 20-80mg/24hr, all to be administered subcutaneously.

64. This case has been reviewed by a number of experts instructed by the police. The first of these was Professor Ford, who reported in December 2001. His conclusions were:

    - The initial assessment and plan as noted by Dr Lord on 10 August 1998 was reasonable.

    - No diagnosis was made to explain the deterioration Mrs Wilkie is reported to have experienced around 15 August 1998, and there was no recorded medical assessment.

    - There is no clear evidence of pain or explanation of why Mrs Wilkie was started on the syringe driver.

    - Oral analgesics could and should have been tried before starting the syringe driver.

    - The undated prescription was poor practice and potentially very hazardous, as Mrs Wilkie was a frail elderly underweight patient with dementia.

    - The medical and nursing records are inadequate.

    - The use of the syringe driver may have hastened death, but Mrs Wilkie was a frail dependant lady with dementia who was at high risk of developing pneumonia even if she had not been administered sedative and opiate drugs.

65. As part of the second police investigation, this case was reviewed by the panel of experts. Their conclusions were:

    - Irene Waters (nurse)

No opinion expressed about the quality of nursing care.

- Robin Ferner (pharmacologist)

Noted that there was a high dose of diamorphine from the outset. Concluded that treatment was sub-optimal or negligent, but unclear as to cause of death.

- Peter Lawson (geriatrician)

Unable to assess cause of death and standard of care as medical notes and a section of the drug chart were not available from the police.

- Anne Naysmith (palliative care expert)

Noted that medical notes and a second drug chart appeared to be missing from the material provided by the police, but concluded that the cause of death was unclear and treatment sub-optimal. This conclusion was based on the inadequacy of the medical notes. The patient was in late-stage dementia and had become very dependent following a UTI requiring IV antibiotics. She may have died of dementia in GWMH whatever management had taken place.

Wilkie – conclusion

66. In my view, there is at least one potential allegation of misconduct that could be put to Code A and it relates to his disputed note on 17 August 1998. Mrs Jackson accepts that there was a conversation about her mother's pain, but denies that she agreed active treatment was inappropriate or that a syringe driver should be used. Accordingly, she alleges that Code A falsified the note of their conversation.

67. There are clear problems in establishing this allegation:

- It would appear that the only people present during the conversation were Mrs Jackson and Code A
- Mrs Jackson accepts that she was concerned that her mother should not suffer pain;
- The passage of time will make it difficult to prove to the required standard exactly what was said during a conversation over 10 years ago.

68. Of the other possible allegations, my views are as follows:

- The failure to carry out a pain assessment on 17 August 1998 is impossible to attribute to a named nurse;
- The PPC may consider that Mrs Jackson's allegation about the start time of the syringe driver on 20 August 1998 is not capable of proof or that, if proved, would be likely to lead to the removal of the nurse responsible. The most that could be proved would be a 5-10 minutes discrepancy between the time Mrs Jackson says she left the ward and the time the syringe driver is recorded as starting;

- Whilst it may be possible to prove that the notes incorrectly record the time of death, and that the family was present at death, and the PPC may consider that this is unlikely to lead to removal;

- It would be possible to prove that the notes contain an incorrect entry dated 13 August 1998 that was then scored through and corrected, but the PPC may consider that this is unlikely to lead to removal;

- It could proved that there was no entry in the notes on 21 August 1998 that the patient's catheter bag contained blood. However, the Council would then have to prove that the catheter bag did contain blood, that an individual named nurse did or should have noticed this and recorded it, and that the individual named nurse failed to record this in the notes. The PPC may conclude that this is not possible.

69. Finally, there is the wider concern about the alleged poor prescribing, the administration of high starting doses, and the failure of the nurse(s) to challenge. Potential evidential issues relating to these concerns are as follows:

- The identity of the nurse who started the syringe driver is not clear, but his/her initials appear on the prescription records and so it is possible that he/she could be identified.

- The Council could seek an independent expert to review the material we have and give an opinion on the prescription and whether a nurse should have challenged it/administered medication on the strength of it as per the prescription record. However, I note that two of the experts instructed by the police comment on the apparent absence of a drug chart and the inadequacy of the records.

- The Council is not in a position to make an allegation of inadequate record keeping against any named nurse(s), as we have no information about who was responsible for the records, who was on duty, etc.

70. [Amend in light of GMC outcome].

Evidence in the case of Devine

71. In June 2002, Mrs Reeves wrote to the NMC to lodge a formal complaint against Code A in respect of the care received by her mother Elsie Devine at GWMH between admission in October 1999 and her mother's death on 21 November 1999 (bundle pp ?? - ??).

72. Mrs Reeves referred to an independent review carried out by the hospital following her complaint to the hospital. Code A gave evidence at that review.

73. Mrs Reeves' complaints may be summarised as follows:

- Code A suggested that Mrs Devine was agitated on the morning of 19 November 1999, but none of the family had ever seen her agitated.

- Code A applied a fentanyl patch one day, and the next day, another nurse (LB) gave 50mg chlorpromazine without removing the fentanyl patch first.

- At 8.15am, Code A n telephoned Mrs Reeves' sister-in-law (and not Mrs Reeves, who was named as the next of kin), to say that Mrs Devine was confused. She did not suggest that there was any urgency, but by 1pm, when Mrs Reeves' brother attended the hospital, Mrs Devine was unconscious and no one could speak to her again.

- Code A made an unprofessional comment about tension between Mrs Reeves and her sister-in-law.

- Staff bathed and washed Mrs Devine's hair excessively, apparently because she asked for it.

- There was an incorrect statement in the notes on 3 November 1999 that Mrs Devine could not climb stairs.

- Code A sent home clothes that had been provided by the family because they were considered "too good" for a hospital stay (they were dry clean only).

- A relative asked to take Mrs Devine to the hospital restaurant and was refused without explanation.

- A kidney infection was diagnosed and antibiotics started, but this was not written up in the notes.

- When Mrs Reeves arrived at the hospital following her mother's sudden deterioration, Code A did not explain the medication and said she could not explain what had happened because she had only just come on duty.

74. The letter contains no specific allegations about SN Barker or EN Bell.

75. In July 2002, the NMC wrote to Mrs Reeves requesting a copy of the independent review report, and consent to approach the GWMH for documents and evidence relating to Mrs Devine's care (p ?). The NMC wrote to Mrs Reeves again in September to inform her that the PPC had adjourned the case pending the outcome of the criminal investigation (bundle p ?).

76. In October 2002, the Fareham and Gosport NHT PCT wrote to the NMC asking for details of the allegations against Sister Code A Code A as the PCT had not previously been aware of this referral (bundle p ?). There is no indication on the file that the NMC responded to this letter.

77. The police have provided voluminous material relating to this case, as it was one of the 10 cases investigated in full. From this material, it is possible to establish the following:

78. Mrs Devine was born on Code A After the death of her husband in 1979, she lived in her daughter Ann Reeves' house. From January 1999, her health deteriorated. In February 1999, it was suspected that she was suffering from

myeloma, but following tests, an expert advised in May 1999 that there was insufficient evidence to support a myeloma diagnosis.

79. In June 1999, Mrs Reeves' husband was diagnosed as suffering from leukaemia. In October and November 1999, he was receiving treatment, including a bone marrow transplant, at the Hammersmith Hospital. As a result, Mrs Reeves was unable to care for her mother at home.

80. On 9 October 1999, Mrs Devine saw her GP complaining of pain when urinating. A suspected kidney infection was diagnosed and she was admitted to Queen Alexandra Hospital for treatment. She was fit to leave by mid-October, but because of Mrs Reeves' circumstances, arrangements were made for her to be transferred to GWMH and she was admitted on 21 October 1999.

81. On the day of admission, she was seen by Dr Barton. The only analgesic prescribed was PRN oramorph (10mg/5ml). No reason for this was given in the notes. In fact, oramorph was never administered during Mrs Devine's admission.

82. On 25 October and 1 November 1999, other doctors noted that Mrs Devine was physically independent and continent but needed supervision with washing and dressing. She was confused and disorientated and wandered during the day.

83. On 11 November 1999, she was prescribed PRN thioridazine, an anti-psychotic. There is no corresponding entry in the notes to explain why. She was also prescribed trimethoprim for a presumed urinary tract infection, but an entry in the notes on 15 November 1999 showed that the urine specimen had not yielded any growth.

84. The thioridazine was first administered on 15 November 1999, when Mrs Devine was reported as being very aggressive and restless at times. It was also administered on 16 November 1999. On that day, Dr Reid the consultant asked for a referral to be made to Dr Luznat, a psychiatrist, as a result of Mrs Devine's worsening confusion, and also noted that renal function was deteriorating. Also, Mrs Devine creatine level had increased from 187 to 360micromol/L between 22 October and 16 November 1999.

85. She was seen on 18 November 1999 by Dr Taylor, who assessed her mental state and agreed that it had deteriorated. Mrs Devine was placed on the waiting list for Mulberry Ward as a result.

86. On 18 November 1999, a fentanyl patch was applied (25micrograms per hour) but there is no explanation for this in the medical or nursing notes. A prescription chart continuation sheet shows that it was prescribed by Dr Barton and administered by Code A at 9.15am.

87. On 19 November 1999, there are records of a marked deterioration, and statements from nurses who came on duty that morning to the effect that Mrs Devine was agitated and physically aggressive towards them. Code A Code A give largely consistent accounts. It is agreed that L Code A gave an injection of 50mg chlorpromazine at Dr Barton's direction, but it is not agreed whether Dr Barton was present or gave the instruction by telephone. The chlorpromazine was given at 8.30am. Mrs Devine was then "specialed" by two of the nurses.

88. There is an undated prescription by Dr Barton for 40-80mg diamorphine and 20 – 80mg midazolam, to be administered sub-cutaneously via syringe driver. On 19 November 1999, Gill Hamblin started the syringe driver with 40mg diamorphine and 40mg midazolam. Dr Barton's note reads:

Code A

89. Gill Hamblin's nursing note for 19 November 1999 reads:

Code A

90. Dr Barton has been interviewed by the police and made prepared statements, then answered "no comment" to all questions asked.

91. The material has been examined by a number of experts, whose conclusions are as follows:

- Dr Wilcock, palliative medicine expert:
    - Use of the fentanyl patch was not appropriate (too strong for the patient, less flexible than morphine solution in dose titration)
    - There was an inadequate assessment and documentation of Mrs Devine's marked deterioration
    - If midazolam was deemed necessary, it would have been more appropriate to give small doses of by intermittent subcutaneous injection as required – to go straight to a syringe driver could only be justified if it was considered without reasonable doubt that Mrs Devine was experiencing agitated confusion as a terminal event and was actively dying
    - In the absence of pain, shortness of breath or cough, there is no justification for use of diamorphine in a syringe driver
- Dr Black, geriatrician
    - There is no apparent justification for prescription of PRN oramorph on admission
    - There is no explanation in the notes for the use of fentanyl patch

- The fentanyl patch was only removed 3 hrs after s/c diamorphine started
- The starting doses of diamorphone and midazolam were higher than conventional guidance
- However, the patient was terminally ill and the drugs given provided good palliation of symptoms

- Dr Dudley, nephrologist
  - Beyond all reasonable doubt, Mrs Devine was dying from amyloidosis, progressive renal failure and dementia
  - Simple measures may have improved or stabilised her condition for a few days, but further deterioration culminating in death was inevitable

92. The police files also contain a copy of the independent review panel report dated 10 August 2001, which concluded that there was inadequate communication between the hospital staff and Mrs Reeves. Code A gave evidence that Mrs Reeves' brother, Mr Devine, gave instructions that Mrs Reeves should not be troubled because she was at the hospital in London with her husband, who was very ill. Code A accepted that this should have been documented, and that greater care should have been taken to ensure that Mrs Reeves was kept informed. The panel concluded that Mrs Devine's medical management was appropriate.

93. Dr Reid, the consultant responsible for Mrs Devine's care, has made a police statement. Generally, he is supportive of the medical notes and treatment given, but has some reservations:

    - In his view, it was not appropriate to prescribe oramorph PRN on admission, as no pain had been noted at that stage. However, oramorph was never administered;
    - Small doses of diamorphine injected over 24 hours may have been more appropriate than the fentanyl patch, but this would have involved multiple injections, which may have increased distress;
    - 40mg diamorphine in the syringe driver was a high starting dose. 20-30mg would have been more prudent;
    - 50mg chlorpromazine is at the upper limit of dosage range. He would expect to see the effect within 3 – 6 hours. Therefore it is of some concern that midazolam was started before the chlorpromazine may have reached maximum effect. However, the midazolam was being administered slowly over 24 hours.
    - It is undesirable that there is no note explaining the reason for high start doses of diamorphine and midazolam

94. Dr Reid also states that he established a good rapport with Mrs Reeves while she was pursuing her complaints with the hospital, and reports that she told him that

had she been able to deal him at the time of her mother's illness and death, she would never have made a complaint.

95. It should be noted that there are no police statements from Mrs Reeves' brother, Mr Devine, as sadly, he has died. It is clear from Mrs Reeves' statement to the police that she had argued with her sister-in-law about Mrs Devine's care, and as a result there was tension between some of the family members.

Devine – conclusions

96. The PPC may conclude that there is no realistic prospect of establishing that any of the nurses was guilty of misconduct in the way in which they communicated with Mrs Reeves about what was happening. Given Mrs Reeves' difficult personal circumstances, and the nurses' account that her brother had instructed that she should not be troubled, the PPC may conclude that it was not misconduct for them to communicate with Mrs Reeves' brother and sister-in-law. Any attempt to pursue an allegation of this sort would be bound to fail because Mr Devine is dead and could not give evidence, and prior to his death, he never made any statement contradicting what the nurses say about his instruction.

97. The PPC may consider that Code A 's comment at the independent review about tension between Mrs Reeves and her sister-in-law does not amount to misconduct. S Code A comment was made when she was giving evidence (not in patient notes) and was accurate.

98. Further, the PPC may consider that Code A 's refusal to accept the clothes originally sent for Mrs Devine was not misconduct. They were dry clean only, and the PPC may concluden that it was reasonable for Code A to ask for clothing that was easier to keep clean.

99. There could be grounds for criticising the nurse Code A who gave the chlorpromazine without removing the fentanyl patch (it was not removed until 3 hours later). However, Code A is not the subject of a complaint from Mrs Reeves. Further, the PPC may conclude that there is no realistic prospect of this amounting to misconduct likely to lead to removal.

100. The PPC may consider that Mrs Reeves' account of Staff Nurse Code A comments is not capable of supporting a charge of misconduct that is likely to lead to removal. Her account is disputed and there is little prospect of it being proved. Even if it was, a panel is unlikely to find misconduct in all the circumstances.

101. The other complaints made by Mrs Reeves are non-specific and do not amount to allegations of misconduct against named nurses that are likely to lead to removal.

102. Therefore, the only potential allegation that could be pursued is the general allegation of failure to challenge inappropriate prescribing. Among the experts (including Dr Reid, Mrs Devine's consultant), there seems to be general agreement that there were defects in Dr Barton's prescribing. Apparently, this is reflected by the decision of the jury at the inquest.

103. [Amend in light of GMC outcome]

The passage of time and delay

104. The events in question took place in 1998 (deaths of Mrs Wilkie and Mrs Page), 1999 (deaths of Mr Carby and Mrs Devine) and 2001 (death of Mrs Middleton).

105. All of the direct complaints to the NMC were made in 2002. Three of those complaints (arising from the deaths of Mrs Wilkie, Mrs Devine and Mrs Page) were considered by the PPC in August 2002 and adjourned. They were in part 1 of the agenda and the allegations were not served on the registrants Code A Code A

106. The other complaints (arising from the deaths of Mrs Middleton and Mr Carby) have never been before the PPC, and so the registrants involved Code A Code A have never been notified these allegations either.

107. The trust was given the opportunity to comment on the complaints arising from the deaths of Middleton and Carby, and on the report of Professor Ford, which dealt with the death of Mrs Wilkie. There is nothing on file to suggest that the NMC served information on the trust about the complaints arising from the deaths of Mrs Devine and Mrs Page.

108. We had obtained an opinion from Johannah Cutts QC, which gives guidance to the PPC on the approach that should be taken when considering this issue at this stage (bundle pp ?? to end).

Clare Strickland
Senior Hearings Lawyer
In-house Legal Team
[date]

Text for letter to Richards complainants (Mrs Gillian McKenzie and Mrs Lesley Richards)

I am the NMC's Director of Fitness to Practise, and I write to inform you of the NMC's current position in respect of the Gosport War Memorial Hospital.

I am sorry that you have not received any direct correspondence from the NMC for some time. As I am sure you will appreciate, the NMC has had to wait firstly for the outcome of the police investigations, and then the coroner's inquest, before taking any further steps of its own.

We have now reached the stage where we will be inviting the Preliminary Proceedings Committee to consider what further steps to take, if any, following those inquiries.

Prior to that, we have conducted an extensive review of our records to establish the status of complaints that have been made to us. During the course of that review, it has come to light that the information you have been given by the NMC has not been complete and may have been misleading.

In September 2000, the NMC received information from Hampshire Police relating to the standard of care given to your mother, Mrs Gladys Richards, at Gosport War Memorial Hospital.

On 18 September 2001, the NMC's Preliminary Proceedings Committee ("PPC") considered documents provided by the police and the Portsmouth Healthcare NHS Trust which related to your mother's care. Having considered those documents, the Preliminary Proceedings Committee decided not to investigate further the conduct of any registered nurse. Accordingly, the case in respect of your mother was closed. From our records, it does not appear that you were informed of this at the time, and I apologise for that.

Further complaints concerning nurses from the Gosport War Memorial Hospital were considered by the PPC in August 2002. The PPC decided to adjourn its consideration pending ongoing police enquiries.

You were sent a letter dated 27 September 2002 informing you of the PPC's decision, a copy of which I enclose. I am concerned that this letter may have given you the incorrect impression that the NMC was still considering issues arising from your mother's case. I am sorry if that was the impression you received.

The NMC's procedures have changed radically since 2002, and I am confident that an error of this sort will not be repeated (perhaps include something here about the NMC's commitment to stakeholder engagement, etc).

Please accept my apologies for any distress that this matter causes.

Checked 3.6.09

Text for letter t Code A prior to PPC

I am writing to inform you that the NMC has received letters of complaint in which you are named, and to explain:

- What the NMC has done with these complaints in the past; and
- What will happen next.

The complaints are as follows:

1. While involved in the care of Mrs Wilkie in August 1998:

    a) On 17 August 1998, you made a false entry in the nursing notes of Mrs Wilkie in that you recorded "Condition has generally deteriorated over the weekend Daughter seen – aware that mums condition is worsening, agrees active treatment not appropriate and to use of syringe driver if Mrs Wilkie is in pain", when Mrs Wilkie's daughter had not agreed that active treatment was appropriate and/or agreed to the use of a syringe driver.

    b) You failed to ensure that a pain assessment was carried out in respect of Mrs Wilkie

        i. when Mrs Wilkie's daughter complained about her mother's pain on 17 August 1998 and/or

        ii. before starting subcutaneous diamorpine on 20 August 1998.

    c) You failed to ensure that Mrs Wilkie's records were full and accurate in that:

        i. they contained an entry stating that a syringe driver had been started at 13.50 on 20 August 1998 when it had not in fact been started until after 13.55;

        ii. there was no record that Mrs Wilkie had blood in her catheter bag on 21 August 1998;

        iii. they contained a statement that Mrs Wilkie's family were with her when she died on 21 August 1998 when they had not been;

        iv. they contained a statement that Mrs Wilkie had died on 21.20 on 21 August 1998 when she had died at 18.30 on 21 August 1998.

    d) You failed to prevent Mrs Wilkie from being started on inappropriate medication, namely subcutaneous diamorphine, hyoscine and midazolam, or alternatively, to ensure that she was started on an appropriate dose.

2. While involved in the care of Mr Carby in 1999, you failed to ensure that appropriate care was given to Mr Carby.

3. While involved in the care of Mrs Middleton in 2001, you failed to ensure that appropriate care was given to Mrs Middleton.

These complaints fall to be dealt with in accordance with the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 Approval Order 1993.

Complaint 1 above (re: Mrs Wilkie) complaint was considered by the NMC's Preliminary Proceedings Committee ("PPC") on 24 September 2002, along with other complaints from members of the public about other nurses at the GWMH.

The complaints in respect of Mr Carby and Mrs Middleton have not yet been considered by the PPC.

The NMC did not inform you of the complaints against you at the time they were received because this was not required under the rules and procedures in place at that time.

On 24 September 2002, the PPC decided to adjourn consideration of the complaints it had considered, including Mrs Jackson's complaint in respect of Mrs Wilkie, pending completion of a police investigation into a number of deaths at the GWMH.

That investigation concluded in 2007 with a decision not to bring any criminal charges.

There then followed a coroner's inquest into the deaths of ten patients at the GWMH, which concluded recently, and a General Medical Council hearing into allegations of misconduct against a doctor.

Now that those inquiries are complete, the NMC is in a position to continue its consideration of these matters.

All matters will be put before the PPC on [date]. Under Rule 8(3) of the Professional Conduct Rules, there are a range of options open to the PPC on that date, including:

- Declining to proceed with the matter;
- Requiring further investigations to be conducted;
- Adjourning consideration of the matter.

If the PPC considers that the allegations may lead to removal, it will issue a notice of proceedings and invite you to respond in writing to the notice. In this event the case will be listed to come back to the PPC for a second consideration in light of any response you may make to the notice. However, it is open to you to make a preliminary written response to the allegations at this stage, and any letter you write will be made available to the PPC at its first consideration of the case. Any such response should reach me within [?] days of the date of this letter.

I enclose a bundle of documents that will be considered by the PPC.

Enclosed with this letter is an information sheet which describes the procedures of the PPC and offers you some advice. Please read this document carefully.

You are reminded to keep the NMC informed of any change of address.

Any queries regarding this matter should be directed to Code A

Code A

Text for letter to Code A **prior to PPC**

I am writing to inform you that the NMC has received letters of complaint in which you are named, and to explain:

- What the NMC has done with these complaints in the past; and
- What will happen next.

The complaints are as follows:

1. That you, while involved in the care of Mrs Eva Page in 1998, failed to ensure that she received appropriate care.

2. That you, while involved in the care of Mrs Elsie Devine in 1999:

   a) Failed to ensure that she received appropriate medication, in that:

      i. On 18 November 1999, a fentanyl patch was applied without any explanation in the patient records;

      ii. On 19 November 1999, she received 50mg chlorpromazine without the fentanyl patch being removed;

      iii. On 19 November 1999, you failed to prevent Mrs Devine from being started on inappropriate medication, namely subcutaneous diamorphine and midazolam, or alternatively, to ensure that she was started on an appropriate dose.

   b) Failed to ensure that she received appropriate care, in that:

      i. Her hair was washed excessively;

      ii. She was bathed excessively.

   c) Failed to ensure that communication with her family was appropriate, in that:

      i. The family was not notified that they should attend hospital urgently at 8.15am on 21 November 1999;

      ii. You made an unprofessional comment about tension between Mrs Reeves and her sister-in-law at an internal review;

      iii. Clothes supplied by the family for her were sent home because they were said to be "too good";

      iv. A relative asked to take her to the hospital restaurant but was refused for no good reason;

      v. Her family was not given an adequate explanation for her sudden deterioration.

These complaints fall to be dealt with in accordance with the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 Approval Order 1993 ("the Professional Conduct Rules").

These complaints were considered by the NMC's Preliminary Proceedings Committee ("PPC") on 24 September 2002, along with other complaints from members of the public about other nurses at the GWMH.

The NMC did not inform you of the complaints against you at the time they were received because this was not required under the rules and procedures in place at that time.

On 24 September 2002, the PPC decided to adjourn consideration of the complaints it had considered, including those in respect of Mrs Page and Mrs Devine, pending completion of a police investigation into a number of deaths at the GWMH.

That investigation concluded in 2007 with a decision not to bring any criminal charges.

There then followed a coroner's inquest into the deaths of ten patients at the GWMH, which concluded recently.

Now that those inquiries are complete, the NMC is in a position to continue its consideration of these matters.

All matters will be put before the PPC on [date]. Under Rule 8(3) of the Professional Conduct Rules, there are a range of options open to the PPC on that date, including:

- Declining to proceed with the matter;
- Requiring further investigations to be conducted;
- Adjourning consideration of the matter.

If the PPC considers that the allegations may lead to removal, it will issue a notice of proceedings and invite you to respond in writing to the notice. In this event the case will be listed to come back to the PPC for a second consideration in the light of any response you may make to the notice. However, it is open to you to make a preliminary written response to the allegations at this stage, and any letter you write will be made available to the PPC at its first consideration of the case. Any such response should reach me within [?] days of the date of this letter.

I enclose a bundle of documents that will be considered by the PPC.

Enclosed with this letter is an information sheet which describes the procedures of the PPC and offers you some advice. Please read this document carefully.

You are reminded to keep the NMC informed of any change of address.

Any queries regarding this matter should be directed to Code A

Code A

Text for letter to Code A prior to PPC

I am writing to inform you that the NMC has received a letter of complaint in which you are named, and to explain:

- What the NMC has done with this complaint in the past; and
- What will happen next.

The complaint is as follows:

1. That you, while involved in the care of Mrs Elsie Devine in 1999:

   a) Failed to ensure that she received appropriate medication, in that:

      i. On 18 November 1999, a fentanyl patch was applied without any explanation in the patient records;

      ii. On 19 November 1999, she received 50mg chlorpromazine without the fentanyl patch being removed;

      iii. On 19 November 1999, you failed to prevent Mrs Devine from being started on inappropriate medication, namely subcutaneous diamorphine and midazolam, or alternatively, to ensure that she was started on an appropriate dose.

   b) Failed to ensure that she received appropriate care, in that:

      i. Her hair was washed excessively;

      ii. She was bathed excessively.

   c) Failed to ensure that communication with her family was appropriate, in that:

      i. The family was not notified that they should attend hospital urgently at 8.15am on 21 November 1999;

      ii. You made an unprofessional comment about tension between Mrs Reeves and her sister-in-law at an internal review;

      iii. Clothes supplied by the family for her were sent home because they were said to be "too good";

      iv. A relative asked to take her to the hospital restaurant but was refused for no good reason;

      v. Her family was not given an adequate explanation for her sudden deterioration.

This complaint falls to be dealt with in accordance with the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 Approval Order 1993 ("the Professional Conduct Rules").

The complaint was considered by the NMC's Preliminary Proceedings Committee ("PPC") on 24 September 2002, along with other complaints from members of the public about other nurses at the GWMH.

The NMC did not inform you of the complaint against you at the time it was received because this was not required under the rules and procedures in place at that time.

On 24 September 2002, the PPC decided to adjourn consideration of the complaints it had considered, including Mrs Reeves's complaint, pending completion of a police investigation into a number of deaths at the GWMH.

That investigation concluded in 2007 with a decision not to bring any criminal charges.

There then followed a coroner's inquest into the deaths of ten patients at the GWMH, which concluded recently.

Now that those inquiries are complete, the NMC is in a position to continue its consideration of these matters.

All matters will be put before the PPC on [date]. Under Rule 8(3) of the Professional Conduct Rules, there are a range of options open to the PPC on that date, including:

- Declining to proceed with the matter;
- Requiring further investigations to be conducted;
- Adjourning consideration of the matter.

If the PPC considers that the allegations may lead to removal, it will issue a Notice of Proceedings and invite you to respond in writing to the Notice. In this event the case will be listed to come back to the PPC for a second consideration in the light of any response you may make to the Notice. However, it is open to you to make a preliminary written response to the allegations at this stage, and any letter you write will be made available to the PPC at its first consideration of the case. Any such response should reach me within [14 days?] of the date of this letter.

I enclose a bundle of documents that will be considered by the PPC when it considers the matter on [date].

Enclosed with this letter is an information sheet which describes the procedures of the PPC and offers you some advice. Please read this document carefully.

You are reminded to keep the NMC informed of any change of address.

Any queries regarding this matter should be directed to Code A

Code A

Text for letter to Code A prior to PPC

I am writing to inform you that the NMC has received a letter of complaint in which you are named, and to explain:

- What the NMC has done with this complaint in the past; and
- What will happen next.

The complaint is as follows:

1. While involved in the care of Mr Carby in 1999, you failed to ensure that appropriate care was given to Mr Carby.

This complaint falls to be dealt with in accordance with the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 Approval Order 1993 ("the Professional Conduct Rules").

The NMC did not inform you of the complaint against you at the time it was received because this was not required under the rules and procedures in place at that time.

On 24 September 2002, the NMC's Preliminary Proceedings Committee ("PPC") considered a number of other complaints from members of the public about other nurses at the GWMH. The PPC decided to adjourn consideration of the complaints it had considered pending completion of a police investigation into a number of deaths at the GWMH. Accordingly, the NMC also postponed consideration of Mrs Carby's complaint.

The police investigation concluded in 2007 with a decision not to bring any criminal charges.

There then followed a coroner's inquest into the deaths of ten patients at the GWMH, which concluded recently.

Now that those inquiries are complete, the NMC is in a position to continue its consideration of these matters.

All matters will be put before the PPC on [date]. Under Rule 8(3) of the Professional Conduct Rules, there are a range of options open to the PPC on that date, including:

- Declining to proceed with the matter;
- Requiring further investigations to be conducted;
- Adjourning consideration of the matter.

If the PPC considers that the allegations may lead to removal, it will issue a notice of proceedings and invite you to respond in writing to the notice. In this event the case will be listed to come back to the PPC for a second consideration in the light of any response you may make to the notice. However, it is open to you to make a preliminary written response to the allegations at this stage, and any letter you write will be made available to the PPC at its first consideration of the case. Any such response should reach me within [?] days of the date of this letter.

I enclose a bundle of documents that will be considered by the PPC on [date]

Enclosed with this letter is an information sheet which describes the procedures of the PPC and offers you some advice. Please read this document carefully.

You are reminded to keep the NMC informed of any change of address.

Any queries regarding this matter should be directed to Code A Code A

GOSPORT WAR MEMORIAL HOSPITAL NURSES

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Private and confidential

<<RecipientForenames>>
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<<RecipientPostCode>>

<<GeneralCurrentDate>>
PRE/16A/<<CaseOfficerInitials>>/<<CaseDetailReference>>
Direct Line :
<<CaseOfficerTelephone>>
Fax : <<CaseOfficerFax>>
fitness.to.practise@nmc-uk.org

Dear <<RecipientTitle>> <<RecipientSurname>>

The Council has received allegations of misconduct from <<Complainant>> which may lead to the removal of your name from the register. Misconduct is defined in the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 as "conduct unworthy of a registered nurse, midwife or health visitor, as the case may be, and includes obtaining registration by fraud".

The allegations are stated as follows:

<<Enter Allegations>>

In accordance with the Rules mentioned above the Council's Preliminary Proceedings Committee will consider the matter. Please find enclosed copies of documents relating to the allegation which the Committee will receive. These are as follows:

<<DocumentsEnclosed>>

If the Committee considers that the allegations may lead to removal, it will issue a Notice of Proceedings and invite you to respond in writing to the Notice. In this event the case will be listed to come back to the Committee for a second consideration in the light of any response you may make to the Notice. However, it is open to you to make a preliminary written response to the allegations at this stage, and any letter you write will be made available to the Committee at its first consideration of the case. Any such response should reach the Council's offices within 14 days of the date of this letter.

Glospara1

The Committee will also find it helpful to see medical reports from your General Practitioner and any other doctors from whom you may be receiving treatment. If you would like to submit these reports for the Committee's attention, then I shall need your doctor's names and addresses together with your permission to contact them. Alternatively, you may submit the reports with your response to the allegation within the time specified above.

Enclosed with this letter is an information sheet which describes the procedures of the Preliminary Proceedings Committee and offers you some advice. Please read this document carefully.

You are reminded to keep the Council informed of any change of address.

Any queries regarding this matter should be directed to <<CaseOfficerForenames>> <<CaseOfficerSurname>> on <<CaseOfficerTelephone>>.

Yours sincerely

<<CaseOfficerForenames>> <<CaseOfficerSurname>>
Case Officer

Enclosure(s) : Preliminary Proceedings Committee Information Sheet for Practitioners
Documents