FILE NOTE

Case	Registered nurses employed at Gosport War Memorial Hospital
Reference	12053 et al
Case officer	Code A
Date	4 January 2010
To	Code A
Copied to *(if applicable)*	Ian Todd

Code A

As discussed the following is information relating to the referral concerning registered nurses employed at Gosport Ward Memorial Hospital.

This note has been prepared in response to the letter from Norman Lamb, MP dated 17 November 2009. In preparing it, I have seen Mr Lamb's letter and Ian Todd's draft responses. In addition, I have been able to refer to a draft report prepared by FtP's in house legal team.

I would appreciate it if you could regard the contents as confidential and prepared for the purposes of responding to Mr Lamb. In addition, I would be obliged if you could advise me when you are sending the response.

1993 Rules

At the outset, can I confirm that this matter is being considered under the 1993 rules ('Old rules').

The case has been considered at an initial stage by the Preliminary Proceedings Committee (PPC) to determine whether the matter is serious enough to lead to removal from the register.

It is possible for a case to be considered by the PPC without having to write to a practitioner beforehand, unless specifically asking them to respond to allegations.

1 Response to Norman Lamb, MP

I propose to address the points in Mr Lamb's letter by going through his letter in paragraph order, but it is necessary to address the points by providing background information.

1.1 History of the referral

Matters were first referred to the NMC in 2001 by Hampshire Constabulary by way of a report prepared by an expert witness, Professor Livesey. Within this report three registered nurses are named. I do not propose to name them here as Mr Lamb does not require this information. Professor Livesey's report related to the care provided to a patient, Mrs Richards. The PPC declined to proceed with the case.

The police commissioned another expert report by Professor Ford into the care of five patients, including Mrs Richards. This was in response to local media interest and complaints from relatives to the police. Professor Ford reported back in December 2001. The police made the report available to

- the Commission for Health Improvement (CHI);
- General Medical Council;
- and NMC.

It should be noted that no individual registered nurse is named within Professor Ford's report. In response to Professor Ford's report, the NMC wrote to the Trust for a view. The response was received on 15 May 2002. The Trust confirmed that disciplinary action had not been taken against any registered nurse.

In May 2002, a complaint was made directly to the NMC by a member of the public, Mr Page, a relative of one of the patients at the hospital naming two practitioners. This is the first occasion in which a complaint was made directly to the NMC by a patient's relative.

In June 2002, three further complaints were received from members of the public concerning treatment of their relatives. In August 2002, this was followed by another complaint by another member of the public about the care of their relative.

CHI conducted an investigation. Those systems in place from 1998 were reviewed. CHI reported in July 2002.

In September 2002, the police reopened the case and began a large-scale investigation into 90 deaths at the hospital.

On 24 September 2002, the PPC considered the case and decided to adjourn the proceedings pending the outcome of the police investigation. It should be noted that there is no record of two of the referrals made in June/August 2002 being considered by the PPC, although the substance of the complaint is the same.

As such, it is incorrect for Mr Lamb to suggest that this case has not been investigated by the Council's practice committees. By considering the referrals, the NMC has been investigating the matter. We have been obliged to await the outcome of major police enquiries at the direction of the PPC.

In terms of the timescales quoted in Mr Lamb's third paragraph, this is inaccurate. The earliest referral was in 2001 by the police in the form of sharing a report that had been commissioned. The earliest direct referral by a member of the public was in 2002.

1.2 Police investigation and coroner's inquest

While respecting the boundaries of the police enquiries, the NMC maintained contact with the police. In October 2004, the police provided the NMC with an update on the investigation.

The way the 90 deaths were categorised is complicated and I do not propose to go into those details here. In summary, the police agreed to partial disclosure of information, with the consent of relatives. It reached a similar agreement with the GMC.

Through 2004, 2005 and 2006, the NMC received files relating to 80 cases. This information has been reviewed by FtP's legal team.

In December 2006, the police announced the outcome of the remaining 10 cases. The Crown Prosecution Service concluded that no further action should be taken on each of the cases.

In March 2007, the police provided the outstanding files with an indication that the coroner may decide to hold an inquest in respect of three patients who had not been cremated. In May 2008, the NMC was informed by the GMC that HM Coroner for Hampshire would be holding an inquest into the deaths of ten patients. The coroner subsequently informed the NMC that the case was scheduled to start in March 2009 and last for six weeks. Some of those nurses referred to the NMC were called to give evidence. In April 2009, a narrative verdict was recorded (that is circumstances of deaths were recorded without attributing the cause to a named individual). The police did not re-open its case. There was a potential that the police case could have been reopened on the basis of the outcome of the coroner's inquest.

In November 2008, advice was sought by the NMC from counsel regarding its own proceedings, the status of the current complaints and of the matters that had arisen from other organisations, to assist any future practice committee. This advice was received at the beginning of February 2009. It is confidential but is available upon request for review but not circulation.

In December 2009, FtP staff met with the director of clinical delivery and excellence, Hampshire Community Health Care Trust. This was an informal meeting but an understanding was reached about obtaining further information regarding individual practitioners. A similar meeting is being set up with Portsmouth Hospitals NHS Trust this month. To explain, the Trust has 'shape-shifted' since 2001 and some of the practitioners have been redeployed (as well as retiring).

In December 2009, the Royal College of Nursing announced its interest informally and FtP is in contact not only providing information but obtaining it.

My reason for providing this information is so that it can be demonstrated to Mr Lamb that, while the NMC has been obliged to await the outcome of the police (and subsequent coroner's inquest) it has not been idle, in that it has maintained contact with Hampshire Constabulary and HM Coroner for Hampshire, reviewed the substantial information that has been obtained and sought advice for the benefit of a future practice committee.

1.4 GMC's case concerning Dr Jane Barton

Mr Lamb compares and contrasts the NMC and the GMC in their respective proceedings. Mr Lamb repeats that the NMC "will not take any steps until the GMC case has been concluded". This is not strictly accurate.

As shown above, the NMC has started its enquiries but has been obliged to await the outcome of other parties' proceedings at the direction of the PPC. These parties' proceedings have run concurrently with the GMC's own enquiries. It should be noted, however, that the GMC postponed holding its own conduct hearing until after the coroner's inquest.

We have maintained contact with the GMC throughout its case and have received limited but appropriate information throughout. It became apparent that three of the patients in the GMC's case were patients in the NMC's case and that the GMC planned to call as witnesses most of the nurses referred to the NMC.

The GMC adjourned its case on 21 August 2009. While it has reached a decision in respect of facts it has yet to make one in respect of misconduct or the final sanction. It is the decision on misconduct that will help inform the NMC's PPC in its decision, but ultimately it will play part of the committee's decision, together with any written response submitted by the RCN on behalf of the registrants.

Certainly there have been strategic advantages to awaiting the outcome of the GMC's case and, having been obliged to await the outcome of other parties' proceedings for so long, I can understand why it was decided to await the outcome of the GMC's conduct case. As some considerable time had been set aside for the GMC's case, it was not anticipated that it would have to be adjourned. The GMC's case is due to resume on 18 January 2010 for a further days.

1.5 Contact with referrers

While the NMC has been dedicated to maintaining contact with Hampshire Constabulary, the coroner's office, the Trust, the GMC and its agents, on review it is recognised that better work should have been done at the time about engaging with those members of the public that have made complaints directly to the NMC.

Following a strategy meeting on 12 June 2009, it was agreed that when we wrote to the practitioners concerned, asking them to respond and advising them of a date of a meeting, we would write to all of the referrers. Since I became lead/point of contact from June 2009, I have engaged by email with one of the referrers, Code A although, admittedly, any update I can safely provide is limited.

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Proposed action

We have been asked to expand on the proposed steps we will take. The following are among the actions agreed at a strategy meeting on 12 June 2009. Given the adjournment of the GMC's case, timescales have had to be altered since the meeting and are still subject to change.

Within the next three weeks, we plan to obtain employments references from the two Trusts where the practitioners have worked. This information will be disclosed to each practitioner.

Following a finding of misconduct and the final sanction by the GMC, allegations and supporting paperwork will be sent to the practitioners concerned. They will be informed of the date of the meeting and a date to respond by. We anticipate the time between writing to the practitioners and the PPC convening to be between 4 – 6 weeks.

Should the GMC's case conclude by 29 January 2009, therefore, the PPC should meet in mid-March 2009, although you will appreciate that this date is subject to many factors: the availability of individual panellists; the availability of documentation.

The PPC will be made up from panellists that currently sit with the Investigating Committee. None of them have considered this case before nor have been provided with any information out it from the NMC but, in July 2009, have received training in considering cases under the 1993 Rules.

The PPC will be allocated one day for reading the prepared bundle provided to the practitioners together with any response received from the practitioners/RCN. The following day it will sit, in private, to deliberate.

The options open to the PPC are as follows:

- To decline to proceed with the case;
- To adjourn in order to obtain further information (through FtP staff);
- To start formal proceedings against any or all of the practitioners following an investigation by the NMC's lawyers

The PPC will announce its decision on the second day. Sitting with the committee on both days will be a legal assessor, who will be available to provide clarification on points of law. In addition, any advice provided by the legal assessor will be provided by that of counsel, provided last year. We anticipate having a shorthand writer to transcribe the reasons for the committee's decision.

Concluding remarks

This is a complicated case and unique in the circumstances in which it not only was referred to the NMC but also in the way it which has developed.

Considerable work has been done following the PPC's decision to adjourn the case in 2002 and continues to be done to ensure that we are in a position to move expeditiously following the conclusion of the GMC's case.

I have attempted to provide a broad summary and chronology in this note, but I accept that it is as likely to raise questions as it is to answer them. I am happy to expand on anything that is unclear.

Finally, I am anticipating having to ensure that a fair proportion of my working day from now until the PPC meets in March 2010 will have to be given over to this matter. As such, I am happy to answer any further communication from Norman Lamb or, if requested, to meet with him.

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