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10 March 2010

Thank you for your letter dated 16 February 2010 regarding our handling of concerns about the Gosport War Memorial Hospital.

My response deals specifically with the questions that you have raised, rather than the current position with our handling of the case. As you will appreciate, the case is still 'live' and has been scheduled for a Preliminary Proceedings Committee panel meeting in the next few weeks.

Given the details of this case and your questions, there is an element of repetition in some of my answers and, where I felt it appropriate, I have addressed my response to a group of questions.

1 How many letters of concern or complaints has the NMC received about nurses employed at the Gosport War Memorial Hospital?

Between May – August 2002, we received five letters from members of the public:

- In May 2002, Mr Page wrote to the NMC. He named two nurses and referred to a number of others who were unnamed. No specific allegations were made.
- On 1 June 2002, a letter from a member of the public, Mrs Jackson, was received. Specific allegations are made against one named nurse and some unnamed.
- On 6 June 2002, a letter from a member of the public, **Code A** was received and named four nurses. Specific allegations were made against two of them.
- On 19 June 2002, a letter from a member of the public, Mrs Bulbeck, was received. Allegations were made but no nurse was identified by Mrs Bulbeck until a subsequent letter, dated 2 September 2002.

- On 22 August 2002, a letter was received from Mrs Carby which alleges "complete negligence" which led to the death of her husband. Four nurses were named.

These letters were in addition to the contacts from the Hampshire Constabulary (detailed below)

2 When were those concerns or complaints received and over what period of time?

In September 2000, the Hampshire Constabulary informed the UKCC (our predecessor body) that it was investigating the circumstances of the death of an elderly patient, Mrs Richards. No specific complaint was made, but the UKCC was informed that three practitioners were being interviewed and that there may be an element of criminal culpability in their conduct. This matter was considered by our Preliminary Proceedings Committee (PPC) on 18 September 2001, which decided to decline to proceed with the case.

The police commissioned a further report by an expert, Professor Ford, to review the deaths of five patients. In December 2001, Professor Ford submitted this report. The police subsequently made this and the previous expert report by Professor Lively (who had submitted an initial report from the police regarding the death of Mrs Richards) available to a number of organisations including the GMC, the UKCC and the Commission for Health Improvement (CHI). CHI's report, made in July 2002, followed an investigation into systems within the Trust since 1998 and was made available to the NMC.

3 What communication has the NMC had with those that referred the nurses to the NMC about their complaints and the registrants involved about the NMC's approach to the complaints?

We wrote initially to the members of the public who had contacted us to ask for further information or clarification. In addition, we wrote to Fareham and Gosport Primary Care Trust for further information regarding the complaints made.

Following the (second) consideration of the case by the PPC in September 2002, the NMC wrote to the Trust in October 2002 to confirm the PPC's decision to adjourn consideration of the case to await the outcome of the police enquiries.

Latterly, communication has been maintained with Code A through email.

In December 2009 and January 2010, the NMC arranged informal visits to the two trusts that are, or were, the last employers of the eight registrants concerned. This has been followed with correspondence and email exchanges.

In respect of the registrants in this case, as no specific allegations were being put to them, in accordance with the 1993 Rules, we did not engage with them.

In November and December 2009, the RCN contacted the NMC and asked for confirmation that eight registrants were the subject of a referral to the NMC. We have confirmed this and have maintained contact with the RCN since then. The exception to this is that we have been

obliged, at the recommendation of the RCN, to ask one of the registrants to complete a consent form to enable the NMC to obtain medical information relating to her current state of health.

4 What action was taken to validate or investigate those complaints?

As referenced earlier in my response, in September 2001, the Preliminary Proceedings Committee (PPC) considered the initial referral by the Hampshire Constabulary and declined to proceed with the matter. The PPC was not obliged to give reasons for its decision at that time and I am afraid that there is no record of why the PPC declined to proceed the case at this time (see reference below).

The PPC considered further information from Hampshire Constabulary (from February 2002) on 24 September 2002 and decided to await the outcome of the police proceedings and any judicial proceedings.

Prior to the PPC's consideration in September 2002, we wrote to the Trust in May 2002 for its view. They advised us that no disciplinary action had been taken against any registrant. It is believed that, until recently, all of the registrants have remained in employment within the NHS, some with the same employer and some 'TUPEd' over to a neighbouring trust. We understand that two registrants have recently retired and one has retrained in another area of health care. No complaints have subsequently been received by the UKCC/NMC from their employer.

5 Was consideration given to referring the cases to an interim order panel?

6 If no action was taken what was the basis of the NMC's decision not to take action?

7 Who made the decision? Was it made at case manager level, by the executive or by the Council?

As this matter is being considered under the 1993 rules, the only sanction available at an extraordinary meeting of the Preliminary Proceedings Committee is to suspend a practitioner's registration while they are the subject of the investigation. Such a suspension would have to be reviewed quarterly.

Interim suspension has been a decision taken by the PPC in the most serious circumstances and is a measure taken with caution, as the allegations against a registrant have not been found proven. In addition, information had to be available to support the argument that a practitioner's registration should be suspended as an interim measure.

The decision to direct an extraordinary meeting of the PPC, to consider the issue of whether or not a suspension was necessary in respect of any or all of the registrants in this case, was one open to the PPC's which met in September 2001 and September 2002. As the committee did not, at that time, have to give reasons for all of its decisions, there is no record of why the PPC did not consider it necessary.

Following the PPC decision to adjourn consideration of the case in September 2002, it was open to Fitness to Practise staff, from its case management staff to the director, to consider referring the case for an extraordinary meeting of the Preliminary Proceedings Committee.

The NMC has maintained regular contact with the police and HM coroners' office since the case was adjourned in 2002 and has been satisfied there is no additional information which would warrant placing this matter for consideration: no arrests have been made or charges made against the registrants concerned nor has there been any disciplinary action taken.

8 Was there liaison with other bodies when reaching the decision such as with the Trust, the GMC or the police?

There has been continuing contact with the GMC and its solicitors, Field Fisher Waterhouse, from whom we learnt that some of the nurses who had been named to the NMC were giving evidence for the GMC. At a meeting on 16 May 2008, the GMC expressed anxiety should the NMC's proceedings risk discouraging its registrants from co-operating with the GMC's proceedings.

The NMC maintained close contact with the police since the case was adjourned in September 2002 while respecting the boundaries of its investigation. In October 2004, the police provided the NMC with an update on the investigation and agreed to a partial disclosure of information with the consent of relatives. Between 2004 and 2006, the NMC received files relating to 80 cases. This information was reviewed by FtP's in-house legal team.

In December 2006, the police announced the outcome of a further 10 cases. The Crown Prosecution Service concluded that no further action would be taken on any 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 committees' deliberations. This advice was received at the beginning of February 2009.

9 Have the complaints, and supporting documents, if any, been retained by the NMC?

The report made to the PPC in September 2001 is available but not the supporting documentation as it was custom and practice to destroy documentation on closed cases after three months (the period when a judicial review could be sought by a complainant).

Otherwise, all letters of complaint and supporting documentation referred to in this letter have been retained and form the body of a bundle of documents that is to be served on the registrants concerned prior to the case being reconsidered in April 2010.

I hope this information is of assistance to you. If there is anything further that you require at this time, please do not hesitate to contact me again.

Yours sincerely

Professor Dickon Weir-Hughes
Chief Executive and Registrar

Code A