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- for your information the GWMH deaths were on the front page of the Independent on Sunday yesterday - copy of article attached

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15 March 2009

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**Among the dead**

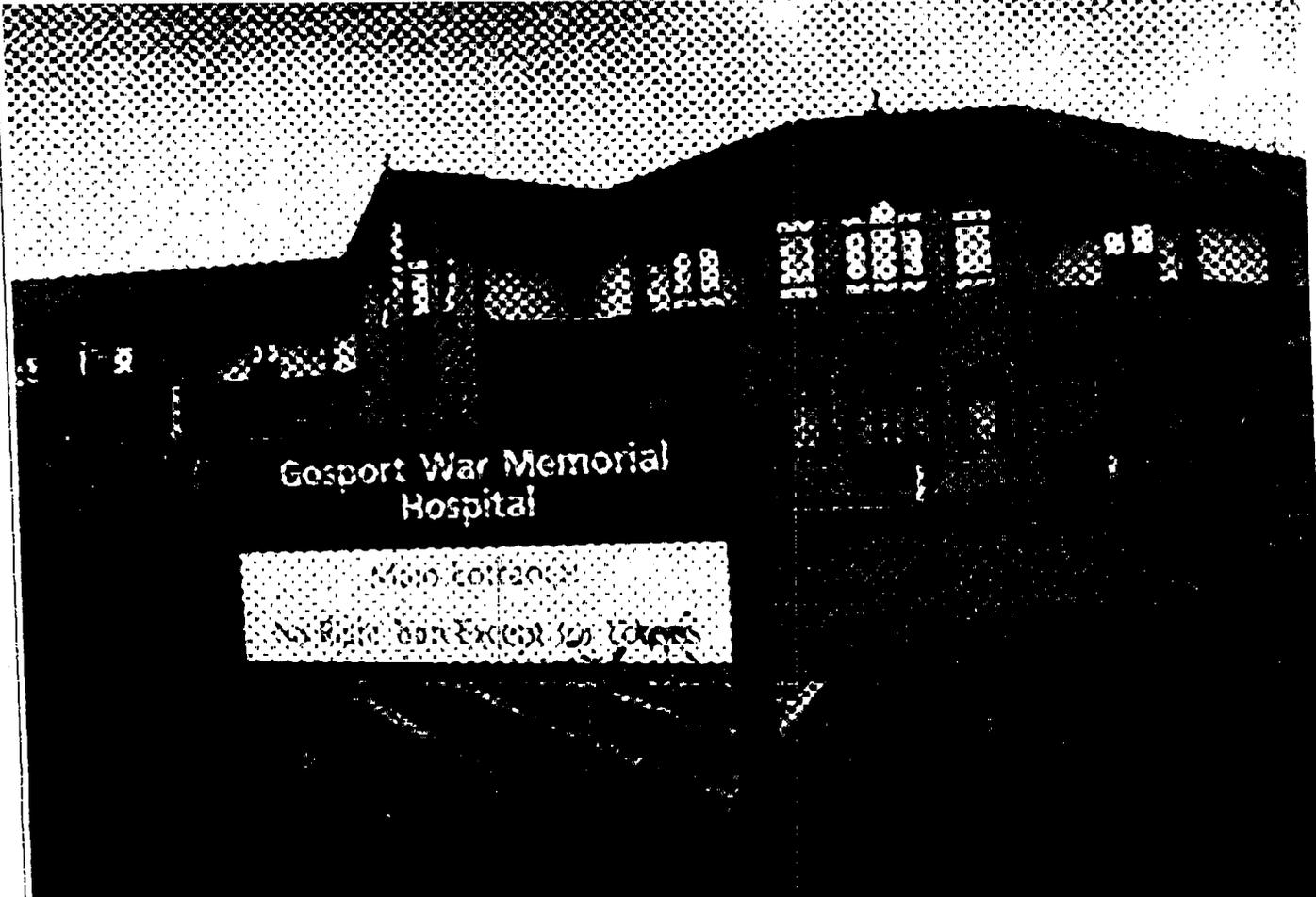
Clockwise from top:
 Elsie Devine, Betty
 Rogers, Stanley Carby,
 Alice Wilkie, Gladys
 Richards and (centre)
 Robert Wilson

The betrayed

In just three years, 92 elderly patients died of suspected drugs overdoses administered at a Hampshire hospital. Inquests on 10 of them finally open this week, a decade after the last fatality. So, were they victims of coincidence, negligence ... or something more

AN IOS INVESTIGATION: PAGES 8-9

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Gosport War Memorial Hospital

Main entrance
No fire exit signs

92 dead. Who's to blame?

Families hope unprecedented inquests will find answers

Police inquiries have failed to throw light on what really happened at Gosport War Memorial Hospital. Now, a decade on, a coroner is to investigate 10 of the deaths - after Jack Straw, the Justice Secretary, gave his go-ahead.

Nina Lakhani reports

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THE INDEPENDENT ON SUNDAY
15 MARCH 2009

An unprecedented inquest will this week begin to examine the suspicious deaths of 10 elderly patients who died unexpectedly after being given high doses of powerful painkillers and sedative drugs at a hospital in Hampshire.

The hearing, granted last year by the Justice Secretary Jack Straw, despite the fact that seven of the people concerned have already been cremated, highlights nearly 100 other cases at Gosport War Memorial Hospital which may be related.

Relatives of at least 92 patients involved in the case have fought for the last 10 years to have the matter investigated thoroughly. They believe the deaths have never been properly explained and want those involved to be held to account. They want to know whether their relatives died as a result of accidents, incompetence or what some fear might be something more sinister. They believe that there was a culture of treating patients with palliative care - as though they were dying - rather than rehabilitating them.

They point out that this week's jury hearing at Portsmouth Combined Court comes seven years after a damning report by the NHS watchdog which identified systemic failings in medication prescribing.

The Government has so far rejected relatives' calls for a public inquiry into the deaths, despite stinging criticisms about the way they were handled by the police and the General Medical Council (GMC). Three police investigations have failed to shed light on why the patients died. The GMC, in particular, has been lambasted by the relatives for its failure to act promptly and decisively.

Wednesday's inquest will examine the deaths of Leslie Pittock, 83; Elsie Lavender, 84; Helena Service, 99; Ruby Lake, 85; Arthur Gunningham, 79; Robert Wilson, 73; Erid Spurgeon, 92; Geoffrey Packman, 68; Elsie Devine, 88; and Sheila Gregory, 91. They all died while in-patients on Dryad and Daedalus wards between 1996 and 1999.

A separate inquest has now been granted into an 11th death, Gladys Richards. Her daughter, Gillian Mackenzie, 75, believes her mother died because she was unnecessarily prescribed high doses of morphine. Mrs Mackenzie's suspicions triggered

an initial police investigation. She has spearheaded the campaign for years. It is not clear why her mother has not been included in the forthcoming inquest. As yet, no date has been set.

Mrs Mackenzie said: "I know my mother was 91, but she shouldn't have died when she did. She was not in pain, so why was she prescribed morphine? Since then, I have been fobbed off by the police time and time again; they closed the first inquiry without taking a statement or looking at my mother's medical notes. I'm 75 now but will not let this go because I know what happened to her, in law, was wrong."

At the time of deaths, Gosport War Memorial Hospital was run by Portsmouth Healthcare NHS Trust and provided long-term care and rehabilitation for elderly patients.

After Mrs Richards's case in 1998, a number of people contacted the police saying their relatives had died unexpectedly after being prescribed high doses of painkillers and sedatives including morphine. Police launched a second inquiry and reviewed a total of 92 deaths. In July 2006, the police announced that after a third investigation they had found no criminal negligence in 80 of the 90 cases they examined. Ten deaths were referred to the Crown Prosecution Service (CPS) but no charges were brought.

The NHS watchdog at the time, Commission for Health Improvement (CHI), identified a number of systemic failings during their investigation into Gosport Hospital in 2002. High levels of powerful painkillers and sedatives were being prescribed without adequate supervision or checks in place. They also found a culture of "anticipatory prescribing", whereby patients were prescribed drugs before the patient displayed any symptoms.

The GMC has attracted bitter criticism for the way it has handled this case, particularly the length of time it took them to take action. Dr Jane Barton, the only doctor investigated in relation to the case, was ordered last July to stop prescribing morphine, many years after the matter was drawn to the GMC's attention.

At least one relative of the dead wrote to the GMC in 2002, expressing her concerns about Dr Barton and asking the GMC to investigate. In reply on 11 June 2002, the GMC said: "We do not consider that the actions of Dr

THE CAMPAIGN

A decade of questions before inquest begins

1998: Gillian Mackenzie reports her mother's death to Hampshire Constabulary which launches an investigation. No charges.

1999: A second police investigation is launched after several families come forward with concerns. No charges.

July 2000: The General Medical Council first becomes aware of concerns relating to Dr Jane Barton (pictured below).

June 2002: Mrs Mackenzie asks the GMC formally to investigate Dr Barton. She is informed there are no grounds for any action.

July 2002: The Commission for Health Inspection finds systemic failings in the monitoring and prescribing of medication for elderly patients at Gosport. In November 2002, the NHS trust which runs Gosport issues an action plan in response.

September 2002: Chief Medical Officer orders an independent audit into the deaths. This report has never been made public.

September 2002: Police begin a third investigation.

October 2002: CPS concludes there is insufficient evidence to prosecute any health professionals. Police reports are passed to the Portsmouth coroner, David Horsley, in early 2008.

May 2008: The Justice Minister Jack Straw announces an inquest into 10 of the deaths.

July 2008: GMC issues an interim order against Dr Barton which allows her to keep working with some restrictions.

18 March 2009: Inquests into 10 deaths begin. The jury will hear evidence from Dr Barton before 10 separate verdicts are returned after six weeks.

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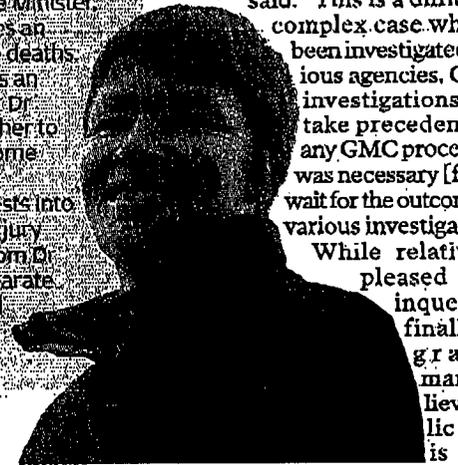
In GMC correspondence to *The Independent on Sunday*, it was aware of the case in 2000 and 2004 to persuade Interim Orders Committee to take action against Dr Barton were unsuccessful. The committee was not convinced of the need to restrict Dr Barton's practice until the inquest was announced.

Peter Walsh, chief executive of the Association Against Medical Accidents (AvMA), said: "This raises serious concerns about the rationale and transparency of the GMC's decision-making. This is another in a long line of cases which must lead the public to question whether the GMC is fit for purpose."

Ann Alexander, the solicitor representing families in the Shipman inquiry and adviser to a number of relatives in the Gosport case, said: "The GMC has made few improvements since the public inquiry in the Shipman case. I do not stand why they failed to impose restrictions on the doctor until the inquest. The GMC must remember that its primary duty is to protect patients and not doctors."

According to the GMC, its investigations were held back while other investigations took place, but says the necessary steps to investigate the case are being taken. A GMC spokesman said: "This is a difficult

complex case which has been investigated by various agencies. Our investigations will take precedence over any GMC proceedings which were necessary for the inquest. We will wait for the outcome of various investigations before we proceed. While relatives are pleased that the inquest has finally begun, many believe the GMC is not doing enough to protect the public."



Breakdown of trust 'I want justice for my mother'

Elsie Devine died in Gosport War Memorial Hospital on 21 November 1998 at the age of 88. She had been recuperating after a urinary tract

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News 9

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In GMC correspondence seen by *The Independent on Sunday*, it admits it was aware of the case in 2000, but repeated attempts by GMC lawyers between 2000 and 2004 to persuade the Interim Orders Committee to take action against Dr Barton were unsuccessful. The committee was not convinced of the need to restrict Dr Barton's practice until the inquest was announced.

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Ann Alexander, the solicitor who represented families in the Harold Shipman inquiry and advised a number of relatives in the Gosport deaths, said: "The GMC has made few improvements since the publication of the Shipman inquiry. I do not understand why they failed to impose restrictions on the doctor until 2008. The GMC must remember that its role is to protect patients and not doctors."

According to the GMC, its actions were held back while other investigations took place, but says the necessary steps to investigate the case fully are being taken. A GMC spokeswoman said: "This is a difficult and complex case which has been investigated by various agencies. Criminal investigations always take precedence over any GMC procedures. It was necessary [for us] to wait for the outcome of the various investigations."

While relatives are pleased that an inquest has finally been granted, many believe a public inquiry is necessary, if all the relevant documents from earlier inquiries are to be uncovered.

The Chief Medical Officer, Sir Liam Donaldson, commissioned a clinical audit to examine death rates at the hospital in September 2002 - only the second time such a review has been carried out. But the report by Richard Baker, a professor of clinical governance at Leicester University who worked on the Shipman inquiry, has never been made public.

Professor Baker's investigation into Dr Harold Shipman found that he may have been responsible for 330 deaths. This persuaded ministers to hold a public inquiry into his crimes. His report in Gosport War Memorial Hospital has been requested under the Freedom of Information Act by AvMA.

Ms Alexander said: "A lack of openness breeds suspicion. Professor Baker's report about Harold Shipman was published so I have no idea why the Gosport families have been denied access to his findings. I think a public inquiry would have been much better in this case as it would have put the families on a level playing field with the health professionals. There is also much scope in a public inquiry to understand what went wrong and for lessons to be learnt."

A spokesperson for NHS Hampshire, which now runs Gosport War Memorial Hospital, said: "The local NHS has been working closely with HM Coroner to ensure that all the relevant information is available to support his investigation. We co-operated fully with previous police investigations and with an earlier independent review by the Commission for Health Improvement. Procedures at Gosport War Memorial Hospital were revised as a result of the earlier inquiries. We are very confident that the hospital provides safe, high-quality care to all its patients."

Hampshire Constabulary declined to comment yesterday, but said it had previously defended its investigations. Dr John White from Blake Laphorn, a Hampshire-based law firm, is representing four of 10 families at this week's inquest. He said: "The inquest will try to establish in each individual case whether systemic or individual failings in prescribing caused them to die. The coroner is faced with a very difficult task and in my opinion a public inquiry would have been better."

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Justice for my mother

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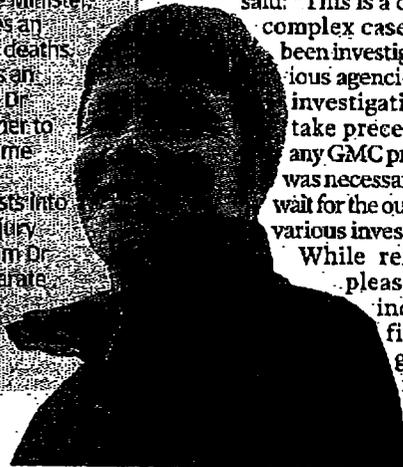
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Breakdown of trust 'I want justice for my mother'



Elsie Devine died in Gosport War Memorial Hospital on 21 November 1998 at the age of 85. She had been recuperating after a urinary tract infection. Her daughter, Ann Reeves, has spent 10 years waiting to find out what happened to her mother.

"My mum was my rock. She had lived with my family for 25 years and had supported us all through my husband's illness [with cancer]. She was admitted to Queen Alexandra Hospital in Portsmouth for a urinary tract infection in October 1999. Ten days later she was ready to go home, but because I was staying with my husband at a London hospital, we agreed she would spend a few weeks at Gosport.

"Initially it was fine. But after a couple of weeks she became really

distressed. She was crying and wanted to come home. When I look back, I'm so angry at myself for not bringing her home.

"Two weeks after my brother called me and said mum had kidney failure and had only hours to live. Just like that, totally out of the blue. I rushed to see her but she was unconscious. I never spoke to my mum again. She died two days later.

"I can't really explain it, but there were a few things her doctor - Dr Barton - said that made me feel uncomfortable, and so I asked to see her medical files. At this point, I had no idea there was already a police investigation going on; the trust didn't tell me. I discovered that my mum had been prescribed strong painkillers and other sedatives. She

had been prescribed fentanyl which is used to treat severe pain in cancer patients. She was also injected with chlorpromazine, an antipsychotic drug, and given midazolam, a sedative and diamorphine. I knew that something had gone wrong because my mum hadn't been in pain, so I started to write letters to the trust to try to find out what happened.

"I want justice for my mother. But I also want transparency, so we can find out what happened at Gosport. It has taken 10 years, but finally people are taking notice. We need a public inquiry. And the GMC is an absolute disgrace. I wrote to it about Dr Barton in 2002 and it robbed off my concerns. Its motto should read 'Guiding doctors, silencing patients', not 'Protecting patients'."