OPERATION ROCHESTER
GENERIC CASE SUMMARY

Further to the individual case summaries and files prepared for the individual patients. A further file of evidence has been prepared that should be read as an over view regarding events at the Gosport War Memorial Hospital from 1990 to 2002. Although this file alone does not pertain to any criminal charges it does corroborate all of the individual case files and should be read in conjunction with them.

The main points covered are as follows:-

1. Working Practices at the Gosport War Memorial Hospital

   Code A is an experienced retired Staff Nurse who joined Northcotte Annexe in 1972, she moved to Redcliffe Annexe and then to Dryad Ward in 1994, she details the general running of the hospital and the changing needs of the patients throughout the years.

2. Concerns raised by the nursing staff in 1991 regarding the excessive use of diamorphine via syringe drivers on Dryad Ward and the resultant management action.

   In 1991 a number of night nursing staff including GRIFFIN, TURBRITT and TURNBALL had serious concerns about the use of syringe drivers on the ward. These concerns included:-

   - Patients placed on syringe drivers when not in pain.
   - The blanket use of syringe drivers before any other analgesics were tried.
   - The blanket prescribing of diamorphine prior to the patient actually requiring a strong opiod, allowing the nursing staff to commence the use of the driver without the knowledge of the Doctor.
   - Used to calm patients who were aggressive or noisy rather than for pain management.
   - Patient deaths were sometimes hastened unnecessarily.
   - The use of the syringe driver or commencing diamorphine prohibits trained staff from adjusting dose to suit the patient needs.
   - That too high a degree of unresponsiveness from patients was sought at times.
   - That sedative drugs such as thioridazine would sometimes be more appropriate.
   - That diamorphine was prescribed prior to such procedures such as catheterisation where diazepam would be just as effective.

- That not all staff views were considered before a decision was made to start patients on diamorphine.
- That other similar units did not use diamorphine as extensively.

These concerns were aired in a meeting held at Redcliffe Annexe on 11th July 1991 that had been arranged in conjunction with the patient care manager Isobel EVANS who addressed the concerns. A number of meetings then took place between nursing, medical and management staff. This resulted in the training of staff in the use of syringe drivers and pain control and an agreement that a policy be written by management on the use of syringe drivers and controlled drugs.

Keith MURRAY a Convenor for the Royal College of Nursing states that: Training was provided for staff by a Mr Steve KING probably, but a policy was never written. Murray's correspondences with regard to these meetings are available identification numbers KPM/1 to KPM/7.

The training did not allay the nursing staff fears and when TURBRITT attended a course in Elderly care at the Queen Alexandra Hospital she chose to speak on 'The use and abuse of the syringe driver'. Her course tutor Geri WHITNEY visited Radcliffe Annexe and met nursing staff on 31st October 1991 after a request by TURBITT. The main conclusion of WHITNEY'S visit was that:-

* The staff are concerned that non opiods or weak opiods were not being considered prior to the use of diamorphine.

* The staff have had some training arranged by the Hospital manager namely

  - the syringe driver and pain control
  - pain control

* Staff Nurse TURBRITT wrote to EVANS, the producers of diamorphine and reviewed literature and a video – Making Pain Management More Effective.

* Staff Nurse TURBRITT is undertaking a literature on Pain and Pain Control.

A copy of WHITNEY'S report was sent to both Mr W HOOPER (deceased) the General Manager, Gosport War Memorial Hospital, Mrs J EVANS the Patient Care Manager, and Susan FROST, Solent School of Health Studies, Principal her CV is available SAF/VC/1).

As a result of this Mrs EVANS circulated a memorandum on 7th November, asking for staff to identify any patient that they felt diamorphine (or any other drug) had been prescribed inappropriately. Due to the memo which mentioned 'allegations' and asking for individual responses to be put in writing Keith MURRAY sought the assistance of the Wessex Regional Office of the Royal

College of Nursing. This prompted a Steve BARNES to write to Mrs EVANS outlining the nurses' position. In the main after the meeting in July it was decided that:-

1. The concerns would be addressed.

2. Clear guidance/policy would be promulgated.

It had now become a matter of serious concern that:-

1. The complaints were not acted upon.

2. The management were now seeking formal allegations.

At this time the RCN stated that the RCN would not be prepared to be drawn into what could emerge as a vindictive witch hunt that would divide nursing staff, medical staff and management. The complaints were adequately repeated to management and that if a policy was not formulated out then action would be taken by way of the grievance procedure.

A further meeting was then held at Radcliffe Annexe on 17th December 1991 with Medical, Nursing Staff and Mrs EVANS. This meeting is described as a 'them and us' meeting, medical staff on one side sat like a panel. During the meeting Mrs EVANS highlighted the action management had taken:-

(i) The staff meeting on 11th July.
(ii) Steve KING lecture on drug control.
(iii) Staff being invited to detail individual cases, none were forthcoming.
(iv) The stressed placed on medical staff and the issue being detrimental to patient care.

She also presented the staff concerns and a Dr LOGAN spoke regarding symptom control.

It was agreed that if any of the nursing staff had concerns in the future they would approach Dr BARTON or Sister HAMBLIN in the first instance and if not resolved they could speak to Dr LOGAN.

The medical staff then left the meeting and Mrs EVANS asked if there was still a need for a policy relating to nursing practice on the issue. No one at this meeting thought it was appropriate. Mrs EVANS then addressed staff stating she was concerned over the manner in which these concerns had been raised, as it had made people feel very threatened and defensive. It is clear that the concerns had been turned around the result being that the syringe drivers were not an issue recognised by the management, but the nursing staff who had raised the concerns and the way the concerns were raised were. As such the nursing staff felt vulnerable and unsupported to such an extent that they stopped complaining.

Due to the fact that the RCN took its lead from the nursing staff and as they did not hear anything further from them they also took the matter no further.

3. The Recovery of Letters and Meeting Minutes regarding the Events in 1991.

On Monday 16th September 2002 in order to inform staff that Professor BAKER had been tasked with reviewing the Gosport War Memorial Hospital and the prescribing procedures and policy's a meeting was called with the nursing staff. Prior to the meeting TURNBALL and TURBRITT approached Toni SCAMMELL a nursing manager at GWMH and handed to her a file containing letters and the minutes of the meetings held in 1991, these were subsequently handed to Jane Parvin and are available (JEP/GWMH/1/). These papers detailed the nursing staff concerns and management action. When asked why they had brought the documents forward now TURBRITT stated that she had seen an article in the Sunday newspaper about the GWMH which stated that no one had ever brought the concerns about syringe drivers to the attention of management before and that there had been no training in their use, but she had received training. When asked whether they felt the matter had been solved, as the documents seemed to stop abruptly, TURBRITT said that things had changed for a short period of time as patients didn't appear to be automatically put on diamorphine and that Dr BARTON had been on a palliative care course and knew what she was talking about. The replies were recorded (TJS/1). A further meeting was held on the 18th September 2002 to investigate the events of 1991 with TURBRITT, TURNBALL, SCAMMELL, Jane PARVIN (Personnel Director) and Betty WOODLAND (RCN Representative) being present. Notes from this meeting (TJS/2) reflect how TURNBALL & TURBRITT felt in 1991 throughout the different meetings and why they decided to speak to SCAMMELL now.

GIFFIN also kept the minutes of the 1991 meetings and letters relating to the concerns (SG/GWMH/1). Beverley TURNBALL identifies her letters from the bundle JEP/GWMH/1 and these are available JEP/GWMH/1/BAT/1.

Jan PEACH corroborates the meetings of the 16th and 18th September 2002 and provides continuity of the Exhibit JEP/GWMH/1. Kathryn ROWLES and Sue GAWLEY also provide corroboration to the events of the 16th September 2002.

The concerns of TURNBALL and TURBRITT and GIFFIN although not shared by all of the staff on Dryad Ward are corroborated by PARTRIDGE and GOLDSMITH. Betty WOODWARD is a RCN Steward and represented TURNBALL and TURBRITT at the meeting on 18th September and she provides a note of the invitation to the meeting (BW/1), notes of the meeting (BW/2) (Typed BW/3). A list of the documents in JEP/GWMH/1 (BW/4).

4. Concerns held by training nursing staff at Gosport War Memorial Hospital relating to diamorphine, syringe drivers and general patient care that were never aired with the management.

A number of nursing staff have subsequently been interviewed and have highlighted concerns that had never been mentioned before these include:-

Enrolled Nurse Code A – syringe drivers were used too often. Rather than being used to control pain they were used on patients who were approaching death and suffering anxiety and distress. Dr BARTON prescribed the diamorphine but it was up to a senior nurse when to use it. It was apparent that an awful lot of patients that died were on syringe drivers.

Sister Code A – shared concerns of the nurses in 1991 and felt optimistic that the issues would be addressed. Left a couple of weeks after the meeting in July 1991 so didn't see how the issues were dealt with or what guidelines were put in place.

RGN Code A – worked on Sultan Ward although covered other wards so is able to compare working practices between the different wards. In Daedalus ward the doses of diamorphine prescribed were set between large parameters leaving the dose administered to be decided by the attending nurse.

Nurse Code A – the needs and demands of the patients changed, by taking more acute patients. Medical cover was not reflected in the changes. Work load increased and patient contact was often less. By 2003 there was a lack of leadership and structure.

By charting a variable dose of medication the responsibility of the dose administered falls to the qualified nurse.

E Grade Nurse – Code A – Dr BARTON would prescribe diamorphine by phone but not conduct a follow up visit. Inappropriate prescribing of diamorphine i.e when a patient was not in pain and/or other analgesics not used prior. 'It seemed that people were going onto syringe drivers for no reason at all. They were not ill or in pain and yet they were dying shortly after going on the drivers'.

Recalls a patient Marjorie that was prescribed diamorphine.

Nursing Auxiliary – Code A – Corroborates the statement of BALL regarding Marjorie. States that Dr BARTON would mention diamorphine and the patient would be dead within the week.

Staff Nurse Grade F Code A – acknowledges that some staff had concerns with regard to the use of syringe drivers but did not have any herself. Attended the staff and management meetings, in 1991 regarding the staff concerns.

Staff Nurse Code A – on a couple of occasions a patient was put onto a syringe driver with diamorphine when there was no indication that they needed it. Attended the 1991 meeting but nothing changed as a result of it.

Staff Nurse Grade F Shirley HALLMANN – syringe drivers were used too early before other methods of pain control had been tried, they were prescribed by Dr BARTON on the admission of the patient as, as and when

required prescription. Doses of diamorphine and midazolam were too high.

Dr BARTON'S actions were ill thought out and could have led to the premature death of a patient. Nurse Hallmann discussed her concerns with her mother Joan McILROY who recorded these concerns in her diary of 2001 (JMI/1) and 2002 (JMI/2)

Grade F Staff Nurse Code A – had concerns over the high dosages of diamorphine given to patients. Drugs including diamorphine and midazolam were prescribed to patient on their arrival. It therefore became a decision for the nurses when to administer it. Patients went onto morphine without starting at the bottom of the analgesic ladder.

5. Concerns of Untrained Staff at Gosport War Memorial Hospital

Nursing Auxiliary Code A – holds concerns about the indiscriminate use of syringe driver. It appeared that euthanasia was practised. All patients upon their admission were written up by Dr BARTON who authorised the use of a syringe driver if appropriate, and that any person put onto a driver would die shortly afterwards.

Nursing Auxiliary Code A – believed that syringe drivers were used too soon on some patients. Patients were put on them because they just moaned and groaned. Patients put on a syringe driver would go into a coma and die a day or two week later.

Nursing Auxiliary Code A – untrained nurse would double check medication with a trained nurse if no other trained nurse was available and give patients medication that had been checked and left out by trained nurses when there wasn't any trained nurses on. Didn't understand why some stroke patients who didn't appear to be in pain were put on syringe drivers. When patients were put on syringe drivers they were not taken off of them until they died. In her opinion the use of a syringe driver shortened the patient's life. Diamorphine was used inappropriately, it made the patient quiet and shortened their life. It was given to patients who didn't require that level of pain relief. Diamorphine was used to keep the patients moving through the Annexe to keep waiting lists down. Dr BARTON didn't spend much time with the patients.

Nursing Auxiliary Code A – on occasions would leave work and a patient would appear to be well. On her return they would be receiving diamorphine through a syringe driver.

Nursing Auxiliary Code A – patients were placed on syringe drivers very early in their treatment. Other types of pain relief were not tried first.

Nursing Auxiliary Code A – syringe drivers used prematurely.

Nursing Auxiliary Code A – wondered why patients were on syringe

drivers.

RGN Grade D Code A – concerns re the lack of labels on drugs, or what was in the syringe driver.

Nursing Auxiliary Code A untrained nurse who would countersign a withdrawal of diamorphine as a witness and was asked to countersign a withdrawal when she hadn't witnessed it.

RGN Staff Nurse Code A – there was a practice of pre-prescribing syringe drivers and diamorphine. This was a practice that was not used on other wards.

RGN Margaret PERRYMAN – worked on Daedalus ward in 1999 – 2000. States that the nursing care provided was very poor due to the poor management of the ward. Pain management was inadequate. No consideration was given to opiod tolerance. Correspondence outlining her concerns are available MRP/1 to MRP/3.

Staff Nurse Leslie ALDRIDGE – there was a culture within Gosport that would not change, there was little support from Doctors and Management. Had to request his own training for syringe drivers.

RGN Sister Sheila JONES – describes how and why it was decided by Dr LORD, Dr BARTON and herself to prescribe medication prior to it being required.

6. Technical Matters, Production of Medical Records and Exhibit Continuity

Julia FLETCHER – provides details as to what Nozinam is used for, its properties, recommended dosages, when caution should be exercised prior to prescribing, and side effects.

Beverley CARTER – produces the medical records of:-

Elsie DEVINE	-	BJC/16
Elsie LAVENDER	-	BJC/30
Arthur CUNNINGHAM	-	BJC/15
Sheila GREGORY	-	BJC/21
Robert WILSON	-	BJC/55
Enid SPURGIN	-	BJC/45
Helena SERVICE	-	BJC/72
Ruby LAKE	-	BJC/67
Lesley PITTOCK	-	BJC/71

showing the deceased's treatment at Gosport War Memorial Hospital and Queen Alexandra Hospital and the admission books relating to Gosport War Memorial Hospital.

Dryad Ward 93/96 BJC/88
Dryad Ward 79/03 BJC/89
Daedalus Ward 01/03 BJC/90
Dc Rushworth provides continuity for these exhibits and also produces cremation certificates for Spurgin and Wilson (PJR/CREM/2) that show that both patients were in a coma prior to death.

Seven of the deceased were treated in Halslar Hospital (Military Hospital) prior to their admission to GWMH and their medical records are produced by Janice RIX.

Elsie LAVENDER	-	JR/11A (Chest X-rays JR/XR/1)
Sheila GREGORY	-	JR/12
Robert WILSON	-	JR/13
Enid SPURGIN	-	JR/14
Leslie PITTOCK	-	JR/15
Helena SERVICE	-	JR/16
Ruby LAKE	-	JR/19A

The GP medical records for each of the patients are produced by Theresa STEPHENS as follows:-

Elsie DEVINE	-	TAS/1
Arthur CUNNINGHAM	-	TAS/2
Elsie LAVENDER	-	TAS/3
Sheila GREGORY	-	TAS/4
Robert WILSON	-	TAS/5
Enid SPURGIN	-	TAS/7
Leslie PITTOCK	-	TAS/8
Helena SERVICE	-	TAS/9
Ruby LAKE	-	TAS/10

The controlled drugs record books for Gosport War Memorial Hospital, Sultan Ward, Dryad Ward, Daedalus Ward, Redcliffe Annexe, the female ward are produced by Janet PEACH and run from JP/CDRB/1 to JP/CDRB/48. Dryad Ward controlled drugs record books are available and cover the following periods,

25/06/95 to 24/05/96 – JP/CDRB/20
06/03/05 to 08/12/96 – JP/CDRB/21
22/11/96 to 23/06/97 – JP/CDRB/22
08/12/96 to 22/12/97 – JP/CDRB/23
02/09/98 to 18/06/99 - JP/CDRB/47
18/06/99 to 04/07/01 - JP/CDRB/48
12/07/97 to 05/03/02 – JP/CDRB/24

The bed numbers register from November 1992 t January 1997; JP/BNR/1 is also produced and covers Sultan, Dryad and Daedalus wards.

Jeffrey WATLING the Pharmacy Services Manager for Portsmouth Hospitals NHS Trust explains how medicines are ordered, supplied and recorded and produces a hand book covering Palliative Care which gives guidance on Clinical management of patients who are dying (JJW/7). This includes, pain, diagnosis, strong opiods and syringe drivers.
Irene DIX produces a fax copy headed 'Protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion' ID/F & GPCT/1 that was sent to her by Yvonne FARMER, Dr REID'S (Medical Director PHCT) Secretary. This would appear to be the earliest protocol or policy regarding the prescribing of diamorphine by syringe drivers issued by PHCT and can be dated around the end of 1999. Even at this time it can be seen by this draft protocol the confusion surrounding the prescribing of diamorphine as it states:-

Dosage

Guidance from the palliative care service indicates that if pain has not been controlled in the previous 24 hours by 'X mg' of diamorphine then up to double the dose should be administered the following day, ie up to 2x 'X mg' should be given.

Prescription

Diamorphine may be written up as a variable dose to allow doubling on up to two successive days,

Although these entries have been corrected to show the correct prescribing regime it clearly demonstrates the lack of knowledge and understanding by the hospital staff.

This is further highlighted by the patient care manager Isobel Evans who was responsible for all nursing care within the hospital who states incorrectly that if a patient was getting 10mgs of diamorphine orally every four hours amounting to 60 mgs over a 24 hour period then they would receive 60 mgs sub cut via the syringe driver over a 24 hour period.
The dose should be reduced by 1:3 or 1:2

Dr Andrew CAIRNS a GP in Petersfield describes the procedure for certifying cause of death within the PHCT and Jacqueline SPRAGG explains the procedure at Gosport War Memorial Hospital producing an administrative form JAS/1 showing the administrative procedure followed in the hospital. Guidance of notice for the completion of cause of death certificates and a certificate JAS/2. Once the certificate is completed by the Doctor certifying death the certificate is placed in an envelope (JAS/3) which is sealed and taken by the deceased's relative or representative to the registrar. If the deceased is to be cremated further forms BC & F (JAS/4) are also completed. She also

produces the Cause of Death Certificate book with the relevant stub for each of the deceased:-

Leslie PITTOCK	- JAS/CODC/1
Robert WILSON	- JAS/CODC/2
Shelia GREGORY	- JAS/CODC/4
Elsie DEVINE	- JAS/CODC/6
Elsie LAVENDER	- JAS/CODC/9
Enid SPURGIN	- JAS/CODC/10
Ruby LAKE	- JAS/CODC/11
Helena SERVICE	- JAS/CODC/13
Arthur CUNNINGHAM	- JAS/CODC/14

A certified copy of the deceased's death certificate is available produced by David BURGESS:-

Leslie PITTOCK	- DB/2001
Robert WILSON	- DB/2002
Shelia Gregory	- DB/2005
Elsie DEVINE	- DB/2007
Elsie LAVENDER	- DB/2010
Enid SPURGIN	- DB/2011
Ruby LAKE	- DB/2012
Helena SERVICE	- DB/2014
Arthur CUNNINGHAM	- DB/2015

Wendy JORDAN a personnel assistant employed by Fareham and Gosport Primary Care Trust produces the job description for the Clinical Assistant at Gosport War Memorial Hospital that would have been applicable to Dr Barton. (WJ/CA/1). This outlines the job summary as,

This is a new post of 5 Sessions a week worked flexibly to provide a 24hour Medical Cover to the Long Stay patients in Gosport. The patients are slow stream or slow stream rehabilitation, but holiday relief and shared care patients are admitted. An important aspect of this role is for the postholder to be seen not only as a medical advisor but as a friend and counsellor to patient's, relatives and staff.

Duties include, (This is not the entire list)

1. To visit the units on a regular basis and to be available "On Call" as necessary.
2. To ensure that all new patients are seen promptly after admission.
3. To be responsible for the day to day Medical Management of the patients.
4. To be responsible for the writing up of the initial case notes and to ensure that follow up notes are kept up to date and reviewed regularly.
5. To complete upon discharge the Discharge summary and HRM60.
6. To take part in the weekly consultant rounds.

7. Other Witnesses

On 4th April 2000 a Mr James RIPLEY, 76 years of age was admitted to Haslar Hospital due to pain from arthritis and gout. As his condition was not acute he was discharged to Sultan Ward at The Gosport War Memorial Hospital for rehabilitation. Once there he was prescribed morphine sulphate tablets, a strong opiod for his pain. He became dozy suffering hallucinations and eventually slipped into unconsciousness. He was transferred back to the Haslar Hospital and diagnosed as having been given an analgesic over dose. Mr RIPLEY has a very poor memory of the whole episode. Mrs Pauline RIPLEY recalls the events. (Further work will be required around this part of evidence).

In 2002 the Chief Medical Officer commissioned Professor Richard BAKER to conduct a statistical analysis of the mortality rates at the Gosport War Memorial Hospital, including an audit and review of the use of opiate drugs. His CV (RHB/CV/1) outlines his qualifications and experience. The report itself RHB/GWMH/1 concludes that a practice of almost routine use of opiates before death had been followed in the care of patients of the Department of Medicine for Elderly People at Gosport hospital, and the attitude underlying this approach may be described in the words found in many clinical records – 'please make comfortable'. It has not been possible to identify the origin of this practice, since evidence of it is found from as early as 1988. The practice almost certainly had shortened the lives of some patients, and it cannot be ruled out that small number of these would otherwise have been eventually discharged from hospital alive.

The practice was disclosed in several key findings.

Opiates had been administered to virtually all patients who died under the care of the Department of Medicine for Elderly People at Gosport, and most had received diamorphine by syringe driver.

Opiates were administered to patients with all types of conditions, including cancer, bronchopneumonia, dementia and strokes.

Opiates were often prescribed before they were needed – in many cases on the day of admission, although they were not administered until several days or weeks later.

In many records, evidence of a careful assessment before use of opiates was absent, and the stepped approach to management of pain in palliative care had not been followed.

In addition to these findings, two other matters also gave rise to concern. The amount of information recorded in the clinical notes was often poor, and recent fractures that had contributed to deaths, most commonly fractured hips, had not been reported on MCCDs.