Noel, Beatrice

From: Code A
Sent: 22 October 2013 11:01
To: Noel, Beatrice
Subject: Op Rochester (Gosport War Memorial Hospital) archived docs
Attachments: LETTER.doc; ROCHESTER REPORT.doc

Hi Beatrice

I was just speaking to Karen about the fact that I have just done a review of one of the patients of the **Gosport War Memorial Hospital investigation** at the request of his family. There was no inquest done on him (Arthur Cousins) but my DI wants the paperwork I generated to be filed with all of the main paperwork held by the Coroner in case it pops up again as there may be a public inquiry in the pipeline.

I enclose a report and a letter to the family of Mr Cousins for adding to the archived paperwork of this investigation.

Any queries, give me a shout.

Thanks

Claire

Code A
Hampshire Major Investigation Team, Fratton

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Hampshire Constabulary

Chief Constable Andy Marsh

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Mrs Pauline Godley

Code A

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Email Code A

Our ref: OP ROCHESTER
Your ref:

September 25, 2013

Dear Mrs Godley,

Further to your enquiry regarding the investigation into the death of your father, Mr Arthur COUSINS, I am now in a position to be able to provide you with further clarification concerning this investigation, having had detailed research completed over the past few weeks by DC Code A You will appreciate that the Police and Coroner hold a vast amount of paperwork regarding the hospital and its patients.

During the review of your father's case, we have examined all information held regarding his time in hospital. We have also reviewed the subsequent findings of the medical experts who were tasked with deciding whether there was any unlawful activity in the care that your father received. We have read the report of DC Code A who interviewed both you and your brother Eric on 19/02/2004, following Eric raising concerns through his solicitor Lisa Elkins, that the police were not investigating the death. We have also considered the Baker Report which was published last month.

I can confirm that the Key Clinical Team, a panel of medical experts, met in autumn 2004 to discuss the care of your father along with six other cases. They were all in agreement that there was no evidence of any unlawful activity in his case. They concluded that he had received 'optimal care and that he died from natural causes'. In reaching this decision they had classified four potential categories of care – optimal, sub- optimal, negligent and intended to cause harm. They had also classified three categories of cause of death - natural, unclear and unexplained by illness.

Your father's records were then forwarded to the General Medical Council and the Nursing and Midwifery Council for review. There has been no indication from either body that they disagreed with the experts' ruling.

Hampshire Constabulary

Chief Constable Andy Marsh

A letter was then sent to Eric by Detective Inspector Niven, advising him of the decision made by Detective Superintendent Williams, that having reviewed the experts' findings there was no evidence of any unlawful activity in the care of your father.

As your father's death was not found to be due to any negligent care, his case was not sent to the Crown Prosecution Service for review as happened with some of the other cases. However it had been fully investigated in 2004, before that decision was taken by the Detective Superintendent.

You will be aware that The Crown Prosecution Service decision regarding the ten cases that were referred to them in 2006 was that there was no criminal case to answer.

Inquests into the ten deaths were held in 2006 which came to the conclusion that all died from natural causes.

In 2009 the GMC held a hearing into the fitness of Dr Barton to practise and placed conditions on her licence. She retired from medicine in 2010.

I understand that Norman LAMB MP may be opening a public inquiry into the deaths within the hospital in the coming weeks. This may help to answer some questions for you and the other affected families. However, this *may* only address those cases which were deemed by the panel of experts as negligent care by the hospital, which would not include your father's case.

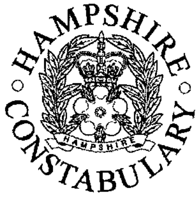
In summary there is no evidence available of any criminality surrounding the death of your father that has not been considered in depth by the Police, with the help of the medical expertise available.

Other cases considered on the same basis as your father's, where the medical experts considered there were failings, have been reviewed by the Crown Prosecution Service who decided the evidential thresholds for prosecution were not met.

I hope that this information may answer some of your concerns. However, should you have further questions or wish to discuss any part of this letter in greater detail, I would be happy to do so.

Yours truly,

T/Detective Inspector
Richard Sellwood
Hampshire Major Investigation Team, Kingston Crescent, Portsmouth



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Chief Constable Andy Marsh

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OFFICERS REPORT

REPORT OF : Code A

RANK & NUMBER : DC Code A

STATION / OFFICE : Fratton HMIT

DATE : 11/09/13

Review of case of Arthur COUSINS in Gosport War Memorial Hospital (GWMH)

Sir,

I was made aware that Mrs Pauline GODLEY and her brother Eric COUSINS attended Gosport Police Station on 9th August 2013. They believe that their father was murdered by Dr Jane BARTON when he was in her care at Gosport War Memorial Hospital in 2000. They had seen a programme on TV which stated that the deaths in GWMH were unlawful killings. They felt regret that they had not been part of the original complaint and want justice for their father. They had spoken to MP Caroline DINENAGE who had advised them to contact police.

T/DI SELLWOOD spoke to Mrs GODLEY and her husband Norman that weekend and explained that we would look into the archives of the investigation and would be in contact with them in around a months time. He warned them to manage their expectations for the outcome as the issues appear to have been NFA'd some years ago.

On 11/09/13 I spoke to Mr GODLEY on the phone. I explained that I had obtained the relevant paperwork from the archive store and that I was now reviewing the case for his father in law. I told him that I would make contact with them again in a couple of weeks once I had compiled a report. He seemed happy with this. He recounted how the death message had been delivered badly over the phone upsetting his wife and that he believed that Arthur had another 10 years left in him.

I have located the records for this case on Holmes Archive under Operation ROCHESTER. I understand that this case is also being looked at by the Crime Review Team currently. There are 16 boxes of paperwork and exhibits held in CAFCAT and these have been reviewed by DC Code A and I on 10/09/13. I have completed a SMART search around Mr COUSINS to find all relevant documentation and these were photocopied at the store.

Persons in enquiry

Arthur Albert COUSINS (N1042) -Deceased
B Code A
D 25/08/00 Aged 82
Cause of death: Chronic Obstructive Pulmonary Disease (COPD) / Carcinoma of lung
Cremated at Portchester Crematorium

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Pauline GODLEY (N1081) – Daughter
4 Code A
Married to Norman GODLEY

Eric COUSINS (N1041) - Son
Code A
Listed as principal relative in original enquiry

Paperwork obtained

- Baker report
- Hospital notes GWMH
- Clinical teams screening form
- KCT findings re categorisation
- FGM Bulletin dated 17/02/05
- Spreadsheet of 90 deceased persons from hospital
- Action review of Det Supt Williams dated 06/01/05
- Policy decision 30 Book 8 dated 03/06/05
- Letter to Eric Cousins dated 03//06/05
- Letter to Eric Cousins dated 18/02/05
- Log of all contact and remarks
- O/R of DC Code A following meeting with family
- Report re disclosure of CPS findings to FGM December 2006
- Diamorphine factfile
- Various newspaper articles throughout the years

Chronology of known events

19/06/00 Admission to Royal Haslar Hospital suffering with shortness of breath (SOB) He had a fall in the hospital resulting in a fractured sternum. He had been diagnosed with lung cancer in Nov/ Dec 1999.

10/07/00 Transferred to GWMH. Notes show he had a cough, chest pains and a wheeze. There was a query as to whether he had suffered a stroke due to the possibility of the cancer spreading to his brain. He had weakness in his right leg. Examined by Dr Wilson.

12/07/00 He was suffering chest pains. The plan noted that he was to be given oramorph (liquid morphine used to treat breathlessness) when needed. Examined by Dr Wilson.

17/07/00 He was in a lot of pain and distress and 5mg oramorph was given with good effect. Examined by Dr Wilson.

20/07/00 Notes show abdominal pain

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24/07/00 He had increased SOB and became dysphonic (hoarse) and cyanosed (blue skin colour). Dr Wilson informed. No complaints of chest pain and condition improved.

25/07/00 Coughing up sputum so put on antibiotics, Seen by Dr Khawaja and prednisolone increased (steroid for inflammatory control such as asthma).

08/08/00 He was feeling well on nocturnal oxygen. Seen by Dr Khawaja.

11/08/00 He had SOB and pain in his chest. Diagnosed with anxiety. He was offered oramorph but declined it. Examined by Dr Beasley. Given 5mg diazepam when needed.

13/08/00 Continues to have SOB. Diazepam and oxygen being used.

18/08/00 Has SOB and anxiety. Plan to increase steroids, humidified oxygen, reg oramorph 5mg and diazepam/ midozalam when required (sedatives). He agreed to try morphine. Oramorph boarded for regular basis 5mg and 10mg given to good effect. He said that he felt unwell and had chest and abdominal pain.

19/08/00 He continued on regular oramorph. The family were made aware of the poor prognosis.

20/08/00 He deteriorated further and was extremely anxious causing SOB. He agreed to try to the syringe driver for 24 hours. Syringe driver commenced with diamorphine 10mg and midazolam.

21/08/00 He had SOB and anxiety. Driver recharged with 10mg diamorphine and 20 mg midazolam.

22/08/00 Seen by Dr Khawaja. He had a distended abdomen and was very agitated. As he was in a lot of pain, the driver was recharged with 20mgs diamorphine, 30 mgs midazolam and 40mcgms hyoscine (relieves cramps).

23/08/00 Driver recharged with 30mg diamorphine, 40mg midazolam and 400mcg hyoscine. The increased dose was due to Arthur becoming distressed and in more pain. Syringe driver recharged to 40mg diamorphine.

24/08/00 At 00.40 Arthur's condition deteriorated suddenly. He passed away at 00.45am. His family received a phone call to notify them.

No post mortem was conducted and Mr COUSINS was cremated at Portchester Crematorium shortly after his passing.

04/02/04 Email received from Lisa ELKIN (Solicitor) to DS Code A on behalf of Mr COUSINS' son Eric. He was concerned that the police would not investigate his father's death.

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20/02/04	Action A780 raised – TI Eric COUSINS re the death of his father. Obtain medical notes and copy to CD. Submit to the clinical team for analysis.
19/04/04	Action resulted by DC Code A who visited Eric COUSINS and Pauline GODLEY. See below for her O/R.
26/04/04	Eric COUSINS had enquired as to whether the police were still investigating his father's case. He was informed that they were.
09/10/04	Key Clinical Team (KCT) met and discussed the cases of TAYLOR, NAYSMITH, LAWSON, WATERS, FERNER, TOWN and COUSINS. They graded each person on an assessment matrix. See below for matrix explanation. Mr COUSINS was graded 1A which was that he received optimal care and died from natural causes.
18/02/05	Letter sent to family from ACC WATTS with update bulletin in relation to the generic case.
03/06/05	Policy decision by Det Supt Dave WILLIAMS re the cases of COUSINS/ TALYOR and TOWN: These have been designated lower category cases by the KCT (Key Clinical Team), accordingly their records will be forwarded to the BMC and NMC for their consideration. Letter sent to Eric COUSINS by DI NIVEN stating that the process has been completed by the team of experts who concluded that there was no evidence of any unlawful activity in the care which Arthur COUSINS received.
19/12/06	CPS decision that no prosecution will be brought.
03-04/2006	Inquest for 10 persons at Portsmouth Coroners Court. Out of the ten examined, the conclusions were that for three cases (WILSON, DEVINE, PACKMAN) that the medication administered was not appropriate for their condition and symptoms but had been given for therapeutic reasons. They also ruled that medication had contributed to the deaths of LAVENDER and CUNNINGHAM but had been given for therapeutic reasons and was appropriate for their condition. They ruled that medication had not contributed to the deaths of PITTOCK, SERVICE, LAKE, SPURGIN and GREGORY. All ten died from natural causes.
06-08/2009	General Medical Council hearing as to whether Dr BARTON was fit to practise as a GP. Ruling was that she was guilty of multiple instances of serious professional misconduct relating to 12 patients who died at GWMH. However she was not struck off the medical register. It ruled that some of her prescriptions of drugs were excessive as well as being inappropriate, potentially hazardous and not in the patients' best interests. They placed 11 conditions on the GP's licence for three years as a sanction.
30/03/10	Dr BARTON retires from medicine.

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09/03/11 Dr BARTON took voluntary erasure from the medical register which means she is no longer able to practise medicine in the UK

04/13 Final inquest held – Gladys RICHARDS. Result – very likely drugs hastened death.

02/08/13 BAKER REPORT published by the Dept of Health. (The 10 year delay in publishing was due to having to wait until the inquests were completed). Richard BAKER was a professor of clinical governance who worked on the SHIPMAN enquiry. It found the use of opiates 'almost certainly shortened the lives of some patients, and it cannot be ruled out a small number of these would otherwise have been eventually discharged from hospital alive.' Dr Barton had a higher percentage of patients whose cause of death was put down to bronchopneumonia, and prescribed a higher number of opiates before a patient's death. It also found there 'were no clear clusters of deaths', but the 'proportion of patients at Gosport who did receive opiates before death is remarkably high'.

08/09/13 The Independent announces that government ministers will open an independent inquiry into the deaths at the hospital within weeks.

13/09/13 Some of the families have a meeting with Norman LAMB MP in Westminster to discuss the findings of the report. Ian WILSON is leading the campaign and is supported by local Gosport MP Carolyn DINENAGE.

Clinical Team's Assessment Matrix

Care Death/ Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to cause harm 4
Natural A	Mr COUSINS 1A			
Unclear B				
Unexplained by illness C				

OR of DC Code A

I visited Eric Arthur COUSINS /N1041 at his home address, Code A Code A in relation to his father Arthur Albert COUSINS /N1042 b Code A d.25/08/2000.

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Also present was his sister Pauline GODLEY /N1081 Code A Code A A third family member, Roger COUSINS /N1082, Code A Code A was unable to be present.

The meeting was arranged in accordance with the policy log and the family are fully aware of the cause of the delay in the police taking their concerns. They are happy with police action to date and I reassured them that the medical records in relation to their father would be obtained and forwarded for review by the medical team. Mr COUSINS was admitted to the GWMH /C31 from Haslar /L14 and next of kin consent has been obtained.

Arthur COUSINS was a local man who worked as a carpenter throughout his life. He was married and had three children. His wife, Amy COUSINS /N1083, is still alive and resides at the Code A. She suffers from dementia and has done for a number of years. She is unable to assist this enquiry and should not be contacted.

Mr COUSINS is described as being fit and healthy; he was a moderate drinker and smoker, though in his later years he suffered from emphysema. The family believe this to be the result of inhaling wood dust. He was alert and mobile and totally independent but required oxygen at home.

His GP was Dr COOMBE /N1084 from the Brockhurst Rd Surgery /L566.

The family gave the following information in relation to their father.

Around May 2000 Mr COUSINS was admitted to Haslar Hospital suffering from shortness of breath. Whilst in hospital, test revealed that he was suffering from cancer of the lung; he also fell and fractured his sternum.

On 10th July 2000 (10/07/2000) he was admitted to Daedalus Ward at the Gosport War Memorial Hospital in order to recuperate.

He is described as being cheerful, mobile and fully lucid. He had a healthy appetite and enjoyed the food at the hospital.

Around 20th August 2000 (20/08/2000), Pauline and her husband visited her father. She describes him as being laid in bed, where normally he was always out of bed.

He was complaining that he was being given too much morphine and it was making his head feel funny. He indicated a tube going into his wrist.

Pauline describes him as being fully alert and lucid.

Eric also recalls his father complaining of being given 'too much' morphine. Eric also recalls his father being surrounded by lots of machinery.

Eric raised his father's concerns with the staff and later they were told collectively that their father was very ill and only had a week to live that he had cancer in his lungs.

The next time Pauline visited she took her mother with her. She states that her father had been moved to a side ward where he was on his own. The window was wide open and the room was freezing. Mr

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COUSINS was unconscious at this point and staff told her that he could still hear her.

Mr COUSINS died in the early hours of 25th August 2000 (25/08/2000). The family was contacted by the hospital by phone.

The family's concerns are that their father appeared to deteriorate very rapidly and that he had complained of being given too much morphine.

The cause of death was given as

1a Chronic obstructive pulmonary

ii Small cell carcinoma of lung

The death was certified by Dr B WILSON /N407. Mr COUSINS was cremated at Portchester Crematorium /L766.

The Baker Report Recommendations: (written Oct 2003)

1. Investigations should continue into the deaths of individual patients. The findings of this review reinforce concerns about what might have occurred in these cases.

2. In the continuing investigation into deaths in Gosport hospital, information about the rota followed by Dr Barton and her partners should be obtained and used to explore patterns of deaths.

3. Hospital teams who care for patients at the end of life should have explicit policies on the use of opiate medication. The policies should include guidance on the assessment of patients who deteriorate and the indications for commencing opiates.

4. The findings should not be used to restrict the use of opiate medication to those patients who need it. Indeed there are reasons to suspect that some patients at the end of life do not receive adequate analgesia.

5. Continued monitoring of outcomes at a local level might have prompted questions about care at Gosport Hospital before they were raised by relatives, but continued monitoring is difficult with current data systems. Hospital episode statistics are an important resource but continued prospective monitoring of the outcomes achieved by clinical teams requires a more detailed set of codes.

Conclusions from my research

1. The case in relation to Mr COUSINS was graded as the lowest category - 1A, by medical experts. As there are no records that I have seen which detail the basis for this decision, I

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cannot query that this is not appropriate. However, it was a panel decision and all of the team members scored each person the same.

2. Mr COUSINS had been admitted for shortness of breath and chest pain. He had been diagnosed with lung cancer the previous year and had COPD. His symptoms appeared to increase to include abdominal pain and anxiety as his stay continued in hospital. His condition deteriorated and the family were aware of the poor prognosis on 19/08/00. This was prior to any diamorphine being administered.

3. Based on the medical notes, Mr COUSINS was given diamorphine in a syringe driver from 20/08/00 until his death on 25/08/00. The dosage increased incrementally but this was apparently justified for his pain and distress. He had been taking liquid morphine (oramorph) when required for his breathlessness from 12/07/00. I am obviously not a medical expert but on researching recommended dosage for diamorphine, BBC News states "for severe pain a dose of 5-10mg intravenously is recommended." Mr COUSINS was administered 30mg then 40mg of diamorphine just before his death. On initial review this appears very high although this was obviously reviewed by the experts and considered normal. Overdose in diamorphine results in stupor, coma and death.

4. There is an abundance of material online in relation to Dr BARTON. There is a report submitted to the CHRE (Council for Healthcare Regulatory Performance) by Dr Rita PAL in November 2012 where she discusses the decision made by the GMC to not have Dr BARTON struck off. It highlights that Dr BARTON's brother was a member of the GMC committee and this was not disclosed. It discusses that no reasonable doctor would ever have signed the high dosage of diamorphine that she did as they would know that it would lead to respiratory arrest.

Recommendation

Based on the records that we have, we can see that Mr COUSINS did form part of the original investigation and his children were interviewed about this in 2004. They may feel that he was not part of the investigation as he was categorised lower than the 12 persons who were taken to CPS and his case was NFAd. There was still an investigation and the KCT did evaluate his case and have sight of his medical notes before making their decision.

As he was cremated, there is no possibility of any posthumous examination of his body. The policy decision at the time was that no one would be reviewed by CPS who was category 1 and it is unlikely that this would change now.

I do not currently see that we can progress this case any further based on the evidence that we have to date. From the letter that the family would have received from DI NIVEN, it is quite bland and only says that there was no evidence of unlawful activity. I don't know if the family may benefit from knowing about the categorisation by the expert team to help put their minds at rest?

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It looks like there will be a public inquiry being commenced in the coming weeks and it may be that the family will look to that to gain answers about their father's death.

Submitted for your consideration

DC Code A
13/09/13
HMIT Fratton