Portsmouth Hospitals NHS Trust
In the Matter of the Gosport War Memorial Inquests
Statement of Lesley Forbes Humphrey

I Lesley Forbes Humphrey, Divisional General Manager for the Division of Medicine for Older People at Portsmouth Hospital NHS Trust will say:-

Introduction

1. This inquest is concerned with the deaths of people who were in-patients on Dryad and Daedalus wards, at Gosport Ward Memorial Hospital (GWMH) between 1996 and 1999. These deaths came to police and public attention through a complaint made by a relative in 1998.

2. I have worked within the NHS organisations and services responsible for providing care at GWMH since 1997, although I will leave my current post in December 2008 to take up a post in the private sector.

3. My sole purpose in producing this statement is to help establish the contextual issues relating to the provision of care for older people at GWMH. In doing this I do not claim to be an expert in any matters, clinical or otherwise, but I have a working knowledge of the events surrounding the investigations into the deaths in question, and the organisational and clinical changes that have transpired in the intervening years.

My role

4. I have been Divisional General Manager (DGM) for the Division of Medicine for Older People (DMOP) at Portsmouth Hospitals NHS Trust (PHT) since October 2006. PHT provides acute hospital services to the city of Portsmouth and the surrounding areas. Prior to that I held the same position at East Hampshire Primary Care Trust (East Hants PCT) from 1 April 2002 to October 2006 and prior to that I held the same position from July 2001 to April 2002 at Portsmouth Healthcare Trust (the Healthcare Trust).

5. From March 1997 to July 2001 I held the position of quality manager for the whole of the Healthcare Trust. As quality manager I was responsible for overseeing complaints and the complaints processes and liaising with the business manager who managed

litigation cases. This included complaints into deaths at the Gosport War Memorial Hospital (GWMH).

6. When I transferred to my current post, I still retained some involvement with the investigations into the deaths at GWMH, which are the subject of the inquest as I had been part of the management of the service since 1997.

Overview of Division of Medicine for Older People Today

7. The Division of Medicine for Older People provides a wide range of services for people over the age of 65 years, who have complex medical problems requiring complex multidisciplinary assessment and treatment. These services are: acute medical care; acute stroke care; palliative care in hospital; general rehabilitation; stroke rehabilitation in hospital and at home; outpatient clinics; day hospital assessment and treatment; and community geriatric services, providing rapid access outpatient clinics and consultant visits at home and in GP run beds in community hospitals. The acute stroke service, provided on one ward at Queen Alexandra Hospital (QAH) in Cosham, is the chronological exception in that it provides care for adults of all ages.

8. Theses services are provided in a wide range of settings. Acute medical care is currently provided at QAH and at St Mary's Hospital (SMH) in Portsmouth, although all acute care wards will move to QAH in June 2009. The acute stroke service is provided at QAH as is palliative care. General and stroke rehabilitation is provided at SMH, GWMH and Petersfield Community Hospital (PCH), with stroke rehabilitation also being provided at home in Portsmouth and south east Hampshire (e.g. Waterlooville to Hayling Island). Outpatient, day hospital and community geriatric services are all provided in or from SMH, GWMH and PCH.

Changes in Management of DMOP and GWMH Services

9. The management of some of these services has changed over the years. With the exception of the medical staff, the services provided at GWMH and PCH were not managed by DMOP until October 2006.

10. When the Healthcare Trust was in existence (April 1994 until April 2002) it managed the GWMH site. It also managed and provided clinical services within GWMH, with the

exception of Sultan Ward, which was a GP run ward and was funded and managed separately.

11. The Healthcare Trust was split into clinical and geographical divisions. One clinical division being Medicine for Elderly People (now known as DMOP): that division provided inpatient services for older people in dedicated wards at St Mary's Hospital (SMH) and Queen Alexandra Hospital (QAH), fully managing the associated nursing, administration and medical staff. The Gosport and Fareham division of the Healthcare Trust managed GWMH, and this division managed the nursing and administration services on Dryad and Daedalus wards. However, DMOP provided and managed the medical staff working on these wards. As both divisions were managed by the one organisation, they worked to common policies and procedures.

12. In summary, at the time of the deaths in question the clinical services provided on these two wards were under two different management teams. The nurses were managed by the Gosport and Fareham Division and the doctors by the Medicine for Elderly People Division, but both divisions were part of the Healthcare Trust.

13. In line with national changes, plans for re-organising local health services, including the Healthcare Trust, began in 2001. In April 2002 the Healthcare Trust was dissolved and East Hants PCT, Fareham and Gosport PCT and Portsmouth City PCT were established. During the planning for the establishment of these PCTs detailed discussions took place to decide which organisation should manage which clinical services.

14. There was much discussion about which organisation should host the Medicine for Elderly People service, this being one of a number of services where it was agreed that it should continue to provide services for the whole district. There was a strong view amongst the consultants, at the time, that Medicine for Elderly People should not become part of PHT, the acute trust. The decision was made that this service would be hosted by East Hants PCT, but would continue to provide services for the Portsmouth, Fareham and Gosport and east Hampshire areas. Likewise the elderly mental health services for these areas transferred into East Hants PCT.

15. Adult mental health services split because Portsmouth City PCT wanted to provide their own service. The adult mental health service for Fareham and Gosport and East Hampshire transferred to Hampshire Partnerships Trust.

16. The community services, which were locality based, were divided between the three PCTs, and as part of this arrangement the management of the GWMH site transferred to Fareham and Gosport PCT.

17. Therefore from April 2002, the management of the medical service for Dryad and Daedalus wards was with East Hants PCT, and the management of the nursing services at GWMH, and the management of the building was with Fareham and Gosport PCT.

18. In October 2006 Medicine for Elderly People, by now referred to as the Division of Medicine for Older People, (DMOP) transferred into PHT. At this time the nursing and administration team for Dryad and Daedalus were transferred into DMOP and thus also became part of PHT. In other words from October 2006 for the first time the whole clinical service on Dryad and Daedalus (medical, nursing and administration) was managed by one division within one organisation, and I was the Divisional General Manager.

Changes in Medical Cover at GWMH

19. At the time of the deaths in question, Dr Jane Barton (a local Gosport GP) was employed by the Healthcare Trust to work as clinical assistant to provide junior medical cover at GWMH. Dr Barton worked nominally under the guidance of a consultant.

20. Dr Barton visited Dryad and Daedalus wards at GWMH each morning, Monday to Friday. Her GP surgery provided an out of hours service where she, or one of her partners, would attend the wards for specific needs when required.

21. Each ward would have a consultant round approximately once a week, a different consultant covering each ward. The consultants, all geriatricians employed by the Healthcare Trust, were based at QAH. Their clinical caseload could include a day hospital session and/or outpatient session at GWMH, and thus they were present on the GWMH site for advice at specific periods in addition to their ward rounds. In addition each consultant may have clinical commitments at other hospital sites such as QAH or SMH.

22. Dr Ian Reid was medical director for the Healthcare Trust between 1998 and 2002: his predecessor was Professor Martin Severs. Dr Reid was also medical director for East Hampshire and Fareham and Gosport PCTs from 2002 until 2006.

Prescribing practices at GWMH

23. At the time of the deaths Dr Barton would have performed much of the prescribing undertaken on Dryad and Daedalus wards at GWMH. However, the ward consultants or Dr Barton's GP colleagues attending in her absence may also have prescribed medication.

24. I note from the CHI investigation report that in the late 1990s, the Healthcare Trust did not have a policy for the assessment and management of pain. At the time in question, staff used a booklet referred to as the Wessex Guidelines (more accurately called "The palliative care handbook guidelines on clinical management") for prescribing drugs to manage pain. This probably created a lack of clarity over prescribing practice, as these guidelines were not designed for a rehabilitation environment. However as far as I am aware, the prescribing policies at GWMH were no different to any other community hospital at the time.

25. The PHT pharmacy supplies medicines to GWMH: there is no pharmacy on site, stocks of medication are provided from the pharmacy at St Mary's hospital in Portsmouth. When the Commission for Health Improvement (CHI) review was carried out they looked at the pharmacy services at GWMH. Jeff Watling, who has recently retired from PHT and was the chief pharmacist for PHT at that time, was involved in this review.

Changes in Clinical Models of Care at GWMH

26. The model of care at GWMH has also changed over the years. In1998 Dryad ward had 20 beds all dedicated to continuing care, and Daedalus ward had 24 beds, 16 for continuing care and 8 for slow stream rehabilitation.

27. In the Commission for Health Improvement (CHI) review report (2002) Dryad was listed as also taking some slow stream rehabilitation patients, but there is no mention of any specific split in bed usage. Daedalus was listed as having 8 beds for general rehabilitation, 8 for slow stream rehabilitation and 8 for fast stream rehabilitation. Whilst I could see no specific mention in the CHI report, any reference to slow stream

or fast stream rehabilitation will always refer to stroke rehabilitation and not general rehabilitation.

28. A further change in the clinical model came on 1st September 2004 when Fareham and Gosport PCT closed St Christopher's Hospital in Fareham, and transferred all rehabilitation to GWMH and all continuing care into specially purchased nursing home places in the community. These changes were brought about for two reasons: St Christopher's Hospital was in a poor state and beyond economical repair, and the new national guidance on the provision of Continuing NHS Care changed the demand for NHS hospital beds.

29. From September 2004 Dryad Ward provided stroke rehabilitation and Daedalus ward general rehabilitation.

30. During the years since 1998, the emphasis of rehabilitation care has also changed. At that time older people would remain in a rehabilitation ward for long periods, at least months and in some cases years. Current practice is more sophisticated in identifying those people who will benefit from a period of rehabilitation, and in ensuring that their stay in hospital is not prolonged beyond that which is needed. Being in hospital is neither a socially pleasant experience nor is it without risk of hospital-acquired infection.

31. It is also fair to say that public expectation quite rightly changed, with the publication of the "National Service Framework for Older People in 2001 and subsequent publications on the needs and health care of older people, providing services closer to home and improving end of life care. Such publications supported the change in clinical focus, away from services with a lack of clear purpose and admission criteria. The services today have clear service specifications and admission criteria.

32. Public concern over the use of diamorphine and euthanasia has also been raised over recent years, through extensive media coverage of high profile cases such as that of Harold Shipman. Internet usage has also heightened public awareness of these matters. Whilst health services must always be subjected to public scrutiny, issues around pain relief and end of life care are seldom as simple or clear cut as often presented by the media or on the net. As a result both patients and their relatives can be caused unnecessary anxiety about treatment, and even worse patients can be left

to die in pain when clinicians become concerned about litigation should relatives disagree with a palliative approach to care.

The issues raised during investigations

33. I understand some of relatives of the patients who died at GWMH are concerned that the use of some drugs and the amounts prescribed caused the death of family members who were in-patients on Dryad and Daedalus wards. That has become clearer to me subsequently, rather than when the initial complaints came in. Some of the complaints at the time related to the ability of staff to talk to families. It became clear to me that often friends and relatives were not really properly informed or aware that a palliative care approach was being taken. As a result, they had minimal or confused understanding of the appropriate medication to be given, and their expectations as to outcome was at variance to that of the clinical team.

34. From my experience of working within the NHS for over 30 years, both as a nurse and as a manager, the term Palliative care means treating symptoms (e.g. pain, nausea, vomiting etc) rather than trying to cure an illness. This approach is taken when it is recognised that a cure is not possible or may in itself pose unacceptable risks, and this could be for a number of reasons. In my experience people may use the term as a euphemism for end of life care, although with the introduction of the Liverpool Care Pathway and the Gold Standard for end of life care this is now less common.

35. Those on a palliative care approach are likely to end their life on this care pathway, however death may be months, or even years away when this approach is commenced.

36. I think that within our current society there is poor understanding of the effect of multiple medical problems, and the aging process on the body. It is not chronological age that creates frailty; it is the impact of multiple medical problems and how the ageing body is able to deal with those. An elderly person may have many problems yet manage well, even living independently, but their body may be swiftly overwhelmed by a seemingly simple illness, or trauma such as a fractured hip and surgery, following a fall. Sometimes their bodily systems are simply unable to cope with this final extra insult. I don't think that health professionals are always skilled in explaining this to their relatives.

37. Having said that, the real concern from the investigations appeared to be about prescribing. In particular that a very wide-ranging dose was prescribed for diamorphine to be given via a syringe driver, for palliative care. A syringe driver is a small machine that electronically presses the plunger on a syringe, giving a measured dose of medication over a set period of time. Diamorphine is a 'controlled drug'. The aim of the use of a syringe driver is to give a total amount of medication over a 24-hour period, to keep the patient pain free. This avoids the "peaking and troughing" in pain control that can occur when medication is given in set doses hours apart, i.e. the person may experience pain when the dose begins to wear off and before the next dose takes effect.

38. I understand that Dr Barton was concerned that her patients could be in pain at night or over the weekend, when there would not be a doctor in the hospital and therefore she would prescribe a range of say 40-200 mgs of diamorphine over a 24 hour period. As I understand it, the risk of this is that a nurse could give an excessive dose at the outset, which could repress respiratory centres in the brain and slow breathing down: this could result in death.

39. In their investigation CHI were concerned with poor prescribing practice as well as poor medical note keeping which was considered to be minimalistic. Patients came in for rehabilitation, their condition changed and they moved into palliative care but it was difficult to see a clear medical rationale to support that in the hospital records.

40. Each ward would have a controlled drug book in which would be entered details of the ward stock levels of the drug in question; the amount administered to any patient at a specific time and date, and a running total of the stock. Before nursing staff could administer a controlled drug, the stock levels and the amount to be given would have to be checked by 2 members of staff. They would then draw it up and prepare the syringe. The syringe driver mechanism would then be set to release the amount of medication prescribed for the 24-hour period.

41. The worry was that a dosage of 40 – 200 mgs of diamorphine prescribed over a 24 hour period was open to very wide interpretation by the nursing team, and there were no explicit guidelines given on how to increase the dose gradually dependent on the pain experienced by the patient. The CHI review considered that this prescribing practice could be risky as it would permit a high initial dosage to be given.

42. I believe that as part of the police investigation the controlled drug books were taken and examined by the police. I also believe that the pharmacy records were also examined. As far as I am aware, no evidence has been found to suggest that any patient had in fact been given too much diamorphine which led to their death.

43. It was not just the use of diamorphine that was considered as part of the CHI investigation and the police investigation. There were also concerns raised about the use of midazolam, which is a drug used in a number of scenarios. At GWMH it was used to reduce agitation, but it is also used in different dosage as an anaesthetic agent.

44. As mentioned above, in the 1990's Dr Barton would have been using the "Wessex Guidelines" for palliative care when prescribing diamorphine and midazolam. This booklet, called the *Palliative care handbook guidelines on clinical management,* was developed by Portsmouth Healthcare Trust, the Portsmouth Hospitals NHS Trust and a local hospice, in association with the Wessex palliative care units. In my understanding, within a palliative care setting a combination of midazolam and diamorphine was reasonable to use.

45. The problem was that because of poor communication it was not clear to relatives when patients had in fact moved from rehabilitation to palliative care and why.

Complaint into the treatment/death of Mrs GR

46. It all started with the complaint into the treatment of GR who was 101 years old and who died on Deadalus Ward in August 1998. I have a copy of the associated complaint file and have used this to help construct this statement (although I suspect this file copy may be incomplete.).

47. The history was that GR had fallen at the nursing home where she lived, broken her hip and been taken to Royal Hospital Haslar where a half hip replacement was carried out (a hemi-arthroplasty). She was then transferred to Daedalus ward at GWMH for rehabilitation. Two days after arrival she was found lying on the floor beside her chair and a dislocated hip was diagnosed by x-ray. She was sent back to Haslar to have her hip manipulated back into place, under anaesthetic. It took her a while to come round from the anaesthetic and she stayed at Haslar for 48 hours before being transferred by ambulance back to Daedalus ward.

48. When GR was brought back onto the ward she was screaming in agony. The ambulance staff transferred her from a trolley onto her bed, using a draw sheet because no trolley canvas was available at Haslar. Usual practice is to make such transfers using a canvas and poles. She was subsequently diagnosed with a haematoma (collection of blood) in the hip. It was felt that it would be unsuitable for this to be dealt with by surgery, because that would have meant a third operation in a short period of time and she had not recovered terribly well from the last operation.

49. There were concerns that she would not survive a third operation. It was felt that the best course of action was to keep her pain free, and after discussion with both of her daughters she was started on diamorphine via a syringe driver. It was recognised that with the trauma history and haematoma, at her age it would be difficult for her to recover.

50. Before she died the Healthcare Trust received a complaint from one of GR's daughters who raised concerns about pain management, the fall and her general care.

51. A complaint file was started and arrangements were made for an investigation to be carried out. Code A who worked for me, usually handled complaints from this geographical area. But I took the initial telephone call from the daughter and remained in contact with the complaint at various stages, although Code A was managing it. Subsequently, and with the benefit of hindsight I don't feel that the investigation was as thorough as it could have been. No one at Haslar or the ambulance service was asked for comments about how GR came back to GWMH from Haslar screaming in pain.

52. A few weeks later GR's second daughter (GM) telephoned the manager who had carried out the investigation, asking for a copy of the correspondence with the first daughter . GM stated that her sister would not tell her the detail of her complaint because of a family feud. However, the first daughter did consent to us sharing this information with her sister.

53. A meeting was offered to the first daughter to discuss her concerns, and subsequently GM asked to attend too but unfortunately she was not able to attend the date that had been arranged. We asked the sisters to identify alternative suitable dates when they could both attend, and then contact us with this information so that the meeting could

be re-arranged. This took place at the end of September 1998. Unfortunately the sisters did not contact the Trust again about a date for the meeting and nobody from the Healthcare Trust contacted them about this either.

54. This was where the formal complaints process ended – the last entry in the complaint file about the proposed meeting was dated 30th September 1998.

The Police investigations

55. It is my understanding that the police have undertaken a total of three investigations into the deaths at GWMH.

56. I first became aware that the police were investigating on 11th December 1998 when Code A from Gosport Police Station telephoned me. He told me that GM had asked the police to bring a charge of "unlawful killing" against the doctor in charge of GR's care. Her concern was that the doctor had "failed to give nourishment" via a drip whilst a syringe driver was being used, therefore causing GR's death. He told me that he had already taken a statement from a Macmillan Nurse, Barbara Davis. DC Code A said that he needed to decide what action to take, if any. He said he felt that the matter was about a clinical decision and therefore not a police matter. He said that he would like a statement from the Trust plus a copy of the medical notes regarding the use of a syringe driver, and details of the information given to the family at the time.

57. Code A also told me that he had been in contact with the GMC who had asked him to write to them explaining that the charge comes from GM, and not the police.

58. I alerted the Chief Executive and the Fareham and Gosport General Manager and I made a file note, which I placed on the complaint file – I have recently obtained a copy the complaint file including this file note. It was at this point that I realised that the complaint had drifted and that we had been waiting for the family to contact us to arrange a date for a meeting. I contacted both of GM's daughters to seek their permission to share information regarding their mother's care with the police. They both agreed but the first daughter telephoned me on 15th December 1998 to say that she was unhappy that her sister had taken this matter to the police. They had fallen out and she was unaware that GM was supposed to be arranging a suitable date for a meeting to discuss the complaint – the first daughter had still been waiting for us to contact her to arrange this. She had been advised by the police not to discuss this

case with anyone and we agreed that it would not be appropriate to meet now that the police were involved.

59. After consultation with various people, including the Trust solicitors and Dr Barton, it was agreed that Dr Lord (consultant) would write a report for the police – which she duly did. This report was dated 22/12/98.

60. The CHI report states that in March 1999 the CPS decided that there was insufficient evidence to prosecute, but I do not believe that we in the Trust were made aware of this decision at that time.

61. I believe that the next we heard was on 7th October 1999 when the Chief Executive received a telephone call from DCI Ray Burt of Hampshire Constabulary to say that he would be writing regarding the police having further access to medical records. This letter arrived a few days latter. From the copy of the letter in the complaint file, I note that this letter was dated 10/08/99 but I believe that this date is written in American format. The Trust stamp for date of receipt is faint but seems to say 16th October 1999, however my file note entry states that the letter was received on 11th October. This letter stated that following a review of the investigation carried out by Code A DCI Burt had been appointed to re-examine the case.

62. On 19th October 1999 DCI Burt telephoned me. He told me that he had been asked to review the previous investigation because a complaint had been made that it was inadequate. He said he would need to review the medical records and probably get an independent opinion on the care provided. We agreed to meet on 27th October 1999 in my office.

63. When we met DCI Burt informed me that in March 1999 the CPS (on second submission) decided that there was not a case of unlawful killing to be answered – on the basis of the evidence presented. Following this there was a complaint that the investigation and thus the evidence presented was not thorough enough. On cursory examination there seemed to be some justification for this complaint therefore DCI Burt was asked to review the case. DCI Burt would need to take statements from key members of staff and we agreed that all arrangements would be made via myself to ensure that staff were supported appropriately.

64. On 6th December 1999 I wrote to DCI Burt, on behalf of the medical team: their medical defence unions had asked for clarification of the allegations. On 16th December 1999 I received a reply from DCI Burt confirming: a) that both daughters of GR had expressed wide ranging concerns about the standard of care which their mother received at GWMH; b) it is possible that taken as a whole these might well have bearing on the case; and c) a key feature of the allegation is the decision taken on 17th-18th August 1998 to not refer GR back to Royal Hospital Haslar for further treatment. This was the first time that I was aware of point c) – I had understood that both daughters had been in agreement at the time with the decision to keep GR at GWMH and focus on treating her pain.

65. On 20th January 2000 I had a telephone conversation with DCI Burt. He informed me that the investigation was progressing slowly; he was still gathering information and was due to see his clinical adviser the next week. He told me that there was no new evidence to lead the police to suspect that a criminal act had been performed. We discussed the interview of Dr Jane Barton which was soon to take place. Jane's actions seemed to becoming the key focus of this investigation. DCI Burt told me that her interview would be part of the information gathering and that he had no reason to believe that she would be held in custody except in the unlikely event that SHE offered information to suggest that she should be held.

66. On 11th February 2000 I received a letter from DCI Burt. This letter mentions a statement that I gave to him at the time, but I cannot find a copy of that. I have a dim, recovered memory that was in relation to the complaint raised by GR's first daughter plus some background information about the services provided at GWMH. This letter mentions a previous letter that DCI Burt had sent to me on 29th January 2000, but I cannot find a copy of that letter in my copy of the complaint file. In this latest letter DCI Burt sought further information and posed a number of points for me to consider, prior to us meeting to discuss the issues raised. I subsequently placed a post-it note on this letter stating "never formally replied to – as situation changed gear".

67. On 15th May 2000 I received a telephone call from DCI Burt to say that as a result of his preliminary screening the police had decided to take a higher profile with this case. When I asked why, he simply replied that he had seen enough to suggest that a higher profile was warranted and to justify increased resources that would be needed. From 22nd May 2000 additional officers would be joining the team and formal interviews would be conducted with staff who had direct contact with GR and with staff who could

explain polices and procedures. Where appropriate he said that staff would be offered some protection. I immediately notified the Trust executive team and put plans in motion to ensure appropriate support for the staff affected, and to manage any media interest.

68. On 26th May 2000 I met with Code A for three and a half hours. He stressed to me that this was not a "hard hitting" investigation, that they had no axe to grind and were simply gathering information to enable the CPS to decide if there was an issue to be addressed. It became clear to me that there was much interest in the prescribing of subcutaneous diamorphine as much as 40 – 400 mgs in 24 hours. He had asked me how the nurses would decide how much to give – although it seemed that the controlled drug register suggested that only 40mgs in 24 hours was ever given. It was clear that there was also interest in the use of midazolam. He said that all staff working on Daedalus Ward would be interviewed.

69. On 12th June 2000 I contacted the police to check on progress with their investigation and was advised that they have changed their approach and will now only be interviewing those people who gave direct care to GR. However these members of staff were to be interviewed voluntarily in a police station, but under caution. It was stressed that this was still information gathering and not the police trying to prove a known crime.

70. On 1st September 2000 I spoke to DCI Burt (presumably by telephone). He told me that all the evidence was currently with their clinical expert, Professor Livesey. He said that after this we might be asked for further information or the case may be passed straight to the CPS. He said it could take three months for the CPS to make a decision. He stressed that the police did not think that there was any individual with criminal intent: they were exploring whether institutional practices might have constituted a breach of criminal law. He also said that this was not the only case in the country being explored in this way – some cases have been taken out of the hands of the local CPS and passed on to London. He mentioned that if either Professor Livesey or the CPS thinks that there might be a basis for proceeding with a criminal case they may want to consider if any other deaths occurred in similar circumstances.

71. My copy of the GR complaint file ends at this point, but the investigation report from the Commission for Health Improvement confirms that in August 2001 the CPS concluded that there was "insufficient evidence to provide a realistic prospect of

conviction". This report also states that in March 1999 the CPS concluded, "there was insufficient evidence to prosecute".

72. Local media coverage in March 2001 made the public aware that the police were investigating the deaths of patients at GWMH, which led to 11 other families raising concerns with the Police. We (the Healthcare Trust) invited anyone who had concerns about the care a relative had received at GWMH to come and talk to us. We were concerned that media attention and publicity would cause anxiety and distress to those who had a relative who had died at GWMH or were in fact themselves patients at GWMH. Several people did contact us, and when they wished we arranged for a member of staff to meet with them and take them through the medical and nursing records.

73. As quality manager I was involved throughout the period of the Police investigation until I moved from that position into my current position. However even in my new role I continued to receive regular information about the investigation until the Healthcare Trust was dissolved.

74. The Commission for Health Improvement report states that in February 2002 the police decided that a more intensive police investigation was not an appropriate course of action – presumably this was in response to further complaints from the families concerned.

75. However a third police investigation was eventually held. When the third investigation took place the police decided to widen the net and rather than waiting for families coming to them they decided to review all deaths occurring at the GWMH over a much longer period. Eventually the police reviewed 90 sets of patient records. I believe this investigation took place between 2004 and 2005. On 20th December 2006 a statement was released saying that the CPS had confirmed that no members of staff would be prosecuted.

76. Following this third police investigation, and requests from the families concerned for a public enquiry, I understand that the Secretary of State decide that an inquest should be held into the deaths of ten people.

77. After any such investigation, the police forward their evidence to the GMC and NMC. I understand that the GMC intends to hold a hearing to explore the conduct of Dr Jane

Barton, but that this has been postponed until after the inquest has been held in March 2009. As far as I am aware the NMC have not taken, or plan, to take any action. Dr Barton no longer works as a medical assistant at GWMH. I cannot remember the detail of her leaving. I can say that she was no longer employed in this role from October 2000, when a staff grade physician role was implemented.

The complaints

78. I believe that the families concerned subsequently reported some of the cases that had previously been raised as formal complaints with the Healthcare Trust to the police, and that the police included those deaths in their investigations. Certainly a number of the cases that will be explored during the inquest had been the subject of formal complaints. Although complaint investigations were still carried out in parallel to the police investigations, these were not in relation to complaints that were subject to the police investigation. Once the police investigation started complainants raised any concerns about the death of a patient with them, rather than with the Trust. Where a formal complaint had previously been raised with the Trust, each case was completed before the police investigation began. The third police investigation postdated any of the deaths and any of the complaints into any of the deaths.

79. Some of the complaints resulted in an independent review. By way of example, we investigated a complaint into the treatment of Elsie Devine who subsequently died in 1999. We commissioned an independent review, which identified areas for improvement, such as communication with families, but did not uphold the complaint that the medical treatment had been inappropriate. In another case (a complaint about the treatment provided to Mrs EP prior to her death) we obtained an independent second opinion about the care and use of drugs in relation and from memory I believe that the conclusion was that the care provide was appropriate.

80. All complaints were managed from the Chief Executive's office of Portsmouth Healthcare Trust. I oversaw those but the Chief Executive was very involved. My assistant, Code A and I each held a separate case load split by division. Code A dealt with complaints in relation to Fareham and Gosport (the Geographical Division) and I dealt with cases in relation to DMOP but we both helped each other out. Once the investigation was complete the information would come back to my office and

Code A or I would check all questions had been answered and draft a complaint response for the Chief Executive to consider and sign.

81. To recap what I said earlier, the Healthcare Trust was divided into divisions (geographical and clinical) namely, elderly mental health, Havant and Petersfield, Portsmouth City, MOPs and the division for Fareham and Gosport. The General Manager of MOPs was responsible for the consultants who worked at GWMH and the General Manager for Fareham and Gosport geographical division was responsible for the GWMH site and for the wards and nursing services. Complaints about GWMH were sent to the General Manager of Fareham and Gosport division for investigation. As far as I can remember, the divisional General Manager for DMOP was not really involved in co-ordinating a response to a complaint about the GWMH and it is fair to say that the knowledge that they would have had about the complaints is likely to have been "patchy".

82. It was not until the police investigation in 2000, that I became aware that the prescribing practice as a whole was considered to be a problem although some complaints raised issues about the use of diamorphine and midazolam. Generally speaking complaints would raise more than one issue. Some expressed concern over nursing care, others would be more a general complaint after a relative had died, and lack of communication featured frequently. However, there was no recognised pattern to the complaints at the time and it would be fair to say that theses are still commonly features in complaints raised across the whole NHS. As quality manager, I, the Chief Executive and the divisional General Manager would all have been responsible for picking up a problem if there had been an emerging pattern to the concerns raised.

83. Although there were some similar issues arising out of the complaints, there was no obvious pattern to the complaints and if there had been a pattern of poor prescribing I feel that I would have picked that up. The complaints did not say, for example, that their relative died as a result of a prescription of diamorphine. During the initial investigation the investigating officer, as required, would have reviewed the records and drug charts. I do not remember personally examining any drug chart related to a complaint at that time. With hindsight now I might question the robustness of some investigations, especially in relation to the complaint made about the events surrounding the death of GR. In my current role I oversee all complaints made about the DMOP service and it is my common practice to ask that the hospital records be

forwarded to me along with the investigation report. This allows me to double check or clarify any issues that I feel have not been answered fully.

84. In the Healthcare Trust we had a very robust system of quality and divisional review meetings where the service team presented their report to Trust directors. Complaints were reviewed as part of this process and individual complaints would not be removed from the report until any resulting action had been completed.

CHI Review

85. I was quality manager when The Commission for Health Improvement (CHI) was called in to carry out an investigation into practices at GWMH. I believe that this happened following a conversation between the Trust Chief Executive, the Strategic Health Authority and the Department of Health. The CHI report confirms that "in July 2001 the chief executive of the health authority asked CHI for advice in obtaining a source of expertise in order to re-establish public confidence in the services for older people in Gosport". In August 2001 the police shared with CHI their concerns about the evidence gathered during their investigations. The Commission for Health Improvement was at the time an independent body created to support and oversee the quality of clinical governance in NHS clinical services in England and Wales. It has since been disbanded and a successor organisation has taken over this role.

86. I was interviewed by CHI after I took my post as divisional manager for the DMOP at the Healthcare Trust in July 2001.

87. The Healthcare Trust was disbanded and in 2002 Fareham and Gosport PCT co-ordinated the response to the CHI recommendations working with East Hants PCT to respond to the recommendations.

88. Dr Ian Reid, who had been medical direct for the HealthCare Trust became Medical Director for both PCTs. The person responsible for overseeing the action plans in response to the CHI report was Fiona Cameron (now Fiona Smart) who was lead for governance in Fareham and Gosport PCT. She co-ordinated and oversaw the CHI investigation and liaised with the police until the two PCTs began working as one organisation in 2005.

CHI Recommendations

89. Code A coordinated a large multi-agency workshop of all stakeholders in August 2002, where the recommendations were considered and draft action plan agreed. Subsequently a small steering group oversaw the implementation of these actions and regular reports were provided to the PCT boards. The action plans evolved over time to encompass service changes and address any other issues that came to light. I believe that most, if not all, actions had been completed by the time East Hampshire and Fareham and Gosport PCTs were disbanded.

90. The complaints and deaths in question pre-dated the introduction of clinical and corporate governance within the NHS. This really started with a document published by the Department of Health in June 2000 entitled "An organisation with a memory". I believe that the current governance systems and processes within Portsmouth Hospitals NHS Trust have minimised the risk of such a situation arising again, i.e. system and process failures not being recognised at an earlier stage.

91. For instance the Trust has a comprehensive system for raising and examining potential serious untoward incidents through the adverse incident procedure. This is used by staff to raise concern about issues such as prescribing of medication. In addition the Trust has clear guidelines on medicines management, including the management of pain. Investment has been made in additional pharmacy cover and there are plans to audit pharmacy provision across the whole DMOP service within the next six months. A Trust wide quarterly complaint report is presented to the Trust board, and each division is required to make a formal report to the Trust Quality and Governance Committee every three months.

92. The action plans undertaken by the NHS as a result of the CHI recommendations have resulted in significant changes to the service provided to older people. In addition there have been other significant changes to ensure a safe and well managed service is provided to patients in the area. To demonstrate the changes put in place and to outline current levels of service and governance arrangements I have drawn up a table for ease of reference. This table is attached to this statement and marked "LFH 1". This table has also been used to assure the Boards of the relevant Trusts and PCTs as to the current management within the DMOP.

The DMOP Service at GWMH now

93. Dryad and Daedalus wards transferred to the full management of the Division of Medicine for Older People on 1st October 2006; i.e. the medical and nursing care is now under the management of this one divisional team.

94. In September 2007 these wards decanted to Royal Hospital Haslar to enable redesign of the GWMH wards. In September 2008 the wards moved back to GWMH, but to a new location on the top floor (previously had been on the ground floor). These moves required a change in bed numbers from a total of 44 beds (20 : 24 beds) to a total of 30 beds (15 : 15), although since return to GWMH one ward can flex up to 20 beds again when needed.

95. This change of location between floors was required to meet mental health standards that require these patients to have outside access.

96. The change in physical locality meant that for reasons of safety the wards had to adopt the name of the pre-existing top floor wards. Dryad ward, which provides stroke rehabilitation, is now on Collingwood Ward and Daedalus ward, which provides general rehabilitation, is now on Ark Royal ward. The names of Dryad and Daedalus wards have been retained but now house older people's mental health services.

97. These two wards have a dedicated matron and operational manager who work closely with the ward sisters, each of whom is supported in turn by the Divisional Senior Nurse and the Divisional General Manager. Each ward has a full time junior doctor 9am to 5pm Monday to Friday, with an associate specialist on site to provide supervision and help. Each ward has two consultant ward rounds per week. The on site out of hours medical cover is provided by the local Out of Hours Medical Service, but clinical advice is available 24 hours per day seven days per week from the DMOP on call consultant and the DMOP Specialist Registrar on duty at St Mary's Hospital in Portsmouth

This Statement is true to the best of my knowledge and belief.
Signed:
Dated:

Portsmouth Hospitals NHS Trust

In the Matter of the Gosport War Memorial Inquests

Statement of Lesley Forbes Humphrey

LFH 1

This is the exhibit referred to in my statement dated the day of 2008 and marked 'LFH 1'

Dated

Signed