Jackson, Angeline

From: Davies, Hilary (HPCT) </O=BAS EXCHANGE/OU=FIRST ADMINISTRATIVE GROUP/CN=RECIPIENTS/CN=DAVIESH02@>
Sent: 13 March 2009 12:46
To: Adamson-Young, Nicky (NFPCT); Anderson, Kay (NFPCT); Archer, Trudi; Banks, Jennifer (HPCT-SE); Barnett, Helen; Barnett, Helen (NFPCT); Blake, Chris; Bobby Scott; Bowell, Catherine (NFPCT); Capper, Julie (NFPCT); Carne, Nicola (HPCT-SE); Caroline Roberts; Carroll, Patrick (HPCT-SE); Chandler, Steve; Clark, Triss; Cooper, Briony; Cubbon, Karen (ETVSPCT); Cummins, Barbara; Dean Garrett; Emms, Elizabeth (HPCT-SE); Ferretti, Suzanne; Forrest-Charde, Moraig; Gilbert-Wood, Lesley (HPCT-SE); Grant, Sandra; Gray, Babs (HPCT-SE); Harriman, Sue; Harvey, Jayne (IPHIS); Holden, Janet; Howard, Jane; Hudson, Val; Hughes, Gethin; Hull, Paula (NFPCT); Jill Angus; Joanne Thomas (Ports Modern Matron); Johnson, Paul (NFPCT); Kerry Salmon (NFPCT); Kewell, Sue; Lee, Jill (HPCT-SE); Lewis, Theresa (NFPCT); Marshall, Stuart (NFPCT); Maton, Fiona; May, Zena; Moraig Forrest Charde; Munro, Lesley; Nicki Rogers; Nicky Seargent; Nina Eastwood; North, Mary; Owen, Amanda; Percival, Alison (HPCT-SE); Percy, Katrina; Price, Sue; Rawat, Taj (HPCT-SE); Robertson, David; Rothery, Laura; Rudland, Karen (NFPCT); Scammell, Toni (HPCT-SE); Smith, Catherine; Stead, Linda (HPCT-SE); Susan Kewell; Taylor, Ginny; Taylor, Ginny (ETVSPCT); Taylor, Liz (HPCT-SE); Wedlake, Lyn (NFPCT)
Subject: FW: Gosport War Memorial Hospital: Inquest Media Pack
Attachments: 090312 FINAL GWMH Inquests Information Pack.doc

Dear All – please find attached, if needed, for when you are on call over the next few weeks.

Hilary

Hilary Davies
Business Administration Office Manager/PA to Katrina Percy, Managing Director
Hampshire Community Health Care (part of HPCT)
Tatchbury Mount
8 Sterne Road
Calmore
SOUTHAMPTON SO40 2RZ
Telephone: 023 80 874353
email: Code A

From: Percy, Katrina
Sent: 13 March 2009 11:58
To: Davies, Hilary (HPCT)
Subject: FW: Gosport War Memorial Hospital: Inquest Media Pack

Could u circulate for the oncall and also print for my oncall please
thanks

Katrina Percy
Managing Director
Hampshire Community HealthCare
Hampshire PCT
T 02380 874353 (PA Hilary Davies)
E Code A

From: Mcbride, Annette
Sent: 12 March 2009 17:53
To: Bradlow, Jean; Percy, Katrina; Jack Climpson; jgodber; Malcolm Heritage-Owen; Mike Petter; Montgomery, Jonathan; Susanne Hasselmann; Tracey Faraday-Drake
Subject: Gosport War Memorial Hospital: Inquest Media Pack

Richard has asked me to forward the attached to you, for information.

Kind regards,

Annette McBride
PA to Chair & Chief Executive
Hampshire PCT
Omega House
112 Southampton Road
Eastleigh
Hampshire SO50 5PB
Tel: 023 8062 7428

Jackson, Angeline

From: Hughes2, John </O=BAS EXCHANGE/OU=FIRST ADMINISTRATIVE GROUP/CN=RECIPIENTS/CN=HUGHESJ04@>
Sent: 04 March 2009 20:40
To: Harriman, Sue; Samuel, Richard
Subject: RE: GWMH case-mix - URGENT

Sensitivity: Confidential

Sue / Richard : met with the Sultan [FACE] GPs tonight. The general issue has been complicated by fact that FACE are now wanting more money to implement the consultant supervision which the governance around the Gosport inquest has suggested. I will take this up with Alex who set the original service spec but I suspect we will have to go out to tender again with a tighter spec than previously.
On the specifics of this case raised by Susan [and a ? related issue raised by Richard with me this afternoon relating to nurse feedback picked up by Toni Scammell] there are a few issues.
Firstly concerns should be raised through the correct process. Eliz Emms was unaware of either issue and neither was the locality manager or the modern matron. Not sure why Susan would take the route she did nor why Richard became involved in the more general nursing issues. I did bring both of these up with the FACE GPs but without rather more considered detail this kind of thing is impossible to investigate. I have concerns about the process being adopted and 'hares' sent running if there is no substantive evidence or issues to address.
The FACE GPs were very surprised that any concerns had been raised over palliative care prescribing especially as they and Susan had jointly attended a palliative care update very recently given by 2 consultant specialists. They are also not aware of any nursing concerns.

There may or may not be any governance issues here to deal with but I think we need to be very clear what the lines of communication are if staff have concerns, and that some substantiating evidence [even if anecdotal] is required before anyone's clinical judgement is seriously called into question.
As far as the palliative care issue is concerned the second hands statement which we were first given differs from the now stated position of Susan. This is a clear example of how not to communicate!!!

We need to keep an open mind about the FACE / Sultan issues but I suspect they will be rectified anyway following the latest discussion with them about their contract.

Happy to discuss but not to take these matters further unless there is a bit more than heresay!!

John

From: Harriman, Sue [mailto: **Code A**
Sent: 04 March 2009 16:08
To: Samuel Richard - Hampshire PCT External
Cc: Hughes John - Chairman for APAC and Medical Director for Care Services
Subject: RE: GWMH case-mix - URGENT
Sensitivity: Confidential

Hi Richard,
By way of an update I have spoken to Susan Chan this morning who wants these issues to be managed through an informal (non-whistle blowing process) and is pleased that I was involving John Hughes. I asked for more clarity around her concerns and although they are not without substance I feel that they are being taken slightly out of context. Susan rightly identifies what we know about community hospitals that the acuity of the patients has increased and matching the skills of the staff to the acuity of the patient is a constant struggle for us, this is one of the main stays of the risk that I have described to you and others before.

Susan reassured me that her advice is never ignored by the GP's but they have different views on what constitutes appropriate levels of opiates in isolated cases. I have asked John Hughes to investigate this point in more detail however John expressed a school of thought about the need to use higher levels of opiate e.g. under direct palliative care team advice. So again this point needs investigating before we raise any alarm bells. Susan did talk generally about communication between GP's and nursing staff and this has been identified in a recent SUI at Havant, John has been working proactively with the GP's and nursing staff to improve communication supported by the governance and contractual elements.

In summary, we will investigate, however I feel that this list of concerns on initial reading is alarming on actually discussing with Susan Chan identifies no new issues that are not already being managed and should not create additional risk in relation to event at GWMH.
We will obviously keep you updated.
We can discuss in full on Friday.
Kind regards
Sue

Sue Harriman
Director of Nursing, Therapies and Clinical Standards
Hampshire Community Health Care
8 Sterne Road
Tatchbury Mount
Calmore
Southampton
SO40 2RZ
Direct Dial Code A
Code A

From: Kimpton, Heather, **On Behalf Of** Samuel, Richard
Sent: 04 March 2009 08:58
To: Harriman, Sue
Subject: FW: GWMH case-mix - URGENT
Importance: High
Sensitivity: Confidential

Sue,

Richard has asked that I forward you the attached

Kind regards

Heather Kimpton

PA to Richard Samuel, Director of Performance and Standards & Hilary Tyler, Director of Finance

Hampshire Primary Care Trust
Omega House
112 Southampton Road
Eastleigh
Southampton
S050 5PB
Tel: 023 8062 7583
Fax: 023 8064 4789

From: Deeks, Mary
Sent: 03 March 2009 11:28
To: Samuel, Richard
Cc: Williams, Elaine
Subject: GWMH case-mix
Importance: High
Sensitivity: Confidential

Richard

I have not shared with you a concern that is an outcome of the complaints work that was done as a follow up to the measuring ourselves against the CHUI recommendations.

It has emerged that the acuity of patients (not only at GWMH, but at Havant and Petersfield as well) being cared for by the GPs has been getting higher over the last couple of years. Susan Chan, the pharmacist employed by Care

Services since the CHI report came out in 2002, rang me with her concerns about the way the GP service is working at GWMH. She didn't know who else to raise them with.

These concerns are:

1. Patients come into a bed and she discovers errors in their medication that they come in with.
2. She raises concerns about patients with either/both nursing staff and the GPs but nothing happens. For example, the appropriate way to escalate opiate prescribing to control pain is by raising the dose by 50%, but they often double it, despite her having pointed out the mistake.
3. More importantly, she thinks the patients are sicker than the staff are used to, and sicker than the admission criteria allow for, and the nurses are sometimes out of their depth. For example, she raised concerns with the nurses about tissue viability of a patient on admission, but nothing was done for days. I suppose the nurses wait for instruction from the GPs, and the GPs don't do anything. She said a lot of the problem was political, as the ward is supposed to reduce admissions to the acute sector, and they feel they must do it, but it is resulting in a potentially risky situation. I wouldn't want an untoward incident on Sultan Ward while the inquests are open.

I wondered if you could raise this with Katrina when you see her to discuss other GWMH matters?

Happy to discuss.

Regards

Mary Deeks
Project Officer (GWMH)
Hampshire Primary Care Trust
HQ, Omega House
112 Southampton Road
Eastleigh, SO50 5PB

Tel: Code A Direct dial
Tel: 023 8062 7444 Office
Fax: 023 80622976 (Safe Haven)
Email: Code A
Secure NHS email: Code A

Please use NHSmail for all personal identifiable data and notify me at Code A of its transmission

Jackson, Angeline

From: Harriman, Sue </O=BAS EXCHANGE/OU=FIRST ADMINISTRATIVE GROUP/CN=RECIPIENTS/CN=HARRIMANS22716806@>
Sent: 04 March 2009 16:08
To: Samuel, Richard
Cc: Hughes2, John
Subject: RE: GWMH case-mix - URGENT

Sensitivity: Confidential

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Hampshire Community Health Care
8 Sterne Road
Tatchbury Mount
Calmore
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SO40 2RZ
Direct Dial Code A
Code A

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PA to Richard Samuel, Director of Performance and Standards & Hilary Tyler, Director of Finance

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I wondered if you could raise this with Katrina when you see her to discuss other GWMH matters?

Happy to discuss.

Regards

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Hampshire Primary Care Trust
HQ, Omega House
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Eastleigh, SO50 5PB

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Tel: 023 8062 7444 Office

Fax: 023 80622976 (Safe Haven)
Email: Code A
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Please use NHSmail for all personal identifiable data and notify me at Code A of its transmission

Jackson, Angeline

From: Harriman, Sue </O=BAS EXCHANGE/OU=FIRST ADMINISTRATIVE GROUP/CN=RECIPIENTS/CN=HARRIMANS22716806@>
Sent: 04 March 2009 09:34
To: Hughes2, John
Subject: FW: GWMH case-mix - URGENT In confidence

Importance: High
Sensitivity: Confidential

Sue Harriman
Director of Nursing, Therapies and Clinical Standards
Hampshire Community Health Care
8 Sterne Road
Tatchbury Mount
Calmore
Southampton
SO40 2RZ
Direct Dial Code A
Code A

From: Kimpton, Heather, **On Behalf Of** Samuel, Richard
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Subject: FW: GWMH case-mix - URGENT
Importance: High
Sensitivity: Confidential

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Secure NHS email: Code A

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Jackson, Angeline

From: Kimpton, Heather, </O=BAS EXCHANGE/OU=FIRST ADMINISTRATIVE GROUP/CN=RECIPIENTS/CN=TILLP@>
Sent: 04 March 2009 08:58
To: Harriman, Sue
Subject: FW: GWMH case-mix - URGENT

Importance: High
Sensitivity: Confidential

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Importance: High
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Jackson, Angeline

From: Samuel, Richard </O=BAS EXCHANGE/OU=FIRST ADMINISTRATIVE GROUP/CN=RECIPIENTS/CN=SAMUELR58003171@>
Sent: 03 March 2009 14:58
To: Harriman, Sue
Subject: FW: GWMH case-mix

Importance: High
Sensitivity: Confidential

From: Deeks, Mary
Sent: 03 March 2009 11:28
To: Samuel, Richard
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Subject: GWMH case-mix
Importance: High
Sensitivity: Confidential

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Fax: 023 80622976 (Safe Haven)
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Jackson, Angeline

From: Samuel, Richard </O=BAS EXCHANGE/OU=FIRST ADMINISTRATIVE GROUP/CN=RECIPIENTS/CN=SAMUELR58003171@>
Sent: 03 March 2009 14:50
To: Harriman, Sue
Subject: FW: GWMH case-mix

Importance: High
Sensitivity: Confidential

From: Deeks, Mary
Sent: 03 March 2009 11:28
To: Samuel, Richard
Cc: Williams, Elaine
Subject: GWMH case-mix
Importance: High
Sensitivity: Confidential

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Secure NHS email: Code A

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Jackson, Angeline

From: Deeks, Mary </O=BAS EXCHANGE/OU=FIRST ADMINISTRATIVE GROUP/CN=RECIPIENTS/CN=DEEKSM09150836@>
Sent: 02 March 2009 14:02
To: Code A Radway Patricia - Head of Governance; Code A Code A Samuel, Richard; Williams, Elaine; Johnson, David; Emms, Elizabeth; Scammell, Toni (HPCT-SE); Harriman, Sue; Tiller, Sara; Julie Dean; Code A Long Susannah - Business Assurance Manager; Jeffs Justina - Associate Director of Governance; Code A Green Chris; Woodland, Betty (HPCT-SE); Benita Playfoot; Watson, Catherine (HantsPT-SW); Shirley, Pat (HantsPT-SW); Code A Code A Lesley Humphrey; Stuart Knowles
Cc: Wright Janet - PA to Head of Governance; rob.dalton@ports.nhs.uk; graham.groves@southcentral.nhs.uk; Lesley Humphrey
Subject: FW: Comms documents for circulation to the group ahead of the meeting
Attachments: FINAL GWMH Inquests Information Pack.doc; FINAL STAFF Comms pack Inquests (2).doc; FINAL SPOKESPEOPLE Comms Pack Inquests.doc

Sensitivity: Confidential

Follow Up Flag: Follow up
Flag Status: Flagged

Dear All

These papers were tabled at the meeting today, as I was on leave when they were sent to me last week. I am afraid that some copies that were tabled today were only printed on one side, and hence were missing half the pages. If you picked up copies at the meeting, you might like to check them, and print them again if you have a faulty copy.

Regards

Mary Deeks
Project Officer (GWMH)
Hampshire Primary Care Trust

From: Julie Dean [mailto: Code A
Sent: 26 February 2009 18:05
To: Deeks, Mary
Cc: Caroline Searle
Subject: Comms documents for circulation to the group ahead of the meeting
Sensitivity: Confidential

Dear Mary

Please find attached the finalised communications packs to circulate to the group ahead of the meeting on Monday.

The attached are all approved, I thought if everyone has have them via email in advance then I don't need to kill so many trees by printing copies for everyone for the meeting.

- Spokespeople Comms pack
- Inquest Information Pack for media
- Staff Comms Pack

The spokesperson's pack also contains our communications policy for dealing with media enquiries.

Kind regards

Julie

Julie Dean
Senior Consultant
Trimedia UK
30 Carlton Crescent, Southampton, SO15 2EW
Switch: +44 (0)23 8038 2970
Direct: Code A
Mobile: Code A
Email:

Holmes World Report: Best Multicountry Agency to Work For
European Excellence Awards: PR Company of the Year

NHS South Central

MEDIA INTEREST ALERT

You must use this form to alert the SHA to issues which are likely to be of more than passing interest to local or national media. Please include actual and potential media issues. Send the form to the South Central SHA comms team at comms@southcentral.nhs.uk. Please note this form may be used to brief the SHA Executive team and the DH. *Please ensure all available information is included and provide updates as required.*

Name of NHS Organisation: NHS Hampshire	**Date of Incident :** January 18 to 29, 2010 **Date Submitted :** January 5, 2010	**Interested media :** BBC TV and Radio (national and local) Channel 4 The Independent The Portsmouth News	**Date due to air/print :**

Details of Incident :

The GMC Fitness to Practice Panel that is considering the case of Dr Jane Barton is due to reconvene on January 18, 2010 for two weeks. The last public session of the Panel was on August 20, 2009 when it announced its findings so far and that the case would be adjourned as there was only one day left in the Panel diaries at that time.

The first two days have been assigned as reading days for the Panel with the first session held in public scheduled for Wednesday, January 20, 2010.

Background:

The case is being considered by a Fitness to Practise Panel applying the GMC Professional Conduct Committee Rules 1988.

The hearing began on Monday, June 22, 2009 with 15 detailed charges relating to 12 patients being read. Eight of these patients were covered by the inquests - Elsie Devine, Robert Wilson, Ruby Lake, Enid Spurgeon, Arthur Cunningham, Leslie Pittock, Helena Service and Sheila Gregory. Four are new cases - Gladys Richards (this case will be subject to an inquest later in the year), Jean Stevens, Eva Page and Alice Wilkie.

Dr Barton immediately admitted a number of elements of the charges – most notably that in 11 cases 'her actions in prescribing (some but not all) of the drugs were potentially harzardous'; that in 11 cases 'the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs'; in 10 cases that 'the dose range was too wide' and that notes in all cases were inadequate.

The GMC Panel held a public session on August 20, 2009 to announce its findings on facts. It has been determined that the facts are sufficient to support a finding of serious professional misconduct – 'the Panel has made multiple findings that Dr Barton's conduct has been inappropriate, potentially hazardous and/or not in the best interests of her patients. It has concluded that the facts found proved (both admitted and otherwise) would not be insufficient to support a finding of serious professional misconduct.'

Next steps

The Panel will invite Counsel for the GMC to adduce evidence, if he wishes to do so, as to the circumstances leading up to the facts which have been found proved, the extent to which those facts indicate serious professional misconduct on Dr Barton's part and as to her character and previous history. The Panel will then invite Counsel for Dr Barton to address it on her behalf in relation to those matters and also to adduce evidence in mitigation, if he wishes to do so.

The Panel will then proceed to consider whether Dr Barton has been guilty of serious professional misconduct in respect of the facts that have been found proved and, if so, they will go on to consider whether or not they should make any direction regarding her registration.

Action taken:

NHS South Central

MEDIA INTEREST ALERT

A handling plan has been put in place which updates the arrangements which were put in place during August 2009. This includes:

- Making contact with interested media to see what their plans are and to re-establish contact with the journalists who will be covering the Hearing.
- Diary planning to ensure communications team attendance on key days.
- Ensuring other Trust communications teams are briefed.
- Daily liaison with the GMC Press Office once the Hearing reconvenes.
- Identifying prospective parliamentary candidates so they can be briefed if necessary.
- Briefing the chair of the Hampshire Overview and Scrutiny Committee.
- Refreshing the Q&A which was prepared for the use by the communications team.
- Sharing the prepared statement with key staff (CEO, SHA, etc).
- Ensuring communications teams of Portsmouth Hospitals NHS Trust, Hampshire Community Health Care and Hampshire Partnership Foundation NHS Trust and modern matrons brief current staff at Gosport War Memorial Hospital.

Your response to media :

Before the Panel reaches a decision we will not comment on the Hearing as it is ongoing. We will answer questions about fact as required (ie current services at the Hospital).

A media statement was approved by our legal advisers and the SHA in preparation for August 2009. This statement will be used once the Panel has announced its decision.

Additional Notes: (e.g. details of further actions required)

Contact Details:

Senior person dealing with incident : Sara Tiller, associate director of communications and engagement

Media alert submitted by : Elizabeth Harris, communications and engagement adviser

NHS South Central

MEDIA INTEREST ALERT

You must use this form to alert the SHA to issues which are likely to be of more than passing interest to local or national media. Please include actual and potential media issues. Send the form to the South Central SHA comms team at comms@southcentral.nhs.uk. Please note this form may be used to brief the SHA Executive team and the DH. *Please ensure all available information is included and provide updates as required.*

Name of NHS Organisation:	**Date of Incident :**	**Interested media :**	**Date due to air/print :**
NHS Hampshire	January 18 to 29, 2010 **Date Submitted :** January 5, 2010	BBC TV and Radio (national and local) Channel 4 The Independent The Portsmouth News	

Details of Incident :

The GMC Fitness to Practice Panel that is considering the case of Dr Jane Barton is due to reconvene on January 18, 2010 for two weeks. The last public session of the Panel was on August 20, 2009 when it announced its findings so far and that the case would be adjourned as there was only one day left in the Panel diaries at that time.

The first two days have been assigned as reading days for the Panel with the first session held in public scheduled for Wednesday, January 20, 2010.

Background:

The case is being considered by a Fitness to Practise Panel applying the GMC Professional Conduct Committee Rules 1988.

The hearing began on Monday, June 22, 2009 with 15 detailed charges relating to 12 patients being read. Eight of these patients were covered by the inquests - Elsie Devine, Robert Wilson, Ruby Lake, Enid Spurgeon, Arthur Cunningham, Leslie Pittock, Helena Service and Sheila Gregory. Four are new cases - Gladys Richards (this case will be subject to an inquest later in the year), Jean Stevens, Eva Page and Alice Wilkie.

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Senior person dealing with incident : Sara Tiller, associate director of communications and engagement

Media alert submitted by : Elizabeth Harris, communications and engagement adviser

Media coverage from Dr Jane Barton's GMC hearing

Date	Media	Link	Opening line
Friday, August 21	Daily Mail	Doctor who gave lethal doses of painkillers to 12 elderly patients faces being struck off	A doctor who gave lethal cocktails of painkillers to 12 elderly hospital patients could be struck off after she was found guilty yesterday by the General Medical Council.
	Portsmouth News	Dr Jane Barton's conduct was 'inappropriate'	A doctor who prescribed 'potentially hazardous' levels of drugs to elderly patients moved a step closer to being struck off today.
	Portsmouth News	Dr Jane Barton could be struck off as panel slams her drug doses	Relatives have welcomed damning proof which could lead to the doctor at the centre of elderly patient deaths at Gosport War Memorial Hospital being struck off.
	Telegraph	Doctor facing disciplinary action over drug prescriptions	Dr Jane Barton, who prescribed "potentially hazardous" levels of drugs to elderly patients at Gosport War Memorial Hospital, could be struck off after she was found guilty of recklessly prescribing the powerful painkillers.
	Metro	'Dangerous' doctor still fine to work	The families of 12 patients who died in the 1990s face another delay to find out if the doctor who recklessly prescribed them powerful painkillers will be struck off.
Thursday, August 20	Daily Echo	Dr Jane Barton closer to being struck off after Gosport War Memorial allegations	A doctor who prescribed "potentially hazardous" levels of drugs to elderly patients moved a step closer to being struck off today.
	Telegraph	Doctor faces being struck off over painkiller prescriptions	A doctor faces being struck off after prescribing overdoses of powerful painkillers to 12 elderly patients who died in her care.
	BBC News	Doctor's conduct 'inappropriate'	The conduct of a doctor in the treatment of 12 elderly patients was inappropriate and possibly potentially hazardous, a panel has ruled.
Wednesday, August 19	No coverage		
Tuesday, August 18	No coverage		
Monday, August 17	No coverage		
Sunday, August 16	No coverage		
Saturday, August 15	No coverage		
Friday,	No coverage		

August 14			
Thursday, August 13	No coverage		
Wednesday, August 12	No coverage		
Tuesday, August 11	No coverage		
Monday, August 10	No coverage		
Sunday, August 9	No coverage		
Saturday, August 8	No coverage		
Friday, August 7	No coverage		
Thursday, August 6	No coverage		
Wednesday, August 5	No coverage		
Tuesday, August 4	No coverage		
Monday, August 3	No coverage		
Sunday, August 2	No coverage		
Saturday, August 1	No coverage		
Friday, July 31	Portsmouth News	Dr Jane Barton described as 'excellent GP'	The doctor at the centre of elderly deaths at a hospital was always 'careful and considerate to patients', a hearing was told.
Thursday, July 30	Portsmouth News	Expert says drug doses 'reasonable'	Powerful drug doses prescribed to elderly patients by a doctor have been defended by a world leading cancer expert.
Wednesday, July 29	No coverage		
Tuesday, July 28	No coverage		
Monday, July 27	No coverage		
Sunday, July 26	Independent	Gosport doctor denies putting patients on 'terminal pathway'	Dr Jane Barton, who is at the centre of nearly 100 suspicious deaths at the hospital between 1995 and 1999, denied she put patients on a "terminal pathway". ...
Saturday, July 25	Portsmouth News	Doctor: No regrets about medication	The doctor at the centre of the deaths of 12 elderly patients at a hospital has 'no regrets' about the medication they received, a panel heard.
Friday, July 24	No coverage		
Thursday, July 23	No coverage		
Wednesday, July 22	No coverage		

Tuesday, July 21	No coverage		
Monday, July 20	No coverage		
Sunday, July 19	Independent	Doctor defends drugs policy at deaths hospital	GMC Gosport hearing told: 'I was aiming to ensure the maximum comfort and dignity for my patients'
Saturday, July 18	Portsmouth News	GP: I wouldn't change the way I treated dead patient	A DOCTOR said she wouldn't change the treatment of an elderly patient whose death sparked a police investigation, a panel heard.
Thursday, July 16	BBC South	Accused doctor gives GMC evidence	Dr Jane Barton, who is accused of prescribing excessive amounts of drugs to patients at Gosport War Memorial Hospital, has been giving evidence at a disciplinary hearing.
Wednesday, July 15	BBC Berkshire	Accused doctor gives GMC evidence	Dr Jane Barton, who is accused of prescribing excessive amounts of drugs to patients at Gosport War Memorial Hospital, has been giving evidence at a ...
Tuesday, July 14	No coverage		
Monday, July 13	No coverage		
Sunday, July 12	Independent	Doctor prescribed sedatives 'for no reason'	Professor Ford was called as an expert witness by the GMC as part of its inquiry into allegations of professional misconduct against Dr Jane Barton related .
Saturday, July 11	No coverage		
Friday, July 10	No coverage		
Thursday, July 9	No coverage		
Wednesday, July 8	No coverage		
Tuesday, July 7	Mail on Sunday	Female doctor 'overmedicated elderly patients with cocktails of ...	Dr Jane Barton allegedly overmedicated patients with 'cocktails' of drugs at the Gosport War Memorial Hospital in Portsmouth in the 1990s. ...
	Telegraph	Hospital doctor 'hastened the death of elderly patient' with ...	Dr Jane Barton faces being struck off over allegations that she over-medicated a total of 12 patients with cocktails of drugs at the ...
Monday, July 6	BBC South Today	GMC panel shown painkiller device	A doctor's panel at a hearing looking into the actions of a doctor accused of serious professional misconduct at Gosport War Memorial Hospital has been shown a device used to give the painkiller diamorphine to patients who

			died there.
	Portsmouth News	Dr Jane Barton to face GMC hearing	Dr Jane Barton to face GMC hearing - The GP at the centre of the Gosport War Memorial Hospital inquests is to appear before the General ...
Sunday, July 5	No coverage		
Saturday, July 4	No coverage		
Friday, July 3	Portsmouth News	GP's care for elderly 'generally sensible'	The doctor accused of misconduct over the deaths of 12 elderly hospital patients has been praised for her standard of care
Thursday, July 2	No coverage		
Wednesday, July 1	No coverage		
Tuesday, June 30	No coverage		
Monday, June 29	Independent	Nurses who blew whistle on drugs 'driven out of jobs'	The panel is inquiring into allegations of professional misconduct against Dr Jane Barton in relation to the treatment and death of 12 elderly patients in ...
Sunday, June 28	No coverage		
Saturday, June 27	No coverage		
Friday, June 26	Portsmouth News	I quit over prescription of drugs, says nurse	Mrs Holman told a hearing in London that she had launched the hospital's official grievance procedure against Dr Jane Barton and Sister Gill Hamblin.
Thursday, June 25	No coverage		
Wednesday, June 24	No coverage		
Tuesday, June 23	No coverage		
Monday, June 22	BBC South Today		
Sunday, June 21	No coverage		
Saturday, June 20	No coverage		
Friday, June 19	No coverage		
Thursday, June 18	Portsmouth News	Unrousable patients 'the norm' after painkillers	Dr Barton's fitness to practise is being assessed by a five-strong panel from the GMC after the death of 12 patients at the hospital in the late 1990s. ...
Wednesday, June 17	No coverage		

Tuesday, June 16	Portsmouth News	Man's relative told doctor she was murderer	Charles Stewart-Farthing said he had asked Dr Jane Barton to remove a syringe driver – an automatic pump for giving drugs – from 69-year-old Arthur ...
Monday, June 15	BBC South Today	**DOCTORS PANEL HEARS FAMILY OF PATIENT AT GOSPORT WAR MEMORIAL HOSPITAL**	The family had asked for drugs to be stopped so that they could hear his final wishes. The GMC heard that Brian Cunningham had been given diamorphine and was unconscious. Dr. Jane Barton faces a charge of serious medical misconduct in her treatment of twelve patients.
Sunday, June 14	No coverage		
Saturday, June 13	Portsmouth News	GP 'didn't tell me mum was dying'	The doctor at the centre of deaths at Gosport War Memorial Hospital has been accused of telling a woman what would be written on her mother's death certificate before even breaking the news that she was dying.
	Independent	Doctor to face hearing over patient deaths	If found guilty, Jane Barton, who was the senior doctor in charge at the Gosport War Memorial Hospital, may be struck off the medical register. ...
Friday, June 11	Portsmouth News	'Nurses can confirm death' – Doctor's note on woman, 84	An elderly woman, described as 'well and comfortable' the day before she was sent to a Gosport hospital, had a note written on her records on arrival saying a doctor was happy for nurses to confirm her death.
Thursday, June 11	Southern Daily Echo	Daughter weeps as court hears of mother's hospital treatment	THE daughter of an elderly patient wept today as she described her mother's treatment by a Hampshire doctor accused of over prescribing painkillers and sedatives to elderly patients.
	Portsmouth News	'Doctor told my mum: It won't be long now...'	A daughter claims her mother died hours after being given a cocktail of drugs at the Gosport War Memorial.
	BBC News	Drug case told of woman's decline	Dr Jane Barton is accused of serious professional misconduct in treating 12 patients at Hampshire's Gosport War Memorial Hospital (GWMH) in the 1990s. ...
	Daily Mail	'It won't be long now': Chilling words of doctor who 'killed 12 ...	Dr Jane Barton's patient Alice Wilkie, 81, was admitted to Gosport War Memorial Hospital in Hampshire for rehabilitation but within two weeks she was dead. ...

Wednesday, June 10, 2009	Portsmouth News	Doctor Jane Barton admits drug mistakes	The doctor at the centre of a probe into the deaths of elderly patients at Gosport War Memorial Hospital has admitted she made mistakes.
	Portsmouth News	Dr Jane Barton gave patients drugs to 'keep quiet' - Portsmouth Today	Dr Jane Barton gave patients drugs to 'keep quiet' - An elderly patient of a doctor accused of over-prescribing painkillers and sedatives was dosed up with opiates to 'keep quiet', a disciplinary panel heard today.
	Daily Mail	Doctor accused over death of 12 elderly patients who were 'over-sedated and left in comas'	Twelve elderly patients died after being over-prescribed painkillers and sedatives by the same doctor, a disciplinary hearing was told yesterday.
	Press Association	Doctor admits over-prescribing	A doctor accused of over-prescribing painkillers and sedatives to elderly patients has made a series of admissions to a disciplinary hearing. Dr Jane Barton ...
Tuesday, June 9, 2009	Nursing Times	Hearing to look at fatal over-prescribing of painkillers	Dr Jane Barton faces a General Medical Council hearing over the alleged over-prescription of painkillers after five patients died at the Gosport War ...
	BBC News	Patients in 'drug-induced comas'	Dr Jane Barton is accused of a series of failings in her treatment of 12 patients at Hampshire's Gosport War Memorial Hospital in the late 1990s. ...
	Daily Telegraph	Patients died after doctor prescribed 'potentially hazardous' doses	A former hospital doctor has admitted prescribing "potentially hazardous" doses of painkillers to elderly patients who later died at the Gosport War Memorial Hospital.
	TeleText Scotland	Doctor faces dosage probe	Dr Jane Barton was in charge of care at Gosport War Memorial Hospital when the patients died in the early 1990s. A General Medical Council panel will look ...
	BBC Radio Solent		
Monday, June 8, 2009	Channel 4 News	Doctor faces hearing on NHS deaths	Now Dr Jane Barton, who was in charge of care at the Hampshire hospital at the time of the deaths in the late 1990s, is to face a General Medical Council ...
	The Guardian	Pressure grows for inquiry into deaths of elderly patients at ...	Jane Barton, who worked with elderly patients at Gosport War Memorial hospital, ... order on Barton, the main doctor in charge of two wards at the hospital, ...

	Portsmouth News	Dr Jane Barton to face General Medical Council hearing ...	Dr Jane Barton to face General Medical Council hearing - The doctor in charge of care at a Hampshire hospital where medication contributed to the death of five patients is to face a fitness to practise hearing today for alleged ...
	Southern Daily Echo	Hampshire doctor admits mistakes over drugs	A HAMPSHIRE doctor accused of over-prescribing painkillers and sedatives to elderly patients made a series of admissions to a disciplinary hearing today.
	Portsmouth News	Dr Jane Barton admits over-prescribing drugs	Elderly patients were left in 'drug-induced comas' after being over-prescribed painkillers and sedatives by a Gosport doctor, a disciplinary panel heard.
	BBC South Today		
	BBC Radio 2		
	Wave 105		

NHS Hampshire

Gosport War Memorial Hospital Patient Inquests

Media Briefing Pack

Office hours Communications Team numbers

Hampshire PCT Communications Team: 023 8062 7434

Other contacts:

Royal College of Nursing

Helen Wigginton (SE Press officer) Code A

National press office: 0207 647 3633

Contents

NHS Hampshire

1. Gosport War Memorial Hospital Inquests

HM Coroner has ordered inquests into the deaths of ten patients at Gosport War Memorial Hospital (GWMH) from 1996 – 1999.

The inquest is concerned with the deaths of people who were in-patients on Dryad and Daedalus wards at GWMH.

The inquests are scheduled for six weeks from 18th March 2009 and ten separate verdicts will be delivered at the close of proceedings. The coroner is A.M. Bradley, HM Assistant Deputy Coroner Portsmouth and South East. The inquests will take place at Portsmouth Combined Court, Winston Churchill Avenue, Portsmouth.

Listed Inquests:

- Leslie Pittock (died 24/01/96) Dryad Ward - aged 83
- Elsie Lavender (06/03/96) Daedalus Ward - aged 84
- Robert Wilson (died 18/10/96) Dryad Ward - aged 73
- Helena Service (died 05/06/97) Dryad Ward - aged 99
- Ruby Lake (died 21/08/98) Dryad Ward - aged 85
- Arthur Cunningham (died 26/09/98) Dryad Ward - aged 79
- Enid Spurgeon (died 13/04/99) Dryad Ward - aged 92
- Geoffrey Packman (died 03/09/99) Dryad Ward - aged 68
- Elsie Devine (died 21/11/99) Dryad Ward - aged 88
- Sheila Gregory (died 22/11/1999) Dryad Ward - aged 91

NHS Hampshire

2. Timeline of key events

- In 1998 the police undertook an investigation into the death of a patient whose family were not happy about the circumstances of their death at Gosport War Memorial Hospital (GWMH). This death will be the subject of a separate inquest.
- In March 1999 the Crown Prosecution Service (CPS) decided that there was insufficient evidence to bring a successful prosecution.
- In 1998 there was a complaint to the NHS Commissioner (Ombudsman) about the care of a different patient. This death is not the subject of an inquest.
- In 2001 there was an independent NHS review panel into the care of a third patient which was subsequently referred to the NHS Commissioner. The Commissioner concluded that the prescribing was appropriate in the circumstances. This death is the subject of an inquest.
- In 1999 following publicity surrounding the initial investigation, the Police looked at the notes of four more patients who had died at GWMH. Two of these deaths are the subject of inquests, Arthur Cunningham, and Robert Wilson. In February 2002 the police decided there was no evidence for a prosecution and they were not going to investigate further.
- In the course of their investigation the Police alerted the Commission for Health Improvement (CHI) in August 2001 and CHI commenced an investigation in October 2001.

CHI

  - In July 2002 CHI published a report with recommendations.
  - In November 2002 Fareham and Gosport and East Hampshire PCTs produced a joint action plan to address the recommendations made in the CHI report.
  - In January 2004 the Fareham and Gosport Clinical Governance group took over responsibility for overseeing the CHI action plan and ensuring objectives were met.

- In September 2002 the Police began a third investigation into the deaths of patients at GWMH.
- In October 2006 Portsmouth Hospitals NHS Trust took over the management of services for Medicine for Older People throughout South East Hampshire including those provided at Gosport War Memorial Hospital.
- Following detailed investigation which included expert reports the Police handed the outcome of their investigation into ten deaths to the CPS in July 2006.
- In October 2007 the CPS concluded that there was insufficient evidence to prosecute any health care staff.
- This Police report was passed to HM Coroner in early 2008.
- Following discussion with the Police and representation from families of the deceased, the Coroner met with the Minister for Justice, the Department of Health and the Assistant Chief Constable in August 2007 to discuss the potential of opening inquests on 10 cases.

- Following this meeting the Coroner (SE Area) opened and adjourned Inquests on 10 named cases in May 2008.

3. Details of investigations

Background

In 1996 GWMH was run by Portsmouth Healthcare NHS Trust (a predecessor of PCTs and a separate organisation from Portsmouth Hospitals NHS Trust).

In April 2002 responsibility for the services transferred to Fareham and Gosport PCT and East Hampshire PCT.

In April 2006 responsibility for Dryad and Daedalus wards and the employment of the nursing and medical staff transferred to Division of Medicine for Older People (DMOP) at Portsmouth Hospitals NHS Trust.
Nursing staff on Sultan Ward transferred to Hampshire PCT and Hampshire Partnership NHS Trust took over responsibility for Older People's Mental Health Services in Ark Royal and Collingwood wards.

In line with national guidance the mental health service was transferred to Dryad and Daedalus wards on the ground floor in Feb 2008.

Early Police investigations

Between 1998 and 2002, Hampshire Constabulary undertook two investigations into the potential unlawful killin of patients at Gosport War Memorial Hospital.

These investigations did not result in any criminal prosecutions, but the police shared their concerns about the care of older people at Gosport War Memorial Hospital (GWMH) with the then Commission for Health Improvement (CHI) (a fore-runner of the Healthcare Commission) in August 2001. These concerns centred on the use of some medicines, particularly analgesia and levels of sedation, and the culture in which care was provided for older people at the hospital.

Commission for Health Improvement investigation

In 2001, CHI commenced an investigation into the management, provision and quality of healthcare at Gosport War Memorial Hospital managed by Portsmouth Healthcare NHS Trust (the predecessor of the then Fareham and Gosport PCT and East Hampshire PCT and a different organisation to Portsmouth Hospitals NHS Trust).

NHS Hampshire

On 1st October 2006, responsibility for the provision of inpatient care at GWMH transferred to Portsmouth Hospitals NHS Trust as part of a service reorganisation involving both elderly medicine and elderly mental health services in the area.

CHI concluded that in the late 1990s there had been a failure of Portsmouth Healthcare NHS Trust's systems t ensure good quality patient care, including insufficient local prescribing guidelines, lack of a rigorous, routine review of pharmacy data, and the absence of adequate Trust-wide supervision and appraisal systems.

CHI also concluded that by the time of their investigation, in 2002, the successor PCTs had addressed these. CHI reported that the reconfigured PCTs (Fareham and Gosport PCT and East Hampshire PCT) had adequate policies and guidelines in place governing the prescription and administration of pain relieving medicines to old patients and that these policies and procedures were being adhered to.

Outcome of the final Police investigation

The publicity accompanying the announcement of the findings of the CHI investigation prompted a number of relatives of patients who had died at GWMH to contact the Hampshire and Isle of Wight Strategic Health Authority regarding the care and treatment of their relatives between 1998 and 2001. Following these contacts the police initiated another investigation into the deaths of patients at GWMH in September 2002.

Following detailed investigation and expert reports ten cases were passed to the Crown Prosecution Service (CPS) for review once the police investigation was complete. The CPS concluded that there was insufficient evidence to prosecute and that there was no realistic prospect of any conviction.

Following the CPS' decision, the police met with the General Medical Council (GMC), the Nursing and Midwifer Council (NMC) and H.M. Coroner to determine whether general 'standard of care' issues in respect of the deaths required further examination. The Police, however, reiterated that their investigation was now closed.

Coroner

Following the meeting with the Police and representation from families of the deceased, the Coroner met with the Minister for Justice, the Department of Health and the Assistant Chief Constable to discuss the potential of opening inquests on 10 cases. Following this meeting the Coroner (SE Area) opened and adjourned Inquests on 10 named cases. The Coroner held a pre-inquest review meeting with the families in August 2008. No NHS representation occurred at the pre-inquest review as the invitation did not reach the appropriate people within the NHS.

The Coroner has announced that he intends to conduct separate inquests into each death, and has set aside six weeks for the inquests to take place. Verdicts into each death will be reached when all inquests have been concluded.

General Medical Council (GMC) and Nursing and Midwifery Council (NMC)

The Police forwarded papers to the General Medical Council and Nursing and Midwifery Council and each organisation is undertaking its own inquiries.

4. What happens at the Hospital now?

Since the time of these deaths over ten years ago and the subsequent CHI review in 2002 much has changed at Gosport War Memorial Hospital, in line with developments in clinical practice across the country.

1991 saw the commencement of a £10.5 million, two-phase development which was complete in 1995. This was followed by a £6m redevelopment in the last year.

The Hospital now houses:

- 20 bed GP ward
- 32 beds for older peoples' mental health
- 35 beds for stroke and general rehabilitation
- Blake birth centre
- Physiotherapy department
- Two day hospitals for older people
- X-ray and ultrasound
- Red Cross
- Minor injuries unit
- Endoscopy unit
- Community health clinics
- GP Out of Hours Service

By the time of the CHI investigation in 2002 the regulator was satisfied that GWMH had adequate policies and guidelines in place governing the prescription and administration of pain relieving medicines to older patients and that these policies and procedures were being adhered to. This remains the case and there have been no incidents subsequently which have required external investigation by CHI or its successor the Healthcare Commission or the Police.

Policies and procedures at the Hospital are reviewed regularly and staff receive mandatory training every year. Details of the policies in place on Sultan ward can be found at:

NHS Hampshire

http://www.hampshirepct.nhs.uk/index/documents/policies-home/policies-clinical.htm
Details of policies in place on Ark Royal and Collingwood wards are available from Portsmouth Hospitals NHS Trust on request.

The Patient Environment Action Team inspection last year rated the Hospital as good on cleanliness, excellent for food and good for privacy and dignity. Patient experience surveys are conducted regularly and feedback is very positive, with comments including 'privacy and dignity is well respected' and 'cleanliness impeccable'.

There were six complaints for the whole of the Department of Medicine for Older people, Stroke and Rehabilitation last year (this includes GWMH and QAH) and five for the other wards at GWMH. All complaints are taken very seriously and investigated internally in line with the PCT and Trust's complaints policy. All complaints in 2007/2008 were resolved locally.

The Hospital also receives many thanks and compliments from patients and their families, with over 200 cards and letter last year.

Staff at the Hospital received a Chairman's award from Portsmouth Hospitals NHS Trust Chairman in 2007 for their professionalism and dedication.

In 2008 Portsmouth Hospitals NHS Trust's modern matron at GWMH received a Clinical Governance Award from the Trust's Patient Experience Council. This award of £9773 contributed to the installation of cushioned floor in both wards, to minimize injury if a patient should experience a fall during rehabilitation.

In February 2009 Ark Royal, Collingwood and Sultan wards have benefitted from anti microbial curtains and new bedside lockers and tables which are much easier to clean. Overhead hoists are available over every bed and in bathrooms and the Trust have increased call bells in day room areas enhancing patient safety.

In 2008/09 Portsmouth Hospitals NHS Trust was independently assessed as providing an 'excellent' quality of services by the Healthcare Commission (formerly CHI).

NHS Hampshire

5. Questions and Answers

Q. What is the purpose of an Inquest?

A. The purpose of an inquest is for the coroner to determine how an individual met his/her death, the cause/ nature of the death and the circumstances around that person's death.

Q. What is this inquest concerned with?

A. 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 following one complaint made by a relative in 1998.

Q. Isn't it rare to have an inquest 10 years after the death of a person and in the absence of a body or post mortem reports?

A. Yes it is. The decision to conduct these inquests was taken by the Coroner following representation from families of the deceased and a meeting with the Minister for Justice, the Department of Health and the Assistant Chief Constable.

Q. Why has an inquest into these deaths been called when the police investigations found no evidence of wrong doing?

A. The police investigations focused on whether there was any evidence of criminality with respect to patient deaths at Gosport War Memorial Hospital. The purpose of an inquest is to determine how a person met their death and potentially the circumstances surrounding that death.

Q. Were any staff disciplined as a result of the police investigations?

A. No. At the time two senior members of management were redeployed for six months, while internal investigations took place. However both internal investigations and the CHI review concluded that there was no evidence to suggest that any individual should be disciplined and the staff members returned to their substantive posts.

Q. What measures have been put in place since these incidents?

Following the CHI investigation in October 2001, CHI concluded that the PCTs had addressed the issues raised and had put in place adequate policies and guidelines governing the prescription and administration of pain relieving medicines to older patients and that these policies and guidelines were and are being adhered to.

Four NHS organisations providing services in the south east Hampshire area have also undertaken their own more recent reviews of compliance with the recommendations CHI made. The Board of each

organisations has received assurances that all policies are correct and current and that the quality of care being provided is of the highest standard and in line with modern Clinical Governance standards. Assurances have also been provided to South Central Strategic Health Authority (SHA) as the organisation responsible for monitoring quality within organisations in its area. The SHA will in turn will provide assurance to the Department of Health.

Since the deaths at GWMH all NHS organisations now work to modern clinical governance standards which require risk management systems and clinical audit departments. These are integral to the delivery of health services in a modern NHS and have been part of NHS evolution over the last decade.

Q. What is CHI?

A. CHI – is the Commission for Health Improvement. This organisation was replaced by the Healthcare Commission (in April 2004). The Healthcare Commission is the independent watchdog for healthcare in England. It assesses and reports on the quality and safety of services for patients and the public. From April 2009 a new "super-regulator", the Care Quality Commission will combine the functions of the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission.

Q. What is Clinical Governance?

A. Clinical Governance is essentially a term used to describe the way the NHS manages the delivery of health services within a structure of accountability and responsibility. It is intended to ensure that clinical care is delivered on the basis of agreed standards and that outcomes are measured against these standards of care.

NHS Hampshire

6. Organisation structure in South East Hampshire 1994 – present

Organisational Structure

- Portsmouth Healthcare NHS Trust managed the Department of Medicine for Elderly People from April 1994 until March 2002 when it was dissolved. Portsmouth Healthcare NHS Trust was a predecessor of PCTs and a separate organisation from Portsmouth Hospitals NHS Trust.
- In April 2002 responsibility for the services transferred to Fareham and Gosport PCT and East Hampshire PCT.
- In October 2006 responsibility for Dryad and Daedalus wards and the employment of the nursing and medical staff transferred to Division of Medicine for Older People (DMOP) at Portsmouth Hospitals NHS Trust.
- At the same time nursing staff on Sultan Ward transferred to Hampshire PCT and Hampshire Partnership NHS Trust took over responsibility for Older People's Mental Health Services in Ark Royal and Collingwood wards.

* Portsmouth Healthcare NHS Trust is not the same organisation as Portsmouth Hospitals NHS Trust