From: McKinney, Emma Code A
Sent: 31 July 2013 15:40
To: Renyard, Jenny (Southern Health)
Subject: FW: GWMH - THE BAKER REPORT
Attachments: GosportProfBakerReport31July.doc

Categories: Urgent

Hi Jen, forwarding for info for on call. Gethin has agreed with Sara Tiller and Richard Samuel that NHS England will lead on the response so Graham Groves might be busy!

Em

From: Hetherington, Gerard [mailto: Code A
Sent: 31 July 2013 15:28
To: McKinney Emma - Head of External Communications
Cc: Bliss Nicola
Subject: GWMH - THE BAKER REPORT

Emma

We spoke about the Department of Health's intention to release Professor Richard Baker's review into Deaths at GWMH between 1988 and 2000 which was commissioned by the CMO in 2002 and completed in 2003. The full content of the report will be placed on the DH website on Friday 2 August.

The report is likely to attract media interest locally, and possibly nationally. DH has prepared some reactive lines to hold against possible press inquiries.

I said I would share with you a briefing note I have prepared for colleagues in NHS England and Monitor. This is set out below.

We have made Professor Baker aware that his report is about to be published and also Sir Liam Donaldson the CMO who commissioned it. I have also informed Dr Jane Barton through her solicitor. I am also making arrangements to contact Hampshire Police and the Portsmouth Coroner to let them know the report is to be made public.

I am also attach, under strict embargo, a copy of Professor Baker's report.

Gerard

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BRIEFING NOTE FOR NHS ENGLAND AND MONITOR

I am e-mailing to let you know that the Department of Health intends releasing on Friday 2 August the report of a review into patient deaths at Gosport War Memorial Hospital (GWMH) between

1988 and 2000.The review by Professor Richard Baker of Leicester University was commissioned in 2002 by the then CMO Liam Donaldson. Publication has been delayed for many years because of legal proceedings.

In the late 1990s, a higher number of elderly patients than might have been expected died in certain wards at Gosport War Memorial Hospital (GWMH). Dr Jane Barton a local GP worked as a clinical assistant at the hospital at the time and some of her actions and prescribing practices came under suspicion. Starting in 1998, there were various police investigations with subsequent referrals to the Crown Prosecution Service, which decided that there was insufficient evidence to prosecute. In June 2002, the Commission for Health Improvement published a report into GWMH indicating that there were no current concerns about prescribing practices.

Professor Baker's review presents an audit of care drawing upon clinical records, medical certificates of cause of death, admissions books, and controlled drugs registers and the work of a sample of GPs. The review concluded that "a practice of almost routine use of opiates had been followed in the care of patients of the Department of Medicine for Elderly People at Gosport Hospital…" and that "…the practice almost certainly had shortened the lives of some patients and that it cannot be ruled out that a small number of these would have eventually been discharged from hospital alive." However, the report also stated that "…the findings tend to indicate that the finding of a statistical excess of deaths among patients admitted to Gosport would be unlikely."

Professor Baker's report made 5 recommendations:

1) Investigations should continue into the deaths of individual patients

2) In the continuing investigation into deaths at Gosport Hospital information about the rota followed by Dr Barton and her partners should be obtained and used to explore the pattern of deaths

3) Hospital teams who care for patients at the end of life should have explicit policies on the use of opiate medication

4) The findings in this review should not be used to restrict the use of opiate medication to those patients who need it.

5) Hospital episode statistics are an important resource but continued monitoring of the outcomes achieved by clinical teams requires a more detailed set of codes.

These recommendations have mainly been overtaken by events. The police investigations and inquests have been concluded without any charges being brought. Procedures for the use of Controlled Drugs were addressed following Dame Janet's Smith's 4th report into the Shipman case; policies on palliative care have been addressed through the development of the End of Life Care strategy; and NICE issued guidelines on the use of opioids in 2012. Professor Baker's point on monitoring outcomes of clinical teams is being addressed by the development of the quality agenda which places increased emphasis on outcomes and increasing transparency.

Although completed in October 2003 and intended for publication, it has not been possible to release the report while police investigations, and other legal proceedings were in progress. An inquest was held into ten of the deaths in April 2009 and a final inquest into an 11th death was concluded in April 2013. There were no further legal proceedings following the conclusion of the inquest.

A General Medical Council (GMC) hearing into Dr Barton's fitness to practise ended early in 2010, deciding that she should not be struck off but that her continued registration should be subject to a series of conditions. The Council for Healthcare Regulatory Excellence considered the GMC's decision and concluded that, in its view, Dr Barton should have been struck off but that the

decision not to strike her off, although lenient, was not so unreasonable that it could be referred to the High Court. Dr Barton has now retired and has, at her own request, had her name removed from the medical register.

GWMH is now part of the Southern Healthcare NHS Foundation Trust which provides community and mental health services. Services at GMWH include a 20-bed GP ward, a 32-bed Elderly Mental Health ward, a rapid assessment service and various out-patient services.

The events at Gosport have attracted publicity over the years at both local and national level. There have been many requests for the publication of Professor Baker's report including under the Freedom of Information legislation. There have also been calls for a public inquiry.

The Department is planning to make the report available by putting the text on the DH website and letting those who have asked to see the report know that it is available. It is likely that the release of the report will attract coverage at least in the local media. We have prepared reactive lines which stress that the events described in the report took place many years ago and that much has changed since that time, and that a public inquiry would be unlikely to discover anything new.

Please contact me if you need any further information or to see the text of Professor Baker's report.
