Expert overview

A Professor Brian Livesley

The involvement of Professor Livesley in the police investigation

A1 During the early stages of the Operation Rochester investigation, Detective Chief Inspector (Det Ch Insp) Raymond Burt of Hampshire Constabulary identified Professor Brian Livesley as a medical expert who could potentially provide an opinion in relation to the case of Gladys Richards (HCO000635, p35). Professor Livesley was a consultant physician at Chelsea and Westminster Hospital (HCO000766, p6).

A2 On 22 November 1999, Det Ch Insp Burt wrote to Professor Livesley *"on the advice of the National Crime Faculty, in order to discover whether it would be appropriate to formally seek your assistance, as an expert witness, in connection with a case I am currently investigating".* The letter then set out *"a fairly detailed introduction to both the history of the Police investigation and the circumstances which gave rise to the allegation which has been made"* (CPS001669, p1).

A3 This was not a formal letter of instruction. Authority for Det Ch Insp Burt to formally instruct Professor Livesley would not be granted for another two weeks (HCO000768, p2). Instead, Det Ch Insp Burt's letter appears to be a form of general enquiry as to whether Professor Livesley might be able to assist in the police investigation. Professor Livesley was not provided with either the clinical notes in relation to the treatment of Mrs Richards or any witness statements that had been obtained. The letter relies heavily on a description of events provided by Mrs Richards' daughter Lesley Lack, derived from a draft witness statement that Mrs Lack had provided to Hampshire Constabulary. If Professor Livesley was going to be instructed by Hampshire Constabulary, it should have been as a suitably qualified clinician who would provide independent expert evidence on the standard of care provided to Mrs Richards. The form and content of Det Ch Insp Burt's letter risked prompting Professor Livesley to take a particular view of what had happened to Mrs Richards before he had the opportunity to consider the evidence.

A4 Det Ch Insp Burt requested that Professor Livesley advise him, asking: *"Is this case wherein you would be able, having had access to all available information, to offer an opinion as regard whether, or not, there is evidence to support criminal proceedings against any party to the care of Mrs Richards?"* (CPS001669, p7).

A5 This was an unfortunate question to ask of a medical practitioner in a formal letter of instruction, and as part of an initial enquiry in the absence of any consideration of the evidence. Professor Livesley should only have been asked questions concerned with the standard and propriety of the care provided to

Mrs Richards and her cause of death, not whether there was sufficient evidence to support a criminal prosecution.

A6 In January 2000, Professor Livesley met Det Ch Insp Burt and was provided with copies of draft witness statements made by Lesley Humphrey (Director of Quality at Portsmouth HealthCare NHS Trust), Gillian Mackenzie (Mrs Richards' other daughter) and Lesley Lack, as well as health records supplied by the Trust and medical records from the Royal Hospital Haslar ('Haslar Hospital') (HCO000769). Exhibits from these statements, which included further health records, were provided to Professor Livesley shortly afterwards (HCO000770, pp1–5). Professor Livesley sent Hampshire Constabulary a list of questions and requests for further material on 28 January (BLI000007, p2).

A7 On 8 March, Professor Livesley visited Gosport War Memorial Hospital ('the hospital') and Haslar Hospital with representatives of Hampshire Constabulary in order to *"visualise the locations mentioned in the medical records"* (HCO003491, p2). In advance of this visit, Hampshire Constabulary provided Professor Livesley with further documents relating to the treatment of Mrs Richards (HCO000774, pp2–5).

A8 The Panel has been unable to locate any formal letter of instruction to Professor Livesley from Hampshire Constabulary, and so he appears to have been reliant on the letter prepared by Det Ch Insp Burt in November 1999. The material provided to Professor Livesley included notes and commentary prepared by Lesley Lack and Gillian Mackenzie, and correspondence between them and Hampshire Constabulary. Professor Livesley was, therefore, being asked to provide an opinion on whether there was any criminality in relation to the treatment of Mrs Richards – an opinion that he was not qualified to provide.

A9 By 23 March, Professor Livesley was expressing the following view to the police: *"I am being led inexorably to the conclusion that I will be supporting an allegation of manslaughter in this case and supporting other allegations including assault and actual bodily harm"* (BLI000008, p1).

Professor Livesley's report on Gladys Richards dated 28 October 1999

A10 Professor Livesley prepared a draft report concerning the treatment of Mrs Richards at Haslar Hospital and Gosport War Memorial Hospital, dated 28 October 1999 (HCO000997, p23).

A11 The Panel considers this date to be incorrect. While Det Ch Insp Burt identified Professor Livesley as a potential expert on 20 October 1999, the first record of any contact between the two is the letter of 22 November 1999. It is noted that the draft report refers in detail to Mrs Richards' medical history. Professor Livesley was not provided with copies of her medical records until January 2000, and so it would have been impossible for him to prepare a report in October 1999. It is also noted that the report refers to witness statements from Mrs Lack and

Mrs Mackenzie (drafts of which were given to Professor Livesley in January 2000) and a witness statement from Lesley Humphrey dated 27 January 2000. The Panel considers that the actual date of this report is more likely to have been on or around 12 May 2000, which is when it appears to have been provided to Hampshire Constabulary (HCO000997, pp1–23).

A12 In this first draft of the report, Professor Livesley offered the following opinion:

> "It is most probable if not certain that the cause of Mrs Richards' death was respiratory depression as a consequence of the large doses of drugs she continuously received by syringe driver from 18th August 1998 until her death on 21st August 1998 and or the effects of dehydration." (HCO000997, p20)

A13 He concluded:

> "I would support an allegation of assault occasioning actual bodily harm by person or persons at present unknown and who were involved in the transfer of Mrs Richards from the Royal Hospital, Haslar to Daedalus ward at the Gosport War Memorial Hospital on 17th August 1998. I would also support an allegation of the criminal assault of Mrs Richards by Dr Barton and occasioned by Dr Barton's prescription of the drugs given by syringe driver. I would also support allegations of the criminal assault of Mrs Richards by the nursing staff involved in the administration of the drugs given by the syringe driver. I would also support an allegation of the unlawful killing of Mrs Richards by the gross negligence of Dr Barton and occasioned by Dr Barton's prescription of the drugs given by syringe driver. I would also support allegations of the unlawful killing of Mrs Richards by the gross negligence of the nursing staff involved in the administration of the drugs given to Mrs Richards by syringe driver. I recommend that additional enquiries be instituted to determine if other patients at the Gosport War Memorial Hospital have been affected in a manner similar to that of Mrs Richards." (HCO000997, p21)

A14 The conclusions Professor Livesley reached in relation to whether he would support criminal prosecutions of various offences are beyond those that would ordinarily be expressed by a medical expert.

Professor Livesley's report on Gladys Richards dated 9 November 2000

A15 On 9 November 2000, Professor Livesley wrote to Det Ch Insp Burt enclosing copies of his medical report on Mrs Richards. Professor Livesley commented that the report was headed *"Initial medical report for discussion only"* because *"I regard it as essential for me to discuss the matters arising with the CPS [Crown Prosecution*

Service], and preferably with experienced Counsel, before I produce a formal statement as an expert witness". He also expressed *"serious concern about what appears to have been a culture of inappropriate clinical practice on Daedalus ward"* at the hospital. He said in his cover letter: *"It appears probable, therefore, that this has been an institutionalised practice that may have led to the premature and unlawful death of other elderly people admitted to Daedalus ward at Gosport War Memorial Hospital"* (CPS001888, p1).

A16 In the 9 November report, Professor Livesley offered the following opinion: *"It is beyond reasonable doubt that the cause of Mrs Richards' death was a result of the drugs she was administered continuously by syringe driver from 18th August 1998 until her death on 21st August 1998."* He concluded that *"Mrs Richards was unlawfully killed by the continuous administration of drugs actively prescribed by Dr Barton"*, and that *"Mr Philip Beed, Ms Margaret Couchman, and Ms Christine Joice knowingly and continuously administered Diamorphine, haloperidol, Midazolam and Hyoscine to Mrs Richards when they should have recognised the fatal consequences of so doing"* (CPS001888, pp20–21).

A17 The offences of *"assault"* had been removed from the conclusions in this version of the report, as had the actions of the more generically named *"nursing staff"*. It is not clear to the Panel why Professor Livesley refined his report in this way.

Crown Prosecution Service review of material generated by Professor Livesley

A18 On 11 December 2000, Det Ch Insp Burt wrote to David Connor at the Crown Prosecution Service (CPS) in Portsmouth setting out the background to the *"Allegation of Unlawful Killing"* of Mrs Richards. Det Ch Insp Burt informed Mr Connor that *"All materials gathered during the Police investigation have been referred to Professor Livesley and his report is incorporated within this submission"* (CPS001896, p3). He also noted that Professor Livesley *"is quite clear in his opinion that Mrs Richards was unlawfully killed"* (p3). He communicated to Mr Connor Professor Livesley's desire *"to be afforded the opportunity of meeting a CPS representative or Counsel … in order to discuss the detailed presentation of his evidence"* (p3). It was also confirmed that Professor Livesley *"recommended that further enquiries be carried out to determine if other patients at the War Memorial Hospital have been affected in a manner similar to that of Mrs Richards"* (p3), although further work was to wait until receipt of CPS advice. Hampshire Constabulary requested advice on the criminal culpability of Dr Jane Barton and other people, as well as on corporate liability (p4).

A19 On 11 April 2001, Det Ch Insp Burt emailed Detective Chief Superintendent (Det Ch Supt) Keith Akerman with a draft letter to be sent to the CPS (HCO003592). The draft letter stated: *"Whilst I understand that the medical opinion of the expert engaged by the Police is likely to be challenged in the event of a trial I have, nevertheless, been disturbed by the unequivocal nature of his evidence in support of*

the allegation which has been made." The draft letter expresses the view *"I am anxious that an outcome is reached as soon as possible"*. It concludes by saying:

> "I would be grateful if you would enquire into the progress of the case and ensure that it receives the priority attention that I feel it warrants given the significance of the case, the possibility of a widened enquiry and the potential for great public concern that the media has now, somewhat prematurely, aroused." (HCO003592, p2)

A20 On 17 April, Det Ch Supt Akerman wrote to Roger Daw, a Chief Crown Prosecutor, in almost exactly the same terms as expressed in the draft letter from Det Ch Insp Burt (HCO000865, pp2–3).

A21 Det Ch Insp Burt's email suggests that he had already discussed the draft correspondence with Det Ch Supt Akerman before he sent it to him. It is unclear when these concerns first arose in Hampshire Constabulary, or what in particular prompted them.

Investigations into Professor Livesley's competence

A22 In May 2001, Detective Sergeant (Det Sgt) David Sackman was tasked with *"conduct[ing] research into previous occasions where Professor Brian Livesley has acted as an expert witness on behalf of the Police Service"*. The National Crime Faculty identified four investigations in which Professor Livesley had been involved. Another investigation team was noted to be *"surprised at the unequivocal nature of Prof Livesley's report"*. This team *"also considered a range of cases and when Livesley was not convinced that criminal acts had taken place he said so. However he was clear that some of [the suspect's] actions were criminal and clearly evidenced his findings".* Det Sgt Sackman noted that another officer who had used Professor Livesley as an expert witness was *"obviously impressed by his performance"* (HCO000873, p2).

A23 On 21 May, Detective Superintendent (Det Supt) Jonathon (John) James recorded in the Hampshire Constabulary Policy File that enquiries had been made to evaluate, objectively, the *"professional status"* of Professor Livesley *"in both a national & international context given the conclusions articulated in his draft report".* The reason given for this was:

> "The report of Professor Livesley makes a series of unambiguous conclusions concerning the death of Richards being unlawful and the criminal liability of number of individuals. The principle may apply to other cases and it is critical that Professor Livesley's status and bona fide as an expert are properly evaluated to assist our own decision making process." (HCO000636, p12)

A24 However, on the same day there is another entry by Det Supt James stating that he will *"seek early meeting with Prof Livesley to discuss: (i) applicability of*

principles – Richards case to other deaths; (ii) to explore parameters for determining extent for further enquiries; and (iii) to explore process for screening other cases for prioritisation should enquiry be widened" (HCO000636, p13).

A25 On 31 May, it was noted that Hampshire Constabulary was considering obtaining the services of a statistician to *"assist in providing comparative analysis of mortality rates at GWMH against demographically similar medical establishments"*. It was noted that this may have provided independent evidence of the *"veracity"* of Professor Livesley's conclusions (HCO000636, p15).

A26 On 14 June, it was noted that Hampshire Constabulary was to make arrangements to identify and consult a practising geriatric consultant at a hospital outside Portsmouth and South East Hampshire Health Authority to determine *"Whether or not Professor Livesley's observations concerning prep prescriptions to patients on admission are reflected in practice"* and *"whether or not Professor Livesley observations concerning continuous administration via syringe driver (as Richards) without review are reflected in practice"*. The reason given for this action was that *"Senior Counsel"* (David Perry QC) had asked that practising consultants be contacted for their views in order *"to assist [the] decision making processes"* (HCO000636, p19).

A27 The Panel notes that Mr Perry's request was made before he had met and had an opportunity to discuss Professor Livesley's evidence with him. This suggests that Mr Perry may have had concerns about the written report, and that the answers he later received from Professor Livesley in conference confirmed those concerns.

A28 On the same day, Hampshire Constabulary noted that it would engage with other senior investigating officers managing investigations in which Professor Livesley had been engaged as an expert witness, in order to determine *"What type of case he had provided expert opinion"* on and *"What if any evaluation has been taken place of his expert status".* The reason given for this was *"in response to request from Senior Treasury Counsel in respect of his continuing deliberations"* (HCO000636, p20).

A29 A briefing note faxed to Paul Close at the CPS on 19 June confirms: *"Following the conference on the 14th June I have consulted other SIO's who have used Professor Livesley as an expert witness"* (CPS001894, p2). It also provides some background information from Essex Police, who had used Professor Livesley *"in two cases"* (p2). Det Supt James also confirmed that he had spoken to Dr Brian Mundy, a geriatrician, *"concerning key elements of the report provided by Professor Livesley"* (p3).

The conference with Counsel on 19 June 2001

A30 On 19 June 2001, a conference took place between Mr Perry, Det Supt James, Detective Chief Inspector Clarke, Mr Close and Professor Livesley. The conference was held at Mr Perry's chambers. Over the course of the conference,

Mr Perry questioned Professor Livesley about certain parts of the report he had prepared concerning Mrs Richards and, in particular, Professor Livesley's unequivocal conclusions concerning the following: Mrs Richards' death being a result of the drugs administered by syringe driver; the suggestion that she was unlawfully killed by Dr Barton; and that the nursing staff should have realised the consequences of their treatment of Mrs Richards. Mr Perry recorded that the following matters emerged from Professor Livesley's answers at the conference:

> "(i) Although Professor Livesley had concluded in his initial medical report that Mrs Richards had been unlawfully killed, he was not entirely clear of the legal ingredients of gross negligence manslaughter;
>
> (ii) That Doctor Barton's decisions were entitled to be afforded some respect because she was involved in Mrs Richards' care as the 'front line' clinician;
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> (iii) Doctor Barton's decisions could find support among a responsible body of medical opinion;
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> (iv) Bronchopneumonia, as a cause of death, could not be contradicted;
>
> (v) It is not possible, in the absence of any post-mortem finding, to exclude a heart attack as a possible cause of death … as a result of what emerged at the conference, I consider Professor Livesley's conclusion that Mrs Richards was unlawfully killed to be untenable." (CPS100079, pp37–8)

A31 Det Supt James recalled that, following Professor Livesley's answers to Mr Perry's questions, Mr Perry suggested to Professor Livesley that *"his report was inaccurate, and more seriously, was misleading to both the Police, the Crown Prosecution Service and himself".* Det Supt James would later recall:

> "I was completely astonished that whilst on paper in his report Professor Livesley had given all the appearances of being a competent, reliable expert, under questioning he had simply collapsed. It was perfectly obvious his expert opinion and his report were deeply flawed … he had inappropriately drawn conclusions about the criminal liability of key people as identified and he was unable to substantiate his assertion that Mrs Richards had died as a result of being knowingly over-prescribed a combination of drugs … he had conceded in the forum of the meeting that his analysis was flawed and founded on superficial understanding of the law and that in key areas of evidence his report was both inaccurate and misleading." (HCO501911, pp15–16)

A32 Professor Livesley later complained to the police about Mr Perry's treatment of him during that meeting.

A33 On 25 June, it was recorded:

> "In light of the difficulties arising from the conference on the 19th / 6 with counsel in regard to Prof Livesley's report there is an urgent need to acquire some further professional opinion in order to gather information which will aid further decision making process." (HCO000636, p23)

Professor Livesley's 10 July 2001 report on Gladys Richards

A34 On 10 July 2001, Professor Livesley prepared a further report on Mrs Richards for Hampshire Constabulary (HCO003145, pp2–36). The opinion and conclusions varied between the version of the report dated 9 November 2000 and the version finalised on 10 July 2001. Most notably, the new version of the report concluded:

> "It is my opinion that Mrs Gladys Richards's death occurred earlier than it would have done from natural causes and was the result of the continuous administration of Diamorphine, haloperidol, Midazolam, and Hyoscine which had been prescribed to be administered continuously by a syringe driver for an undetermined number of days." (HCO003145, p20)

A35 The conclusions in the earlier report that Mrs Richards was *"unlawfully killed"* by Dr Barton, and that Nurse Philip Beed, Staff Nurse Margaret Couchman and Nurse Christine Joice should have recognised the fatal consequences of what they were doing, were removed.

Dissemination of Professor Livesley's report

A36 Hampshire Constabulary disclosed a copy of Professor Livesley's 9 November 2000 report to the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) in May 2001 (HCO000861, pp2–3). However, no such disclosure was made to the General Medical Council (GMC) at this time as, under GMC rules, the GMC would have had to disclose the report to Dr Barton and she had not yet been interviewed by the police (HCO003139, p3).

A37 On 5 and 6 February 2002, Det Supt James sent copies of Professor Livesley's 10 July 2001 report to Portsmouth HealthCare NHS Trust (DOH700384), Hampshire and Isle of Wight Strategic Health Authority (DOH603405, pp1–2), the UKCC (HCO003853) and the GMC (HCO003854).

A38 On 5 November, it was noted that Professor Robert Forrest, Professor of Forensic Toxicology at the University of Sheffield, requested an opportunity to review Professor Livesley's report (HCO000637, p36).

A39 The Panel has not seen any evidence that the report was provided to Professor Forrest or the Clinical Review Team (see section D), although Hampshire Constabulary indicated, on 28 November, that it would be made available to Professor Forrest and his team (HCO000636, p51).

Breakdown in the relationship between Professor Livesley and Hampshire Constabulary

A40 On 31 July 2002, Mr Close wrote to Mr Daw and confirmed:

> "I have absolutely no hesitation in saying that the Police totally agreed with the advice that there was insufficient evidence to provide a realistic prospect of conviction. Indeed following a conference with Counsel, at which Professor Livesley attended the Police were only too thankful that no proceedings had been commenced." (CPS000985, p4)

A41 On the same day, Professor Livesley made handwritten notes, which he later typed. He said:

> "I was telephoned by DSupt. James and asked to meet Mr James [sic] Perry, Counsel, at his Chambers on 19 June 2001. At this meeting which lasted from 11.30am - 13.30pm I was verbally abused, bullied, and attacked by Mr Perry so much so that I complained loudly that this was not professional. Throughout this meeting DSupt. James and DS. Sackman … sitting on my left kept his back to me and did not move [or speak] but sat facing Mr Perry. On one occasion at the end of the meeting DS Sackman came to my defence over the financial aspects of the case. Mr Perry made great play of the fact that the documents were now in the public domain and could be shared so that I could be sued for libel. It was a very bruising meeting in the presence of DSup. James / and DS Sackman ? and the CPS representative. On leaving the meeting I immediately contacted the MDU Medical Defence Union and then spoke to DSupt James mobile-mobile telephones and said I would be withdrawing my doc, which had been prepared for discussion only … I believed there had been a breach in the administration of the law which could lead to a miscarriage of justice and that this matter had been inappropriately buried." (BLI000035, pp1–2)

A42 On 18 December 2003, Professor Livesley wrote to the Chief Constable of Hampshire Constabulary, Paul Kernaghan, asking for:

> "… a few lines about the contributions, if any you think my final report has made to the investigation … my request does <u>not</u> refer to the preliminary report dated 9 November 2000 which was solely an invited

‘initial medical report for discussion only’ … that was withdrawn and replaced by my final report.” (BLI000041, p1)

A43 Detective Chief Superintendent (Det Ch Supt) Watts responded by letter on 26 January 2004, stating:

> “It was made clear to you that your [09/11/2000 report]… was the basis upon which your witness statement would be produced and further, upon which enquiries and decisions as to prosecutions were to be formed … when you met with the Senior Investigating Officer and Treasury Counsel, on 19 June 2001, the detail of the report was tested and you were not able to evidentially substantiate many of the assertions that you made. The report was therefore of no help to the investigation or to any prosecution that may arise at that time, indeed it hindered that process and it was necessary to engage further experts to review the same material. The report of 10 July 2001 made following the meeting with Counsel had little value either investigative or evidentially produced as it was following the identification of significant flaws in the earlier report … It is not possible in criminal investigations for information or documents to sit in isolation, your report of 9 November 2000 made clear assertions which were not capable of substantiation, that report cannot be put aside and the second report of 10 July 2001 substituted … your reports were unhelpful to the enquiry, in that they gave conclusions not supported by evidence.” (BLI000041, pp 2–3)

B Dr Keith Mundy and Professor Gary Ford

The perceived need to obtain further expert evidence

B1 Even before the scheduled conference between Counsel and Professor Livesley that took place on 19 June 2001, Hampshire Constabulary had decided to:

> “Make arrangements to identify & consult with a practising geriatric consultant at hospital outside Portsmouth HA area to determine:
>
> (i) Whether or not professor Livesley observations concerning prep prescription to patients on admission are reflected in practice.
>
> (ii) Whether or not Professor Livesley observations concerning continuous administration via syringe driver (as Richards) without review are reflected in practice.” (HCO000636, p19)

B2 In documenting the reason for this course of action, the police noted that the *“issues raised are central to Professor Livesley’s conclusion. Senior Counsel*

requests that practicing consultants (interim)? View is sought to assist decision making processes" (HCO000636, p19).

B3 Consequently, Hampshire Constabulary identified Dr Keith Mundy, a consultant geriatrician at Frimley Park Hospital in Surrey, as a suitable expert. On 18 June, arrangements were made to brief Dr Mundy by telephone and to obtain his preliminary views in relation to the Gladys Richards case and the general principles identified by Professor Livesley: that is, pre-prescription, delivery via syringe driver, and the absence of any review of drug treatment. The police also wanted to seek his general views on the processes employed at Gosport War Memorial Hospital (HCO000636, p21).

B4 Dr Mundy expressed to the police his concerns regarding the pre-prescription of diamorphine, hyoscine and midazolam. He stated that the use of a syringe driver was not necessarily inappropriate where it had been determined at a review that this was the most efficient way to provide pain relief. However, he did express concerns about the clinical care at the hospital more generally, such as the lack of review processes, the apparent lack of reference to a formula for switching from morphine oral solution to morphine-based drugs, and administering drugs via syringe driver where the patient had not clearly reached the terminal phase (CPS001894).

B5 The belief that the police needed to obtain further expert evidence was reinforced by what was perceived to be Professor Livesley's poor performance when questioned by Mr Perry in the conference on 19 June. As Det Supt James later noted:

> "… I suspect others before me, had appropriately concluded that a referral from the National Crime Faculty of a person as an expert in a particular field, who had previously been used in criminal investigations, could be considered a reliable source of information on which to make decisions. We now found ourselves in the unfortunate position where we were effectively now seeking to gain further expert evidence, after extremely long periods of time had elapsed, and implicitly having little information on which we could properly guide ourselves or others." (HCO501911, p27)

B6 On 25 June, the decision was made to *"make contact at the earliest opportunity with Dr Mundy … and arrange personal briefing re Rochester case"* (HCO000636, p23) It was also decided to *"make contact with Professor Ford at Newcastle University and arrange personal briefing re Rochester case"* (p24). These decisions were recorded as being *"in light of the difficulties arising from the conference on 19/6 with Counsel in regard to Professor Livesley's report there is an urgent need to acquire some further professional opinion"* (HCO000636, p23).

The instruction of Dr Mundy and Professor Ford

B7 On 3 July 2001, Hampshire Constabulary determined that it should *"engage services of Dr Mundy and Professor Ford to review Richards case and 4 other cases identified [and] to provide written report on findings … these reports to be available by end July where possible".* The purpose of this instruction was *"to engage further expert/professional view on Richards and other cases to determine appropriateness of current criminal investigation and to assess extent of any widening of investigation"* (HCO000636, p30).

B8 The other cases that Dr Mundy and Professor Ford (Professor of Pharmacology at Newcastle University) would consider were: Patient L; Arthur Cunningham; Robert Wilson; and Alice Wilkie (HCO000636, p28). By June 2001, up to ten people had contacted the police raising concerns about relatives who had died at the hospital (HCO000636, p25). Det Sgt Sackman conducted a review of these cases and chose four to be referred to the experts on the basis that they had similarities to the Gladys Richards case: *"ie. non - life threatening condition on admission, syringe driver used to administer drugs, death within short period of admission respectively"* (HCO000636, p28).

B9 The Panel recognises that the purpose of providing the additional cases to the two experts was to determine whether the investigation should be widened. It is not clear to the Panel on what basis Det Sgt Sackman was suitably qualified to determine whether a case might have given rise to concerns in relation to the standard of medical care provided to individual patients at the hospital.

B10 Hampshire Constabulary prepared written briefs for the two experts (HCO000636, p32). However, delays in obtaining medical records from Portsmouth HealthCare NHS Trust meant that it was not until 21 August 2001 that the relevant material and terms of reference were sent to Dr Mundy and Professor Ford. The terms of reference were:

> "To construct a report of your professional opinion based on your qualifications, experience and knowledge. The areas to which you are required to apply your professional judgement are:
>
> - The gamut of patient management and clinical practices exercised at the hospital in these cases.
>
> - An articulation of the leadership, roles, responsibilities and communication in respect of the clinicians involved in these cases.
>
> - The accuracy of diagnosis and prognosis including risk assessments.

- An evaluation of drugs prescribed and the administration regimes.
- The quality and sufficiency of the medical records.
- The appropriateness and justification of the decisions that were made.
- To comment on recorded causes of death.
- To articulate the duty of care issues and highlight any failures.
- Not to comment on any individuals criminal liability and not to make any analysis of the criminal law in regard of these cases." (HCO500255)

The reports prepared by Dr Mundy and Professor Ford

B11 Hampshire Constabulary expressed concern about the length of time it took the two experts to produce their reports (HCO501911, p36). Dr Mundy produced a report dated 18 October 2001 in which he commented on the use of opioid analgesics in respect of four patients: Mr Cunningham, Patient L, Mrs Wilkie and Mr Wilson (CPS001017). It is not clear when Hampshire Constabulary received this report. An entry in the Hampshire Constabulary Policy File suggests that the report was received on 22 November (HCO000636, p45).

B12 In respect of Mr Cunningham, Dr Mundy's report concluded: *"Morphine was started prematurely, the switch to a syringe driver was made without any clear reason and the dose was increased without any clear indication"* (CPS001017, p4).

B13 In respect of Mrs Wilkie, Dr Mundy commented: *"In my view the dose of Diamorphine that was prescribed at 30 mg initially was excessive and there is no evidence that the dose was reviewed prior to her death."* As with Mr Cunningham, Dr Mundy was critical of the range of diamorphine prescribed to Mrs Wilkie (CPS001017, p5).

B14 In respect of Mr Wilson, Dr Mundy said: *"It is clear that Mr Wilson's condition suddenly deteriorated probably due to a combination of worsening heart failure and terminal bronchopneumonia and I consider that the palliative care given was appropriate"* (CPS001017, p6).

B15 In respect of Patient L, Dr Mundy again criticised the prescribing range and concluded that the patient was *"started on opioid analgesia … inappropriately"* (CPS001017, p7).

B16 Dr Mundy concluded by commenting that *"the nursing records at Gosport War Memorial Hospital were comprehensive on the whole"* (CPS001017, p7).

B17 Later criticisms were made of the nursing notes (CPS001017, p7).

B18 Dr Mundy went on to state:

> "… the reason for starting opioid therapy was not apparent in several of the cases concerned. There had been no mention of any pain, shortness of breath or cough requiring relief … the reason for switching to parenteral Diamorphine via subcutaneous infusion was not documented and the prescription of tenfold range of Diamorphine on the 'as required' section of the drug chart is, in my view unacceptable … the use of Diamorphine as described in these four cases suggest that the prescriber did not comply with standard practice." (CPS001017, p7)

B19 On 12 December, Professor Ford produced his report. It considered the treatment of five patients: Gladys Richards, Arthur Cunningham, Alice Wilkie, Robert Wilson and Patient L. Professor Ford also commented on general aspects of the care provided at the hospital (CPS001563).

B20 In respect of the care provided to Mrs Richards, Professor Ford stated:

> "… there was inappropriate prescribing of opiates and sedative drugs by Dr Barton. These drugs in combination are highly likely to have produced respiratory depression and/or the development of bronchopneumonia that led to her death. In my opinion it is likely the administration of the drugs hastened her death. There is some evidence that Mrs Richards was in pain during the three days prior to her death and the administration of opiates can be justified on these grounds. However Mrs Richards was at high risk of developing pneumonia and it [is] possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative and opiate drugs." (CPS001563, p11)

B21 In respect of Mr Cunningham, Professor Ford stated:

> "… although Mr Cunningham was admitted for medical and nursing care to attempt to heal and control pain from his sacral ulcer, Dr Barton and the ward staff appear to have considered Mr Cunningham was dying and had been admitted for terminal care … The initial prescription of subcutaneous Diamorphine, Midazolam and Hyoscine by Dr Barton was in my view reckless. The dose increases undertaken by nursing staff were inappropriate if not undertaken after medical assessment and review of Mr Cunningham. I consider it highly likely that Mr Cunningham experienced respiratory depression and profound depression of conscious level due to the infusion of Diamorphine and Midazolam. I consider the doses of these drugs prescribed and administered were

inappropriate and that these drugs most likely contributed to his death through pneumonia and / or respiratory depression." (CPS001563, p21)

B22 Professor Ford's opinion of the care provided to Mrs Wilkie was:

"… the prescription of subcutaneous Diamorphine and Midazolam was inappropriate and probably resulted in depressed conscious level and respiratory depression, which may have hastened her death. However, Mrs Wilkie was a frail very dependent lady with dementia who was at high risk of developing pneumonia. It is possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative and opiate drugs." (CPS001563, p25)

B23 Professor Ford's opinion of Mr Wilson's clinical care was:

"Following his admission to Dryad ward he was, in my opinion inappropriately treated with high doses of opiate and sedative drugs. These drugs are likely to have produced respiratory depression and / or the development of bronchopneumonia and may have contributed to his death." (CPS001563, p29)

B24 In respect of Patient L, Professor Ford stated:

"In general I consider the medical and nursing care she received was appropriate and of adequate quality. However I cannot identify a reason for the prescription of subcutaneous Diamorphine, Midazolam and Hyoscine by Dr Barton on 03 March. In my view this was an inappropriate, potentially hazardous, prescription. I would consider it highly likely that Patient L experienced respiratory depression and profound depression of conscious level from the combination of these two drugs and Fentanyl but I cannot exclude other causes for her deterioration and death at this time such as stroke or pneumonia." (CPS001563, p35)

B25 Professor Ford also gave his broader medical opinion on the five cases. He expressed the view that *"Examination of selected cases is not an appropriate mechanism to comment on the general quality of care of an institution or individual practitioners"*. He stated that the five cases raised *"a number of concerns by independent enquiry"*, but queried whether it would be more appropriate for the NHS, the Commission for Health Improvement (CHI), the GMC or the Nursing and Midwifery Council to visit the hospital (CPS001563, p36).

B26 Professor Ford's principal concerns were threefold: *"prescription and administration of subcutaneous infusions of opiate and sedative drugs in patients with non-malignant disease"*; *"lack of training and appropriate medical supervision of decisions made by nursing staff"*; and *"the level of nursing and non-consultant*

medical skills on the wards in relation to the management of older people with rehabilitation needs". He continued:

> "There is a possibility that prescriptions of subcutaneous infusions of Diamorphine, Midazolam and Hyoscine may have been routinely written up for many older frail patients admitted to Daedalus and Dryad wards, which nurses then had the discretion to commence. This practice if present was highly inappropriate, hazardous to patients and suggests failure of the senior hospital medical and managerial staff to monitor and supervise care on the ward. Routine use of opiate and sedative drug infusions without clear indications for their use would raise concerns that a culture of 'involuntary euthanasia' existed on the ward." (CPS001563, p37)

Professor Ford indicated that further enquiry would be required to determine if this was in fact correct.

B27 Professor Ford was of the opinion that the five cases raised serious concerns about the treatment of elderly people admitted for rehabilitation on Daedalus and Dryad wards. He recommended a *"review of practice at the institution"* and that in the event that criminal proceedings were not commenced, the cases be brought to the attention of medical regulators (CPS001563).

The reaction to the reports

B28 On 15 January 2002, the Hampshire Constabulary Investigation Team met to discuss the reports of Professor Ford and Dr Mundy (HCO501911, p37). On 28 January, it was noted in the Policy File that Det Supt James had decided that further investigation into deaths at the hospital would not be appropriate. He listed a number of reasons for reaching this conclusion, including the comment: *"Some conflict between Practitioners and medical evidence i.e. see case of Wilson. Ford/Mundy fundamentally disagree. Their language is different in terms of conclusive judgements re adequacy of care."* One of the reasons he gave for reaching this decision was: *"The threshold of medical evidence concerning the liability of those concerned and death contributors i.e. Ford refers to the likelihood of patient management contributing to death. This falls short of any lawfulness issues"* (HCO000636, p49).

B29 Later in the document, Det Supt James reflected:

> "Nowhere in Professor Ford's report is there any evidence of a direct cause or link between the regime of care offered to the four patients concerned and their death. Professor Ford's language and connection for that cause or link only goes as far as to say: 'may have contributed, could have contributed'. In my professional judgement this fell short of the unequivocal cause or connection that was necessary and which

had been very clearly articulated by Senior Treasury Counsel. Further, whilst Professor Ford is extremely critical of the standard of care for which Doctor Barton was the most specifically involved Clinician, this seemed to me to fall short of the extreme degree of negligence that would be required to support a criminal investigation or a criminal prosecution." (HCO501911, p39)

B30 Professor Ford had stated that he *"felt that the most appropriate course was a combination of referral to the relevant regulatory body, the HMC and or action by the Trust or the Health Authority as Doctor Barton's employer and any work would be undertaken by the Commission for Health Improvement"* (HCO501911, pp39–40).

B31 Fundamental differences between the evidence of experts can prove to be a bar to a successful prosecution. However, the Panel notes that while there was conflict in relation to the experts' opinions on the clinical care afforded to Mr Wilson, there does not appear to have been a great deal of conflict in respect of the other patients. In the cases of Mr Cunningham, Mrs Wilkie and Patient L, both experts were critical of the use of opioid analgesia. The Panel does, however, recognise that the degree of negligence required for the offence of gross negligence manslaughter is *"truly exceptionally bad"*. This is a question which should have been left to the consideration of the CPS.

B32 Dr Mundy and Professor Ford's reports were disclosed to Portsmouth HealthCare NHS Trust and the regulators of the medicaland nursing professions in early February 2002 (DOH700384, DOH603405, HCO003854, HCO003853).

B33 Portsmouth HealthCare NHS Trust wrote to Hampshire Constabulary on 8 March, following receipt of Professor Ford's report. It stated that it had identified several inaccuracies in the text of the report. The letter said:

> "I am quite sure that these are to do with a misreading of the draft when finally being typed up, but given that the GMC and UKCC, along with ourselves are considering individual staff on the basis of these reports, I felt that I should write highlighting the points so that they can be corrected." (HCO003081, p1)

B34 However, an Operation Rochester briefing document shows that the reports were not forwarded to the CPS:

> "The reports from Professor Ford and Professor Mundy were reviewed and a decision was taken not to forward them to the CPS as they were all of a familiar nature to the Richards case and would therefore attract a similar reply. A decision was then made that there would be no further police investigations at that time." (HCO000638, p43)

B35 Given that the reports tend to suggest that there were systemic failings within the hospital and a practice of over-prescribing opioid analgesia. It would have been appropriate for the police to forward this material to the CPS for review.

B36 In September 2002, Det Ch Supt Watts replaced Det Supt James (now Detective Chief Superintendent) as the Senior Investigating Officer in Operation Rochester (HCO000637, p8). Hampshire Constabulary met with the CPS in November in order to discuss the development of a strategy for the investigation. At the meeting, the following actions were agreed:

- "Re-interview experts Ford & Mundy in detail to clear ambiguities in their reports, obtain witness statements in support of the reports.
- Draw together a team of experts under the leadership of Professor Forrest to examine all future material. The team to include experts in; palliative care, geriatric care (not Dr Livesley), and to consider a pathologist if felt appropriate. Professor Forrest will deal specifically with toxicological issues.
- The team as above to review all 50+ cases now known to Police, to include the case of Mrs Richard and the 4 cases recently submitted to CPS. The team to be given the material produced by Livesely, Ford and Mundy.
- The expert team to be invited to identify a scientifically sound method of reviewing a representative sample of cases going back to 1991. Professor Baker to be included in this deliberation. The recommendation to be discussed with the CPS and / or Counsel prior to embarking upon it.
- The expert team to comment upon the scientific / evidential need to exhume in cases where there is a buried body." (CPS001008, pp1–2)

B37 The Panel has seen no documents which confirm that either Dr Mundy or Professor Ford were re-interviewed by Hampshire Constabulary, or that they produced further versions of their reports.

Professor Ford's instruction by Field Fisher Waterhouse and involvement with the GMC

B38 On 1 November 2007, the solicitors Field Fisher Waterhouse (FFW) wrote to Professor Ford regarding their instruction by the GMC to investigate Dr Barton's fitness to practise. FFW stated that they needed to instruct experts and that *"it would be efficient and most economic"* to use the reports Professor Ford had previously

prepared for Hampshire Constabulary, with addenda as necessary (GMC101030, p499).

B39 On 2 November, Professor Ford contacted FFW and told them:

> "Hampshire Constabulary had come to him as another expert had not provided them with a proper report. The Police came and discussed the cases with him. There was no Clinical Governance and the Trust was not interested. In his view there was a systemic failure and the doctor was completely unsupervised and working outside her remit." (GMC101030, p491)

B40 Professor Ford informed FFW that *"he is a pure stroke specialist. He is also a Professor of Pharmacology of Old Age. He does fulfil the criteria for acting as an expert but he does not treat these sorts of patients anymore. He did have significant experience of care of the elderly until 2000"* (GMC101030, p492).

B41 The remit of the GMC investigation was discussed with Professor Ford, as were the practicalities of him acting as an expert. FFW confirmed that they had five reports from him, which they planned to use alongside a supplementary list of questions.

B42 On 6 November, Sarah Ellison, a partner at FFW, sent an email to a colleague discussing the difference in the reporting styles of Professor Ford and Professor David Black, a consultant geriatrician. The email states: *"The broad view is they are similar but different – Ford is generally a little harsher in his views but blames teams a bit more, Black is slightly less harsh in his views."* The email discusses the viability of using Professor Ford as the sole expert, but concludes that he has only prepared five brief reports. Sarah Ellison goes on to say: *"I remain of the view that having two experts may be the way forward although the defence may try and emphasise where they differ"* (GMC101030, p487).

B43 On 12 December, an internal FFW email trail regarding instructions to Professor Ford confirmed that he had agreed to act as an expert in the GMC case. The email noted that FFW had *"embarked on a programme of weekly instructions asking him to first prepare reports on the seven cases he has not seen and then to revamp the reports he did for the Police for GMC purposes"* (GMC100107, p76).

B44 The first of Professor Ford's reports prepared for FFW, dated 2 April 2009, was in respect of the care of Geoffrey Packman. In it, Professor Ford concluded that the *"medical assessment and management of Mr Packman did not reach the standard expected"* (GMC100109, p70).

B45 This report, and each of those that followed, gave reasons why Dr Barton had failed to meet the requirements of good medical practice. These reasons are not reproduced in full here, but for each patient a short paragraph encapsulating Professor Ford's conclusions is included.

B46 On 4 April, Professor Ford produced a report in respect of Ruby Lake (GMC100109, pp51–56). He concluded:

> "Dr Barton was responsible for her day to day medical care, there was inadequate medical assessment both when she was initially admitted and then a failure to adequately assess Mrs Lake when she developed agitation and then chest pain. The prescription of opioids was in my opinion not justified there was no justification for the prescription of Diamorphine and Midazolam by syringe driver. The prescription and administration of these drugs are the most likely cause of Mrs Lake's subsequent deterioration and her death. There was a failure of adequate assessment by Dr Barton in particular when Mrs Lake developed chest pain there should have been a physical examination and investigations undertaken and recorded in medical notes." (GMC100109, p56)

B47 On 5 April, Professor Ford finalised his report in respect of Patient L. He concluded:

> "There was an inadequate medical assessment when she was initially admitted and a failure to subsequently assess Patient L prior to the prescription of Midazolam, Diamorphine and Hyoscine by subcutaneous infusion using syringe driver. The dose ranges were inappropriate and potentially hazardous. My opinion is that the prescription of these drugs in conjunction with the previous prescription of a Fentanyl patch at a much higher equivalent dose than the oral morphine she had been taking were likely to have contributed to her death." (GMC100109, p49)

B48 Professor Ford produced a report in respect of Enid Spurgin on 5 April. This concluded:

> "There was inadequate investigation of Mrs Spurgin's hip pain. Specifically there is no record of an adequate examination of the hip by Dr Barton as the doctor responsible for her day to day care, and an x-ray of the right hip was not obtained. In my opinion the prescription of Diamorphine and Midazolam by Dr Barton were dangerous and reckless and the administration of these drugs by subcutaneous infusion at the doses used led to depression of her conscious level and respiration and most likely contributed to her death." (GMC100109, p46)

B49 In his report on Alice Wilkie, dated 6 April, Professor Ford concluded:

> "In my opinion the prescription of subcutaneous Diamorphine, Hyoscine and Midazolam in the wide dose range was poor practice, potentially

very hazardous and not consistent with good medical practice. The prescription of large dose ranges of these drugs in the absence of clear protocol understood by all nursing staff indicating the symptoms that should lead to the administration of the drugs placed Mrs Wilkie at high risk of being administered an inappropriately high dose of opiate. In my opinion the administration of the Diamorphine and Midazolam infusions very likely led to further deterioration in Mrs Wilkie and contributed to her death, which could lead to respiratory depression, coma and in some cases death the day after these commenced." (GMC100109, p39)

B50 On 21 April, Professor Ford produced his Generic Report on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital (GMC101214, p47). In this report, he acknowledged that in 2001 he had prepared a report for Hampshire Constabulary on the treatment of five patients at the hospital, and stated that he had not changed his views or opinions as expressed in that report.

B51 On 21 April, Professor Ford produced a number of other reports on patients at the hospital. In his report on Arthur Cunningham, he concluded:

> "The medical and nursing notes following Dr Lord's assessment provide little detail but in my view it was reasonable to commence [Mr Cunningham] on as required oral morphine and then move subsequently to regular administration of an opiate drug to control his pain , at a dose that did not cause undue side effects. I consider the prescription and administration of Diamorphine and Midazolam by subcutaneous infusion was not justified and that there was inadequate assessment of [Mr Cunningham]'s pain and the cause of subsequent deterioration by Dr Barton. There was a failure to discuss the management and seek advice from Dr Lord or another consultant when [Mr Cunningham] deteriorated. In my view the doses of Diamorphine and Midazolam used were inappropriately high and were increased excessively without good cause. These prescriptions likely led to a shortening of [Mr Cunningham]'s life." (GMC101214, p136)

B52 Professor Ford's report on Elsie Devine, also dated 21 April, concluded:

> "The notes do not suggest that Dr Barton conducted an adequate assessment of [Mrs Devine] before prescribing the opiate Fentanyl and then subcutaneous infusions of Diamorphine and Midazolam. In my opinion Fentanyl and Diamorphine were not indicated. The prescription of Midazolam infusion without an initial loading dose was not in my view optimal management, but if this had been administered alone without Diamorphine would not in my opinion have been a breach of duty of care if there had been an adequate clinical assessment. The doses of

> Diamorphine and Midazolam prescribed by Dr Barton were excessive, dangerous and reckless. In my opinion the administration of these drugs by subcutaneous infusion at the doses used led to depression of her conscious level and respiration and most likely contributed to her death." (GMC101214, p177)

B53 Professor Ford prepared a second report in respect of Ruby Lake on 21 April. However, there were no significant changes to the opinions expressed in his original report on Mrs Lake (GMC101214, p123).

B54 On 21 April, Professor Ford also finalised a report in respect of Elsie Lavender. In that report, he concluded:

> "The information in the notes suggests there was an inadequate assessment of [Mrs Lavender] by Dr Barton as the doctor responsible for the day to day medical care of the patient. Dr Barton's prescription of morphine slow release tablets on 24 February was inappropriate because an adequate clinical assessment had not been performed and the response to paracetamol and moderate analgesia had not been assessed. The prescription of subcutaneous Diamorphine and Midazolam by Dr Barton on 26 February were too wide a dose range and potentially hazardous. The prescriptions of subcutaneous Diamorphine and Midazolam on 5 March were not justified, reckless and in my opinion led to deterioration in [Mrs Lavender], contributing to her death." (GMC101214, p95)

B55 On 21 April, Professor Ford prepared a second report on Geoffrey Packman. In that report, he expanded on the opinion he had offered previously, stating:

> "In my opinion the information in the medical records indicates an adequate assessment was not performed by Dr Barton when [Mr Packman] deteriorated on 26 August and the verbal order to administer Diamorphine before a medical assessment was not justified. The prescriptions of Diamorphine and Midazolam and the reasons for increasing the doses infused were not justified by the information in the medical records." (GMC101214, p166)

B56 Professor Ford also produced a second report on Patient L on 21 April (GMC101214, p169), but there were no significant changes to the opinion he had given in the first report.

B57 Professor Ford produced a report on Patient M on 21 April. In that report, he concluded:

> "The initial prescription of oral morphine was appropriate. The medical and nursing notes are limited but document he had persistent

symptoms of agitation which merited treatment with a sedative such as Diazepam or antipsychotic drug such as haloperidol. However there was inadequate assessment of [Patient M] by Dr Barton with no clinical findings or other information recorded to justify the prescription of subcutaneous infusions of Diamorphine and Midazolam. The prescriptions of both these drugs in the wide dose ranges used were not justified and highly risky because of the risk of respiratory depression. There was no justification in the medical or nursing notes for the prescription of Nozinan by Dr Barton. However the very poor quality of the medical and nursing notes make it difficult for me to be certain that these drugs were not justified given [Patient M]'s clinical condition and reported pain and agitation." (GMC100059, p9)

B58 Professor Ford's report in respect of Gladys Richards, dated 21 April, concluded:

> "The information in the notes suggest there was inadequate assessment of [Mrs Richards] by Dr Barton as the doctor responsible for the day to day medical care of the patient when transferred to Daedalus ward on 11 August 1998. The medical notes record no evidence of hip pain at this time and no justification was provided for the prescription of oramorphine and subcutaneous Diamorphine and Midazolam. The prescriptions of subcutaneous infusions of Diamorphine and Midazolam in the high dose ranges were highly risky. [Mrs Richards] deteriorated rapidly after dislocating her hip on 14 August and treatment with opioids and haloperidol was appropriate. The medical records do not provide any justification for the prescription of Midazolam by subcutaneous infusion or its administration on 18 August until [Mrs Richards]'s death on 21 August. In my opinion the Midazolam infusion at the dose infused very likely led to respiratory depression and shortened [Mrs Richards]'s life although at this stage she required palliative care and was likely to die within a few days or weeks." (GMC101214, p119)

B59 Professor Ford produced a second report in respect of Enid Spurgin on 21 April (GMC101214, p149). However, this contained no changes to the opinions he had expressed in the first version of the report concerning Mrs Spurgin.

B60 Professor Ford produced a report in respect of Jean Stevens, also dated 21 April, that concluded:

> "The information in the notes suggest there was inadequate assessment of [Mrs Stevens] by Dr Barton as the doctor responsible for the day to day medical care of the patient with no clinical findings recorded of an assessment of [Mrs Stevens]' abdominal pain or

justification for the prescriptions of oramorphine and subcutaneous Diamorphine and Midazolam. The prescriptions of subcutaneous infusions of Diamorphine and Midazolam in the wide dose ranges were highly risky. In my opinion the combination of Diamorphine and Midazolam very likely shortened [Mrs Stevens]' life. However the very limited content of the medical notes make it difficult to exclude the possibility that [Mrs Stevens] developed a new medical problem on transfer to Daedalus Ward that led to her deterioration and death." (GMC101214, p188)

B61 Professor Ford produced a second report on Alice Wilkie on 21 April. The last line in the report was amended from the first version of his report on Mrs Wilkie. It stated: *"In my opinion the prescriptions of Diamorphine and Midazolam by subcutaneous infusion were not justified by the information recorded in the medical records, were in too wide a dose range and were potentially hazardous"* (GMC101214, p110).

B62 Professor Ford produced a report on Robert Wilson, dated 21 April, that concluded:

> "Dr Barton failed to undertake or record an adequate clinical assessment of [Mr Wilson] when he was admitted to Dryad Ward or adequately assess his subsequent deterioration. The prescription by Dr Barton of subcutaneous Diamorphine and Midazolam infusions was not justified and the dose ranges used were inappropriately wide. The subsequent increase in Diamorphine and Midazolam doses that were infused were not justified. In my opinion the doses of Diamorphine and Midazolam received by [Mr Wilson] led to his subsequent deterioration and most likely led to [Mr Wilson]'s death through producing respiratory depression." (GMC101214, p146)

B63 On 13 May, Professor Ford produced a second report on Patient M. The language and tone used in the second report were stronger than in the first version. The last two sentences of the second report stated:

> "The prescribing of Diamorphine and haloperidol on 17 January was hazardous as more than one regular prescription for both these drugs was active on the drug chart. There was no clear justification in the medical or nursing notes for the prescription of Levomepromazine (Nozinan) by Dr Barton." (GMC101214, p86)

B64 On 23 May, Professor Ford produced a supplementary report on Patient L, correcting drafting errors. In the main body of the report, he changed the phrase *"significant risk"* to *"very high risk"*, so that the relevant sentence read: *"There was a very high risk of adverse effects from the combination of the Fentanyl patch and the*

Diamorphine and this was the most likely cause of [Patient L] developing drowsiness" (GMC101214, p105).

B65 On 25 May, Professor Ford produced a supplementary report on Elsie Devine. The purpose of this report was to correct drafting errors, but also to comment on a prescription that had been omitted from the first report. Professor Ford stated: *"In my opinion the prescription of oral morphine by Dr Barton on 21 October was not consistent with good medical practice as the prescription did not service [Mrs Devine]'s needs"* (GMC101214, p179).

B66 On 25 May, Professor Ford produced a supplementary report on Jean Stevens (GMC101214, p190). The purpose of this report was to correct drafting errors, but there were also changes in the report in respect of prescriptions and a dose of diamorphine. Professor Ford was asked to comment on whether an entry in the medical records could have been made without Dr Barton seeing Mrs Stevens, which Professor Ford concluded was possible. The amendments did not change the opinions Professor Ford had expressed in his original report.

B67 During May 2009, Professor Ford produced supplementary reports in relation to a number of other patients in order to correct drafting errors in his original reports. However, unless specified above, these corrections did not change the substance of the opinions he had originally provided.

Professor Ford's attendance at the GMC Fitness To Practise Panel

B68 Professor Ford attended the GMC's Fitness to Practise Panel in respect of Dr Barton on 6, 7, 10 and 14 July 2009 – Days 20 (CPS000097), 21 (CPS000099), 22 (CPS000102) and 23 (CPS000106) respectively. There were no significant deviations from Professor Ford's written reports in the oral evidence that he gave before the GMC.

C Professor Baker

The instruction of Professor Baker

C1 Following the publication of the CHI report in May 2002, Sir Liam Donaldson, the Chief Medical Officer (CMO), commissioned Professor Richard Baker, Head of the Department of Health Sciences at the University of Leicester, to conduct *"a statistical analysis of mortality rates at GWMH, including an audit/review of use of opiate drugs"* (RBA000016, CPS000171, p3). This statistical analysis would eventually become *The Review into Deaths at Gosport War Memorial Hospital* (RBA100036).

C2 Professor Baker produced a *Proposal for a Clinical Review of Deaths at Gosport War Memorial Hospital*, dated 30 August 2002. This stated that the purpose of the review was:

(i) “To identify any excess mortality or clusters of deaths among patients who were on Daedalus and Dryad Wards between 1988 - 2000 and to identify initial evidence to explain any excess or clusters; and

(ii) To determine whether the numbers of deaths among Dr Barton’s general practice patients was higher than would have been expected.” (RBA000067, p3)

C3 The Terms of Reference for Professor Baker’s investigation were defined as follows:

“To carry out a critical audit to cover the following:

(i) Pattern of observed compared to expected deaths in particular age groups in the Gosport War Memorial Hospital and relevant general practice patients.

(ii) Deaths showing unusual clusters by place of death and time.

(iii) Certified cause of death in relation to medical history.

(iv) Prescribing of opiates and related sedation.” (RBA100280, p1)

C4 Professor Baker would later explain that point (i) meant comparing the number of deaths at the hospital with similar hospitals caring for similar patients. Point (iii) meant that Professor Baker would examine the medical history of the patient and use clinical judgement to decide whether the given cause of death was supported by that history. Point (iv) was both a clinical and a statistical review to ensure that prescribing was in accordance with clinical need (RBA000016, p3).

C5 On 16 September, staff at the hospital were assembled to be informed of Professor Baker’s review. Immediately after the meeting, Staff Nurse Anita Tubbritt, who had been employed at the hospital since the late 1980s, handed hospital managers a bundle of documents comprising memos, letters and minutes of meetings relating to concerns raised by nursing staff in 1991 and 1992 (the nurses’ dossier). The dossier was reported to the police, and it was determined that further police enquiries were necessary (CPS000171, p3).

C6 On 23 September, Rachel Dickson, Private Secretary to the CMO, wrote to Professor Baker enclosing a *“copy of the dossier of papers presented by a group of nurses at the Gosport War Memorial Hospital, as discussed briefly last week”.* She added:

“Sir Liam has suggested that the time period pre and around 1991 seems important for this investigation. Sir Liam has also suggested that you may wish to include pharmacy records of opiate supply to the

wards in your review as patient records of prescribed opiates." (RBA000042, p1)

C7 On 17 October, Professor Baker received statistics regarding admissions, discharges and deaths for the period 1995 to September 2002 on Daedalus, Dryad and Sultan wards (RBA000011, p3).

Professor Baker's first report

C8 On 11 November 2002, Professor Baker produced a report entitled *Deaths at Gosport War Memorial Hospital, 1987-2000; Summary report of review of MCCD [Medical Certificate of Cause of Death] counterfoils* (RBA100269) and emailed it for the attention of the CMO (RBA100123). From his analysis of the statistics derived from the MCCD counterfoils, Professor Baker felt it appropriate to write to the CMO with his preliminary findings. He explained his concerns in a covering email:

> "A pattern can be identified associated with the deaths certified by Dr Barton – the greater the proportion of the deaths certified by her, the higher the total number of deaths, and Dr Barton was more likely to give bronchopneumonia as the cause of death. These features could potentially be explained by clinical factors, but are also compatible with the concerns expressed about the excess use of the opiate and sedative medication." (RBA100123, p1)

C9 While recognising that much work needed to be done as part of his review, *"in view of the potential danger to patients if Dr Barton continues in practice, the continuing police investigation, and concern among relatives, [Professor Baker] wished to inform [the CMO] of these findings at once"* (RBA100123, p1).

C10 Professor Baker explained in his report:

> "This analysis is based on a data source with several limitations, and it is therefore conceivable that the findings have an innocent explanation. Review of other sources of information is needed to establish the true explanation, including review of clinical records and completion of statistical analyses comparing deaths rates in GWMH and other community hospitals. Nevertheless, the preliminary findings reported here can be interpreted as supporting the concerns already raised by the relatives of some patients." (RBA100269, p5)

C11 The Panel notes the equivocal nature of the findings. The Panel also notes the repeated concerns regarding data limitations, which meant that any criminal or disciplinary proceedings brought at that time would have been premature.

C12 On 18 November, Sir Liam wrote to Professor Baker, having spoken to him at length three days previously. He stated:

> "At this stage, the data take us no further in deciding whether there is a sinister explanation. This was the purpose of your investigation and you are now exploring other data sources to try to 'get behind' the preliminary analysis. We agreed that there were no grounds for alerting the police until further analysis is available. We were both surprised that Dr Barton is apparently still undertaking some work at the hospital (albeit not as a clinical assistant) and I agreed to speak to Dr Gill (the Regional Director of Public Health) about this as a matter of urgency." (RBA100281, p1)

C13 Over the course of the following months, Professor Baker was provided with a large amount of material in relation to the hospital, the patients who had been treated there and Dr Barton's general practice.

Professor Baker's review of the five cases investigated by Hampshire Constabulary

C14 On 6 December 2002, Professor Baker emailed Hampshire Constabulary to request the clinical records of patients whose relatives had raised concerns. The reason for the request was to establish the features of those cases that had given rise to concern (RBA100075). On 9 December, Detective Inspector (Det Insp) Nigel Niven noted that Professor Baker would be granted access to records held by the police in order to facilitate his work, as commissioned by the CMO (HCO000637, p55).

C15 On 23 December, Professor Baker produced his *Review of records of five patients investigated by Hampshire Constabulary* (RBA100389).

C16 In respect of Gladys Richards, Professor Baker said:

> "The patient was clearly highly dependent because of advanced Alzheimer's; her general condition must have deteriorated following the fracture and surgery, although when she was admitted to Gosport on 11.8.98 she was not reported as in pain, and was receiving co-codamol only. For some reason that is not recorded in the notes, the co-codamol was replaced by oramorph; it is extraordinary that diamorphine, hyoscine and medazolam were also written up on an as required basis on this date since there is no clinical reason for these drugs indicated in the records (perhaps an explanation is an error over the date, but such errors do not occur elsewhere on the drug chart). Indeed, the decision to start oramorph is not accompanied by any explanation. The over-sedation of a patient primarily admitted to be remobilised is inappropriate. The phrase 'Please make comfortable' looks initially benign, but the patient had been admitted to be given a trial of remobilisation. The phrase 'please make comfortable' re-appears on 18.8.98 (JAB) when the syringe driver was started, and raises the

possibility that this term has sinister implications. It is possible that over-sedation led to the fall that precipitated the dislocation. The decision to start the syringe driver appears hasty - essentially it implies that the patient is terminally ill, has uncontrolled pain, and the risks of high doses of opiate are outweighed by the benefits. The cause of the new pain is not diagnosed (although an X-ray was taken), and no therapies are tried before resorting to diamorphine. The addition of hyoscine and medazolam indicate that continued high doses were anticipated; the dose allowed for use was 40-200mg per day. I am uncomfortable with the range of dose for which the patient was written up, and it suggests that the doctor in charge of daily care did not take a daily decision about the amount required. The early use of oramorph and quick resort to a syringe driver in the absence of clear clinical indications are findings that give rise to considerable concern." (RBA100389, p3)

C17 In respect of the death certificate, which read *"1(a). Bronchopneumonia"*, Professor Baker said:

> "This is misleading; there is no entry in the records to indicate Mrs Richards had bronchopneumonia; the recent fractured hip is not mentioned, and it would have been usual to have notified the coroner of a death following a fracture and a surgical procedure. This was not done. The R hemiarthroplasty is mentioned on the cremation form." (RBA100389, p3)

C18 In respect of Arthur Cunningham, Professor Baker concluded:

> "The patient's sacral ulcer was not treated aggressively; there is no record of the indication for use of a syringe driver, and the early resort to this medication suggests the opposite of aggressive treatment. The patient was certainly ill, although the explanation for the sudden deterioration in the days before admission are not entirely clear. It is not possible to be certain that more aggressive treatment would have led to a different outcome, but such an approach was not given the chance." (RBA100389, pp5–6)

C19 In respect of Alice Wilkie, Professor Baker concluded:

> "The cause of the deterioration before death is no stated, and no action appears to have been taken to investigate or actively treat the problem. One can only speculate on what might have happened. Subcutaneous diamorphine was started (30mg/day, not a high dose) with midazolam. The reason for starting this medication is unclear, there is no distinct history of pain, of condition that would give rise to pain. At best, the brevity of the clinical records should be criticised, at worst the patient

was given diamorphine instead of more appropriate investigation and management." (RBA100389, p6)

C20 In respect of Robert Wilson, Professor Baker concluded:

> "Discharged on paracetamol to GWMH, where oramorph was immediately started (no reason for switch given), and patient began to decline; started on sc diamorphine and medazolam, not clear why, or which doctor made this decision. At the very least this is poor record keeping; it is also likely to indicate inadequate assessment and a too rapid decision to accept decline and death. It could reflect a locally accepted policy of early use of opiates and a passive attitude towards severe illness in the elderly." (RBA100389, p8)

C21 In respect of Patient L, Professor Baker concluded: *"A patient admitted for palliative care who died rather more quickly than expected. It is not clear why she died so quickly. Again, opiates were started early, - evidence for pain was weak, and no analgesic was used before opiates"* (RBA100389, p9).

C22 Professor Baker also made general comments, including the following:

> "All these patients had advanced illnesses, and relatively low doses of opiates were used – but they were used earlier than would have been expected. There is no evidence of overdose, but there is evidence of early resort to opiates rather than continued investigation and aggressive management. The use of a cocktail that includes medazolam should be noted." (RBA100389, p9)

Professor Baker's review of sample records from the hospital

C23 On 31 March 2003, Professor Baker sent a fax to the medical records department at the hospital requesting *"an entirely random sample"* of medical records (RBA100316, p1).

C24 Professor Baker then conducted a review of this sample, which comprised the records of 81 patients who had died at the hospital under the care of Dr Barton. This accounted for just under 10% of the 833 deaths certified by Dr Barton between 1988 and 2000. The purpose of the review was (i) to determine whether other cases shared the features identified in relation to the five cases investigated by the police; and (ii) to describe the pattern of care of the patients who died at the hospital.

C25 On 30 April, Professor Baker produced a report concerning his review of the sample records. In it, he noted that he had previously conducted a review of the five cases investigated by the police and had concluded that they shared the following features:

1. "All were frail, with major clinical problems.

2. In some cases active treatment had been planned.

3. Oramorph was written on the drug chart on admission.

4. Diamorphine was administered by syringe driver in all cases.

5. Doses of opiates were not excessive … although it should be noted they were all very frail and elderly, and Diamorphine was administered along with a sedative.

6. The records do not contain full explanations of the treatment decisions.

7. Remarks in the records suggested a conservative rather than active attitude towards clinical management." (RBA100127, pp1–3)

C26 Of particular significance, Professor Baker's review of the 81 cases revealed:

"Forty-eight records contained sufficient details to enable a judgment about the appropriateness of care to be made. In 32 (66.7%) of these, care was judged to have been appropriate. There were some concerns about care in the remaining 16 (33.3%). The concerns related to the decision to start opiate medication. The indications for starting drugs were either not clearly stated, or if pain was mentioned it had not been investigated, and neither remedial treatment or alternative analgesia had been attempted." (RBA100127, p10)

C27 Professor Baker's concerns about these 16 cases, repeated in later drafts of the report, would lead to them being individually considered by the Key Clinical Team (see section D).

C28 Professor Baker concluded:

"… in some cases, care appeared to have been excellent and appropriate, in others the details of what had happened during the final illness were not clear, but the review as a whole highlighted a consistent pattern. The features of that pattern were:

1. All patients were severely ill, having major disabling, or progressive conditions, or illnesses that were unlikely to substantially improve …

2. Opiate medication was frequently used when patients suffered a deterioration in their condition. Further investigation or active treatment were often not undertaken, and alternative analgesics were generally not used first …

3. In most cases, opiates were not used for prolonged periods, nor were doses excessive …

4. Prescriptions for opiate medication were often written on drug charts on the day of admission, although there was no immediate indication for the use of those drugs.

5. In the case of patients whose deaths had been preceded by the fracture of a bone (most commonly the hip), Dr Barton did not note the fracture on the medical certificate cause of death … It is conceivable that the local coroner would have undertaken at least some investigation into a number of deaths that had followed fractures." (RBA100127, pp11–12)

C29 From this pattern, Professor Baker drew the following conclusions:

(i) "Cannot eliminate unlawful killing.

(ii) The culture at Gosport appeared … to have been conservative with regard to treatment and modest with regard to expectations of improving patient health … It is possible that in a few patients, a more active clinical policy would have extended life.

(iii) The lack of detail recorded in the notes about medical decisions … suggested that the level of collaboration and teamwork was poor.

(iv) The completion of medical certificates of cause of death was inadequate." (RBA100127, pp12–13)

C30 Professor Baker sent this report to Sir Liam on 30 April. The CMO's view was that it suggested instances of *"poor standards of care in relation to opiate prescribing"*. Sir Liam also confirmed that he would like to discuss this issue and that, in the meantime, he was happy for Professor Baker to discuss his findings with the police (RBA000073, p1).

The May draft of Professor Baker's report

C31 On 26 May 2003, Professor Baker and Professor David Jones (Department of Epidemiology and Public Health, University of Leicester) produced the first draft of *A Review of Deaths at Gosport War Memorial Hospital* (RBA000036). This set out the background to the deaths at the hospital, described the CHI investigation and referred to the involvement of Hampshire Constabulary. Professor Baker noted:

> "I have sought to come to an independent view based on an analysis of clinical information from surviving documentary evidence (for example, clinical records, drug registers, medical certificates of the cause of death, and ward registers). The review does not consider statements

> from witnesses, and does not involve a detailed forensic enquiry into particular deaths, since these aspects are the proper responsibility of the police and other agencies." (RBA000036, p11).

C32 The Panel notes that the report is not a *"detailed forensic enquiry"*, which immediately brings into question its utility in any future criminal proceedings.

C33 The report contained a chapter on *"Review of Records".* This was broadly the same as the document produced by Professor Baker on 31 March 2003, but included greater discussion of the *"Features of Care"* identified from the random sample of medical records.

C34 The conclusions Professor Baker reached in relation to the *"Pattern of Care"* were broadly the same as in the document he produced on 31 March 2003, although the conclusion *"Cannot eliminate unlawful killing"* had been removed. The report also contained a chapter on the review of the MCCD counterfoils, with the same concerns and conclusions as expressed in the document produced on 11 November 2002.

C35 The report also included a chapter on *"Prescribing of Opiate Drugs"*. A review of the prescribing of controlled drugs at the hospital indicated:

> "… patients in GWMH [Gosport War Memorial Hospital] whose deaths were certified by Dr Barton were more likely to have been prescribed an opiate (most commonly diamorphine or oramorph). The excess was most evident among patients who were certified as dying from bronchopneumonia with or without other conditions, or from some other condition that was not cancer or cerebro- or cardio-vascular disease. This finding is a cause for concern, since the use of opiates for pain relief in terminal care is more common in conditions in which pain would be expected, in particular cancer. Furthermore, a high proportion of the initial cases referred to the police by concerned relatives had been certified as dying due to bronchopneumonia." (RBA000036, p64)

C36 Professor Baker noted that he had carried out an analysis of a random sub-sample of patients who had died at the hospital and who had been prescribed opioids. This indicated that Dr Barton had not prescribed large quantities of opioids to the patients in her care. However, he also noted:

> "… this finding does not eliminate the possibility that some patients were given opiates unnecessarily. Therefore, the findings of the analyses reported here are consistent with a policy of prescribing opiates to an inappropriately wide group of older patients, although the quantities prescribed to each patient were not abnormal." (RBA000036, p64)

C37 A further *"Draft One"* of the report was produced on 2 June 2003 (RBA100028). While this contained amendments to the original draft, the findings were generally the same.

The June draft of Professor Baker's report

C38 Professor Baker prepared a further draft of the report on 7 June 2003. This included an acknowledgements section and a new summary. The summary concluded:

> "I have concluded that a policy of almost routine use of opiates before death had been followed in Gosport Hospital, and the attitude underlying this policy may be described in the words found in many clinical records – 'please make comfortable'. It has not been possible to identify the origin of this policy, since evidence of it is found from as early as 1988. The policy almost certainly have shortened the lives of some patients, and it cannot be ruled out that a small number of these would otherwise have been eventually discharged from hospital alive." (RBA100031, p7)

C39 The report also included the following information:

(i) "93.8% of patients examined in Professor Baker's sample of 81 received an opiate, and almost half received Oramorph. Opiate medication was frequently prescribed on the day of admission … There was little evidence of use of weak or moderate analgesics before resort to oral morphine, opiate medication being used when patients suffered a deterioration in their condition.

(ii) Diamorphine was administered to 88.9% of patients, almost always by syringe driver and accompanied with other drugs with sedative properties … in those patients in whom the dose of oral morphine could be established, the starting dose of diamorphine tended to be higher than would have been expected.

(iii) In most cases, opiates were not used for prolonged periods, 61.8% dying within five days of starting treatment.

(iv) The reasons for starting opiate medication were often not adequately recorded, and in 39.5% of cases it was not possible to assess the appropriateness of care."

C40 The Panel notes that the implicit criticism in this statement is of the hospital rather than of any individual, particularly as Professor Baker went on to suggest in Chapter 2 of this draft that the policy was in use before Dr Barton arrived at the

hospital. This finding should, arguably, have been reported to the Health and Safety Executive (HSE).

C41 The chapter of the report on *"Prescribing of Opiate Drugs"* was amended. One line was changed to state *"there does appear to have been a change in the use of opiates at the end of life at about the time Dr Barton ceased to have principal responsibility for patients"* (RBA100031, p86). Similarly, in the conclusions, the following statement was inserted:

> "Is does appear that the practice of almost routine use of opiates before death in Redclyffe Annexe changed when Dr Barton ceased principal responsibility for patients in the Annexe. This may have been a consequence of a change in the policy followed by the doctors who took over from Dr Barton, or a change in the mix of patients who were admitted to the Annexe." (RBA100031, p90)

C42 Significantly, Professor Baker added a new chapter drawing together his conclusions. He stated:

> "Patients admitted to Gosport were elderly and with severe clinical problems. Most had been transferred from acute hospital settings after a period of intensive management, at the end of which it had been concluded that further intensive management would have little or no benefit. Patients were transferred to Gosport either for rehabilitation or for continuing care (defined by CHI as 'a long period of treatment for patients whose recovery will be limited'). In this group of very ill and dependent patients, a policy for the liberal use of opiate medication can be discerned from the findings of the review. Patients who experienced pain, and in whom death was judged to be a likely outcome in the short term, were given opiates. Alternative management with other analgesics or detailed assessment of the cause of pain or distress was generally ruled out. This policy may be described as the almost routine use of opiates before death. The policy was followed irrespective of the principal clinical condition. Patients whose main problems were dementia, strokes, bronchopneumonia or neurological problems all received opiates. The policy may be regarded as in advance of care elsewhere in the NHS at the time, and it may be relevant to note that in 1990 the Department of Medicine for Elderly People developed a palliative service at Queen Alexandra Hospital for patients dying from heart failure, dementia and other chronic disorders, and not just patients with malignancy. Concerns have been raised about the end stage care of people with dementia and other problems, in particular the finding that many such patients have not received adequate analgesia, although they have received antibiotics or other treatments intended to be curative.

However, the proportion of patients at Gosport who did receive opiates before death is remarkably high, and it is difficult to accept that the policy of almost routine use of opiates before death, dating from 1988 or earlier, merely represents clinical practice in advance of practice elsewhere. The policy may be summed up in the words found in many clinical records – 'please make comfortable'. This phrase also points to a prevailing attitude or culture of limited hope and expectations towards the potential recovery of patients in Gosport. But in some patients, a different attitude that might be phrased 'determined rehabilitation' would have led to a different outcome.

The review of records has raised concerns about the degree of assessment of patients whose condition deteriorated, and the level of consideration given to decisions to commence opiates. Consequently, it is difficult not to conclude that some patients were given opiates who should have received other treatment. Only a detailed investigation of individual cases, in which the accounts of witnesses as well as documentary evidence are considered, can conclude whether lives were shortened by the almost routine use of opiates before death, but I would expect such case by case investigations to conclude that in some cases, the early resort to opiates will be found to have shortened life. I would also expect that in a smaller number of cases, the policy will be found to have shortened the lives of people who would have had a good chance of surviving to be discharged from hospital.

From the evidence considered in this review, it is not possible to determine how the policy on opiates at Gosport originated. Whilst much of the review has focused on the work of Dr Barton, this is because she issued the MCCDs and made most of the entries in the clinical records. However, this should not be taken as meaning that she was the origin of the policy, she may merely have been implementing it. Indeed, the policy may have been introduced before Dr Barton began work in Gosport as a clinical assistant in 1988." (RBA100031, pp116–18)

C43 Professor Baker made the following recommendations:

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

2) In the continuing investigation into deaths in Gosport hospital, information about the rota followed by Dr Barton and her partners should be obtained and used to explore patterns of deaths. In addition, attempts should be made to identify other community hospitals that have retained detailed episode statistics data.

3) Hospital teams who care for patients at the end of life should have explicit policies on the use of opiate medication. These policies should include guidance on the assessment of patients who deteriorate, and the indications for commencing opiates. The development of national guidelines would help the development of local policies.

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

5) In this review, evidence has been retrospectively pieced together from a variety of sources. Continued monitoring of outcomes at a local level might have prompted questions about care at Gosport hospital before they were raised by relatives, but continued monitoring is difficult with current data systems. Hospital episode statistics are an important resource, but continued prospective monitoring of the outcomes achieved by clinical teams requires a more detailed set of codes." (RBA100031, p118–19)

C44 The conclusions Professor Baker reached would not have been capable of sustaining a criminal prosecution of Dr Barton or any other clinician for any homicide offence.

C45 Another draft of the report was prepared on 11 June (RBA100032). However, no changes were made to the conclusions reached.

C46 Professor Baker sent a copy of the report to the Department of Health (DH) on 11 June (RBA100195).

C47 On 14 June, it was noted at a meeting between Hampshire Constabulary and the Key Clinical Team that Professor Baker had identified a further 16 cases of some concern (HCO005281, p2).

The July draft of Professor Baker's report

C48 The May and June versions of the report had been drafted in the names of both Professor Baker and Professor Jones. In correspondence in June 2003, Professor Jones suggested that Professor Baker *"acknowledge my help but don't share authorship, as the report is overwhelmingly your work, and substantially 'clinical'"* (RBA100378, p1).

C49 Professor Baker also took advice from the Medical Defence Union in relation to the contents of the report. It advised that he:

> "… may wish to add a sentence somewhere to say that you have not heard a first-hand account from the doctor, and that your opinion may

> be substantially altered in the light of further information. Conclusions about the merits of the concerns against the doctor should not be reached without giving her an opportunity to put her side of the story, because to do so would be contrary to natural justice and the Human Rights Act." (RBA000012, p1)

C50 Professor Baker produced another version of the report on (or around) 3 July (RBA100029). The July version was the first to *"acknowledge"* Professor Jones's input and name only Professor Baker as the author. The *"Key Findings"* had been removed from the summary section at the beginning of the report. The recommendations had not changed, apart from the following sentence, which had been removed: *"In addition, attempts should be made to identify other community hospitals that have retained detailed episode statistics data."*

C51 At the end of Chapter 1, Professor Baker concluded:

> "The audit relied on documentary evidence about care of patients at Gosport, and did not involve consideration of statements from individuals. Therefore, conclusions about the actions of individuals should not be reached since they have not had the opportunity of presenting their own side of the story." (RBA100029, p28)

The final version of the Baker Report

C52 The final version of Professor Baker's report was completed in October 2003 (DOH000072). It named Professor Baker as the sole author and was 121 pages long. It confirmed that the documents reviewed included: *"A random sample of 81 clinical records of patients who died in Gosport hospital between 1988 and 2000"*; *"The counterfoils of medical certificates of the cause of death (MCCDs) retained at Gosport hospital relating to deaths in the hospital 1987-2001"*; *"The admissions books of Dryad ward at Gosport, 1993-2001"*; *"Surviving controlled drugs registers at Gosport hospital"*; and *"MCCDs completed by a sample of general practitioners in Gosport"*. The aims of the report had not changed since 30 August 2002 (DOH000072, p4).

C53 Some changes had been made to the final version of the report compared with the July version, although few of these were of particular significance. Importantly, the conclusions were the same, in substance, as those made in the report dated 7 June 2003. While there were some amendments in wording, these were not significant. By this stage, the word *"policy"* had been replaced with *"practice"* (or similar).

Requests for disclosure of Professor Baker's report

C54 Even before Professor Baker produced the final version of his report, consideration was being given as to who it should be disclosed to, and requests were being made for its disclosure. After receiving an email from Lee McGill at DH,

Professor Baker asked if he could share his report with the police, as he was expecting them to contact him on or around 10 September 2003. The email was forwarded within DH. It was made clear to Professor Baker that legal advice was being sought regarding his request and that DH would get back to him (RBA100134).

C55 On 11 September, a Family Group Meeting was held in which an attendee asked: *"Is there any progress from Professor Baker?"* Det Insp Niven responded: *"I spoke to Professor Baker this morning and he has submitted his report to the Chief Medical Officer in which he will articulate any concerns. This should be available to us soon and when it is we will be able to consider his findings."* A further question was asked: *"When will you get his report?"* Det Insp Niven responded: *"Not too far down the line"* (HCO000638, p93).

C56 This was an unfortunate response by Det Insp Niven. No decision had yet been made as to what would be done with the report. The suggestion that the report's release was imminent would naturally create suspicion, if it was not then released, that matters were being hidden from the families.

C57 On 29 September, an entry was made in a Policy File: *"Persist to have sight of Prof Bakers report."* The entry continued: *"16 cases have been identified by Professor Baker as giving him cause for concern. There are at least four (4) other cases that have come to notice. They should be analysed by Clinical Team using the same model"* (HCO000638, p106).

C58 On 3 October, the CMO wrote to Det Ch Supt Watts about the report. The CMO stated: *"We have decided that it would not be appropriate at this time to make a decision as to whether or not to publish the report. However, I understand from Professor Baker that the police have asked for a copy of the report."* He confirmed that he had no objection to the police having a copy of the report, but stressed that it should remain confidential (DOH000118, p2). On 9 October, Det Ch Supt Watts replied, confirming that the report would remain confidential in the event that it was passed to the police (HCO000638, p129).

C59 On 28 October, the CMO provided a copy of Professor Baker's report to Det Ch Supt Watts (DOH000109).

C60 On 14 January 2004, Det Insp Niven wrote to the CMO regarding the report. He confirmed that they had agreed that the *"report would not be published until a later date"*. They had also agreed that *"publication at this time could prejudice the investigation"*, possibly by contaminating the recollection of witnesses. Det Insp Niven also confirmed that Professor Baker had identified 16 deaths that caused him concern, and that Hampshire Constabulary were having the medical records for those patients analysed by the Key Clinical Team. It was noted that the deceased's relatives were unaware of the situation (DOH000366, p1).

C61 The 16 cases that Professor Baker had raised concerns about were identified by the police as: Patient M, Helena Service, Frank Horn, Patient A, Rhoda Marshall,

Patient C, Phyllis Horne, Mabel Leek, Patient Q, Patient D, Patient K, Euphemia Skeens, Wilfred Harrington, Ruby Lake, John Richie and Patient E.

C62 The KCT categorised three of these cases as falling within Category 3B – negligent treatment where the cause of death was unclear. These three cases were also the subject of inquests in 2009. Dr Baker had identified the 16 cases as part of a random sample comprising 10% of the 833 deaths certified by Dr Barton between 1988 and 2000. Further investigation of the records in relation to the remaining 748 cases could and arguably should have been conducted, in order to determine whether there were concerns relating to the decision to start the patients on opioids. However, Hampshire Constabulary had decided to *"draw the line"* at the 16 cases (as Det Insp Niven explained at a meeting with the KCT) (HCO005281, p2).

Professor Baker's witness statements and subsequent reports on Arthur Cunningham and Robert Wilson

C63 Professor Baker produced a witness statement for the police dated 8 September 2004, concerning the production of his report. In it, he stated:

> "As made clear in the report, I became concerned about aspects of care at Gosport War Memorial Hospital, including aspects of the care provided by Dr Barton. I concluded that it was probable that a small number of patients who had been given opiates and had died might, if they had not been given opiates, have sufficiently recovered to be discharged from hospital eventually. An attitude or culture of limited hope and expectations of recovery appeared to have existed at the hospital. I was unable to identify when this culture had first gained hold at the hospital and it may have existed before Dr Barton's appointment in 1988. In addition, I have not identified the underlying motivations responsible for this culture." (HCO006045, p4)

C64 On 28 September, members of the Hampshire Constabulary Investigation Team met Mr Perry, Treasury Counsel. Professor Baker's report was discussed and *"Counsel was reminded of the heavyweight comments of Professor Baker"*. It was also noted that *"The reporting of Professor Baker and the CHI in addition to the police investigation provided a formidable case for the GMC and possibly a health and safety prosecution, although the value of an HSE prosecution would be debatable"* (HCO000041, pp1–2).

C65 The meeting note does not say what might prompt such a debate on the value of an HSE prosecution, nor to whom such a prosecution might have value. Fines for health and safety offences (the only available penalty for corporate offences) were considered to be relatively low at the time.

C66 On 31 October 2005, Detective Constable (Det Con) Anthony Tenison from Hampshire Constabulary emailed Professor Baker and informed him that a file had been passed to the CPS and was being reviewed by Treasury Counsel (Mr Perry).

Professor Baker was asked if he could *"expand upon the comment in your statement that the patients might have recovered had they not been given opiates"*. The cases of particular note in this regard were *"Cunningham and Wilson"*. Professor Baker was asked to consider these issues by the end of November, marking his reports as *"draft"* in the first instance (RBA100191, p1).

C67 On 28 November, Professor Baker finalised a report in response to Det Con Tenison's request (RBA000025).

C68 This *"Report"* was not produced in the format of a section 9 Criminal Justice Act 1967 statement (that is, as a witness statement to be used as written evidence in criminal proceedings); nor was it explicitly an expert report prepared for criminal proceedings. Professor Baker did not, for example, set out what his duties to the court would be as an independent expert witness. However, he had not been given any guidance or meaningful instruction in this regard.

C69 Professor Baker concluded in respect of Mr Cunningham:

> "The commencement of diamorphine by syringe driver, by promoting the onset of bronchopneumonia, would have played a significant role in leading to death. It is not possible from the information in the records to judge whether Mr Cunningham's ulcer would have responded to 'aggressive' treatment, how long he would have otherwise lived, or whether he would have been discharged from Dryad ward alive." (RBA000025, p3)

C70 In respect of Mr Wilson, Professor Baker asked:

> "Was the commencement of opiate analgesia premature? Since there is so little about this decision in the records it is very difficult to reach a firm conclusion. When viewed in the context of the other cases that I reviewed, there must be concern that opiates were started too soon." (RBA000025, p5)

C71 Professor Baker noted, more generally:

> "… liberal use of opiate medication, amounting to almost routine use reflecting a culture of making 'comfortable' rather than treating vigorously … In some cases therefore, it seems to me very likely that conditions that could have been readily treated were instead followed by the administration of opiates and subsequent death. This means that some patients would not have lived as long as they would have done if they had received more vigorous treatment. I do not know how many patients' lives were shortened and cannot identify individual cases with confidence, although those in which concerns about the decision to start opiate medication were identified during the review of medical records would be the cases to assess in more detail … In those lives

that were shortened, the amount of life lost is very difficult to estimate … Nevertheless, I did feel that some patients, who I could not identify, would have lived long enough to be discharged from hospital." (RBA000025, p5)

C72 On 12 December, Detective Inspector (Det Insp) David Grocott of Hampshire Constabulary sent Professor Baker a letter, asking if he *"could now prepare a statement of evidential use that could be used in the event of criminal proceedings arising from the case of Robert Wilson. This would be in addition to the statement you prepared last year."* Det Insp Grocott continued: *"I have no idea what information you have seen or been given access to specifically in relation to Mr Cunningham or Mr Wilson"* (RBA100062, p1).

C73 In February 2006, Professor Baker prepared a report detailing the chronology of Mr Wilson's care (GMC101068, pp2–22). This was more comprehensive than his previous comments to Hampshire Constabulary and was in the same format as the reports prepared by Professor David Black and Dr Andrew Wilcock (see section E). Professor Baker confirmed that he had been asked to address three questions:

a. "Certified cause of death. In this case, was the certified cause of death supported by the medical history of the patient?

b. Prescription of opiates and sedatives. In the case of Mr Wilson was his prescribing in accordance with his clinical need?

c. Leaving hospital alive. In my statement (080904) I had referred to patients who were administered opiates and eventually died who may have recovered and left hospital had they not received this medication. The issue to be addressed was whether, in my opinion, Mr Wilson fell into this category." (GMC101068, p5)

C74 Professor Baker concluded:

"With respect to death certification, I have concluded that the certificate was inaccurate in that Mr Wilson did not have renal failure, and had liver dysfunction but not failure. He probably did have heart failure, although I believe the initiation of opiate medication was an important factor in leading to death." (GMC101068, p4)

C75 In relation to opioids, he said:

"With respect to the prescription of opiate drugs, I have concluded, on the evidence available to me, that the initiation of opiate medication on transfer to Dryad ward was inappropriate; I have also concluded that the starting dose was too high. The prescription of hyoscine and midazolam was justified by the use of opiates." (GMC101068, p4)

C76 Professor Baker concluded, taking into account a number of qualifying factors, that *"Mr Wilson was in the category of patients who might have left hospital alive if he had not been commenced on opiate medicine on transfer to Dryad Ward"* (GMC101068, p4).

C77 This appears to be a significant departure from Professor Baker's earlier conclusion on the same issue, as expressed in the 28 November 2005 report. There, he had said: *"Since there is so little about this decision in the records it is very difficult to reach a firm conclusion. When viewed in the context of the other cases that I reviewed, there must be concern that opiates were started too soon"* (RBA000025, p4).

Continued embargo and subsequent publication of Professor Baker's report

C78 On 9 January 2007, Detective Superintendent (Det Supt) Williams recorded in a Policy File that he had liaised with the CMO's representative, Colin Philips, regarding *"the issue of embargo of Professor Bakers statistical analysis of deaths"* at the hospital (HCO000644, pp135–7). The reason given was that Professor Baker *"has supplied witness statement referring to his report. Will be required by GMC but remains embargoed."* Emails attached to this entry show that Det Supt Williams' understanding (on 8 January) was *"that the Baker report was to be held by the CMO in confidence so as not to prejudice the police inquiries"* (HCO000644, p137).

C79 Professor Baker's report was not released prior to the inquests held in 2009 into the ten Category 3B cases. In fact, DH received legal advice that the report should not be released until after the conclusion of the Gladys Richards inquest (MOJ000102). This did not take place until 2013. Professor Baker's report on Robert Wilson was read to the jury at the inquests in 2009.

C80 The final version of the report was made available in 2013. It is published on www.gov.uk, alongside the following statement:

1. "Professor Baker completed the review in October 2003. It has not been possible to release the report before now because it formed part of the evidence for police investigations and other legal proceedings. The final inquest into the deaths considered in the review ended in April 2013. The text of the report is being released in full.

2. Professor Baker's review presents an audit of care drawing upon clinical records, medical certificates of cause of death, admissions books, controlled drugs registers, and the work of a sample of GPs.

3. Professor Baker made 5 recommendations in his report. These have been largely overtaken by developments since the review was carried out."

D The Key Clinical Team

The formation of the Key Clinical Team

D1 Professor Livesley had been instructed solely to prepare a report into the death of Gladys Richards. Despite this, he told Hampshire Constabulary that there were grounds to believe there were institutional practices at the hospital that may have led to the premature deaths of other elderly people (CPS001888, p1). At a meeting on 31 May 2001, Professor Livesley and Det Supt James discussed how to proceed in terms of examining additional cases. It was agreed that Hampshire Constabulary would consider cases over a significant time span (from 12 months before Dr Barton's employment at the hospital to the date of the second investigation into the death of Mrs Richards). They would also need to develop a mechanism to examine individual cases, in order to identify *"those that may be categorised as unlawful [and] the criminal liability of any individual"* (HCO000906, p3).

D2 Professor Livesley later suggested that Hampshire Constabulary obtain assistance from the statisticians who had been engaged in investigating the Harold Shipman murders. Hampshire Constabulary arranged to meet Professor Forrest, a member of the team who had worked on the Shipman case, to *"discuss opportunities for gathering best evidence"* (HCO000637, p33).

D3 On 28 November 2002, Hampshire Constabulary decided to draw together a team of experts from palliative, geriatric, toxicological and other disciplines, under the leadership of Professor Forrest. The team would be asked to review all the cases subject to police investigation, including the case of Gladys Richards and the *"4 cases studied by the CPS"*: Patient L, Arthur Cunningham, Robert Wilson and Alice Wilkie (CPS001008, pp1–2).

D4 On 12 December 2002, Det Ch Supt Watts met Professor Forrest at the Sheffield Medico-Legal Centre. Professor Forrest agreed to form the team referred to as the 'Key Clinical Team' (KCT) (HCO000637, p59). The KCT's terms of reference were to examine the patient notes independently and to assess the quality of care provided to each patient. The KCT was not confined to looking at the specific issue of syringe drivers or administering diamorphine, but was to look more generally at overall care. The purpose of the reviews was to screen the cases and identify, where appropriate, areas of concern that warranted further investigation by the police. At the same time, the team could identify cases where there were no concerns and the treatment that had been provided was appropriate in the circumstances (HCO006798, p5). Professor Forrest estimated that the team's work could take in the region of three to six months. The analysis was to encompass all the cases referred to the police and a sample of cases going back to 1989, as determined to be statistically relevant by the team.

D5 On 12 February 2003, it was confirmed that the KCT would comprise Professor Robert Forrest (lead), Dr Robin Ferner (a consultant pharmacologist),

Dr Peter Lawson (a consultant geriatrician), Dr Anne Naysmith (a consultant in palliative medicine) and Irene Waters (a consultant in nursing). Their role was *"To analyse the medical records to ascertain & explain their evidence. By contributing upon the basis of their individual disciplines will allow Police, CPS & counsel to determine if offences have been committed"* (HCO000637, p95). As the work of the KCT developed, Professor Forrest would take on the role of co-ordinator and step back from considering individual cases (HCO000638, p72).

D6 On 13 May, Barry Glanfield, Contracts Officer for Hampshire Constabulary, submitted to Hampshire Police Authority a *"Single Tender Application"* to cover the cost of the work that the KCT would undertake. The application noted that allegations had been made by 62 relatives of patients who had died at the hospital, and that concerns had also been raised regarding further deaths going back to 1989. The proposal was that the team would *"review the case notes in respect of the 62 patients and provide a view as to the appropriateness of the treatment given"*. It was noted:

> "Each expert will be required to review the first 20 medical records based within his/her area of expertise and give an opinion of the care and treatment received by each patient using an agreed formula. Based upon their findings they may then be required to make a statement to the Police and if required to do so, attend court in connection with any hearings held at a later date." (HCO003334, p5)

D7 It appears to have been envisaged that the members of the KCT might give evidence in criminal proceedings.

The first meeting of the KCT

D8 On 8 and 9 March 2003, the KCT met representatives of Hampshire Constabulary at Cheadle House near Manchester (HCO004714, HCO004729). Professor Forrest confirmed that the KCT had devised a matrix to score and assess each patient's care . Individual cases would be categorised as A, B or C (where the deaths were natural, unclear or unexplained by illness) and 1, 2, 3 or 4 (where the care was optimal, sub-optimal, negligent or intended to cause harm) (HCO000638, p48). In a later meeting it was explained that 'Category C – unexplained by illness' *"meant that the treatment had killed the patient and there was no explanation for that treatment"* (HCO005151, p2). During the meeting:

> "[Det Ch Sup Watts] asked for clarification of Band C. Professor FORREST explained that in basic terms the treatment a patient falling into that care band had received had killed the patient. DI Niven asked why this was not specified on the chart. Doctor NAYSMITH responded that the definition should read there was no explanation for the treatment meted out to patients falling into band C. No explanation for treatment was agreed as the rating explanation." (HCO005151, p2)

D9 The KCT would examine the medical records of the first 20 cases, alphabetically, and then meet to discuss their *"findings/mechanism"*. The KCT requested that the police provide them with a large amount of material that they considered would assist them with their work. A large number of requests were made in respect of material directly related to Dr Barton. However, *"Detective Inspector Niven informed the clinical team that Dr Barton is not a suspect in this case. The clinical team were reminded that their only task is to review the medical notes and raise comment about treatment"* (HCO004729, p2). A PowerPoint presentation was prepared for the KCT setting out the background and progress of the police investigation (HCO116169). Although this was not recorded in the minutes or the PowerPoint presentation, members of the Hampshire Constabulary Investigation Team noted in other documents that each expert was briefed about the need to keep their notations and findings for possible later disclosure to interested parties in line with the Criminal Procedure and Investigations Act 1996. They were not required, however, to produce evidential expert reports on each individual patient for presentation in court (HCO006798).

D10 In a memorandum dated 13 March 2003, Det Ch Supt Watts recorded that at the meeting on 8 March, the proposal put to the *"five experts"* was to:

> "… review the case notes in respect of all 62 patients and give a view as to the appropriateness of the treatment in order to answer the questions;
>
> (i) Were these people so ill that they were going to die?
>
> (ii) Was an honest mistake made by a member of medical staff?
>
> (iii) Did any member of medical staff behave negligently?
>
> (iv) Did any member of medical staff deliberately cause the death of any of these patients?" (HCO004725, p2)

D11 Det Ch Supt Watts also stated that *"those questions are essential to move the investigation on and enable the Force to demonstrate to the families and other interested parties that a thorough investigation has been carried out"* (HCO004725, p2).

D12 The Panel notes that the four questions listed above were omitted from the minutes taken on 8 and 9 March.

The KCT meeting to discuss the first batch of 20 cases

D13 On 26 April 2003, the KCT met representatives of Hampshire Constabulary for a conference. Professor Forrest stated that *"after discussing half of the material available with the rest of the team the consensus was that between 10 and 20% of cases was indicative of possible deliberate harm. Dr Ferner scored lower stating that*

the intent to cause harm was difficult to argue". The standard of nursing at the hospital was said by the Clinical Team to be poor. Deficiencies in the medical records and note taking were observed: for example, *"prescription sheets were missing, … Deemed to be one of the most vital documents"* and *"there were omissions in note making where major medical decisions were made, i.e. why a patient had been placed on syringe driver"* (HCO005282, p3).

D14 Dr Ferner concluded that *"so far results do not suggest they represent the practice of one Doctor, rather they suggest more a practice specific to the hospital"* (HCO005282, p4). Det Ch Supt Watts asked whether there was a commonality in the profile of the people affected. Dr Naysmith noted that in some notes there was no mention of pain, while in others there was the suggestion that patients were *"difficult, noisy or disruptive".* Professor Forrest was of the view that *"initial results suggested there was something less than random"* (HCO005282, p4). The KCT was asked to flag up such issues so that they could be investigated further if a pattern began to emerge. The KCT had identified four patients (described as 17, 16, 15 and 4) whose treatment had caused them the most concern, and seven cases where drug charts were missing (HCO005282, p5).

The KCT meeting to discuss the second batch of 20 cases

D15 On 14 June 2003, the KCT met representatives of Hampshire Constabulary in Northampton to consider the findings of the KCT in relation to the second batch of 20 cases. Det Insp Niven informed the meeting that Professor Baker had highlighted *"a further 16 cases of some concern, but assured the meeting that in order for the investigation to reach a conclusion a line may have to be drawn under an agreed amount"* (HCO005281, p2).

D16 The KCT had categorised the latest cases as raising either *"No Concerns"*, *"Middle"* or *"Serious Concerns".* The KCT considered that eight cases raised *"no concerns"*, seven cases fell into the *"middle"* category and in four cases there were *"serious concerns"* (HCO005281, pp2–3).

D17 It is not clear to the Panel why only 19 cases were considered.

D18 It is clear that the members of the KCT were not always unified in their decisions. For example, Patient BJC27 was categorised as being of *"no concerns"*, but a comment in the notes states *"most of the team were comfortable with this decision though there were some discrepancies"*. In the case of Patient BJC26, *"this case was graded A2 with Mrs Waters placing it at 2B".* In respect of one patient listed in the *"Serious Concerns"* category (BJC31), it was noted that there were *"some concerns but there were worse cases"*. The case of Patient BJC29 was described as *"at the very least negligence".* Professor Forrest summarised the KCT's views by saying that *"although in the previous batch there had been a number of cases of note, files in this 2nd batch raised higher concerns"* (HCO005281, pp2–3).

The KCT's categorisation of the 62 cases

D19 On 7 September 2003, representatives of Hampshire Constabulary met the KCT again (HCO005151). Professor Forrest presented the KCT's findings in relation to all 62 of the cases assessed. The definitions of the care bands A, B and C and 1, 2 and 3 were explained. Seven cases had raised concerns, and those cases had been given a 3B rating, which meant that the care provided was negligent (3) and the cause of death was unclear (B). That group comprised: Arthur Cunningham, Elsie Devine, Sheila Gregory, Elsie Lavender, Enid Spurgin, Jean Stevens and Robert Wilson. Det Ch Supt Watts requested all the KCT's original notes for disclosure purposes and as *"part of the analytical process"* (HCO005151, p4).

The review of further cases by the KCT

D20 On 29 September 2003, Det Insp Niven noted:

> "16 cases have been identified by Professor Baker as giving him cause for concern. There are at least four (4) other cases that have come to notice. They should be analysed by Clinical Team using the same model. This is essential - we are trying to do this by 6/12/03." (HCO000638, pp106–107)

D21 Over the course of the next few months, the KCT reviewed the further cases it had been provided with. A further meeting of the KCT was held on 29 February 2004 to review these *"outstanding"* cases. At this meeting, KCT members produced their findings in relation to seven cases they had already reviewed. Notably, the case of Mrs Stevens was changed from Category 3 to Category 2B. The meeting also considered eight cases provided to the KCT by the police, following complaints made to the police by concerned relatives. These cases were categorised by the KCT, but were not deemed to fall into Category 3. During the meeting, the members of the KCT also provided their categorisation of the cases that had been referred to them following the review conducted by Professor Baker. The KCT determined that the cases of Helena Service and Patient M fell into Category 3B (albeit with a suggestion that Patient M could be categorised as a Category 3C case). The KCT was unable to categorise the case of Ruby Lake due to the absence of drug charts, nursing notes and notes from Haslar Hospital (HCO110298).

The involvement of Matthew Lohn and the review of the KCT findings

D22 On 14 August 2003, shortly before the KCT had completed its review and categorisation of the 62 cases originally referred to it, Hampshire Constabulary decided to employ Matthew Lohn, a partner at the law firm FFW, to assist the Investigation Team. It was noted that Mr Lohn was *"medically and legally qualified"*. His role was to be *"separate and distinct"* from that of the CPS. It was intended that

Mr Lohn would assist with the investigation and interview strategy (HCO000638, p85). Det Insp Niven visited Mr Lohn on 14 August to provide a briefing.

D23 However, Mr Lohn's role quickly developed from one of assisting the police with their investigation to reviewing and quality assuring the work carried out by the KCT. On 11 September, Deputy Chief Constable (Dep Ch Con) Ian Readhead met Det Ch Watts, Chief Superintendent (Ch Supt) Derek Stevens and Alison MacDougall (a member of the Police Complaints Authority) to provide an update on Operation Rochester. Det Ch Supt Watts explained that he had a role on the Homicide Working Group, which did work for the Association of Chief Police Officers, and was responsible for assisting with the production of guidelines in relation to health-related deaths. He said that he had:

> "… spoken to many SIOs to find the best way forward, and it was decided that there was a need to form a panel of experts. This was seen as best possible practice to have a screening panel of experts, which gives the SIO more indication as to whether more evidence is needed, whether the deaths were caused by natural causes, whether there was suboptimal treatment, that there was not gross negligence, or whether there was gross negligence, or even an intent to kill … That process has taken until last weekend, by which time the panel had analysed all the cases and scored them on a range of 1(a) to 3(b)." (HCO005270, pp3–4)

D24 He went on to detail how FFW was going to:

> "… review what the experts had said, and that there was now a deliberate intention to build a Chinese wall between the panel and what was not going to go forward as 'expert opinion'. There was always a possibility in any future potential criminal proceedings, that the defence would use the fact that a group of people had got together to agree upon the conclusions, whereas now these conclusions would be reviewed by individual experts, and that's what the Court would require, should there be subsequent proceedings." (HCO005270, p5)

D25 On 16 September, Mr Lohn emailed Det Insp Niven, undertaking to *"Produce a file for each individual including a copy of medical records, copy of each individual expert report, and a copy of summary report (produced during KCT meeting 6/7th Sept)"* (HCO000640, p32).

D26 Mr Lohn would also produce his own analysis of the cases reviewed by the KCT. In respect of the cases the KCT had classified as Category 1, Mr Lohn would *"ensure that the decision taken is capable of justification, and exit strategy for this group at the end of the year"* (HCO000640, p32). In respect of the cases deemed to have fallen into Category 2, Mr Lohn would:

> "… ensure consistency of decision over the period of analysis to ensure that no case should have otherwise been classified [as a Category] 3. Explore possibility that sub optimal [Category] 2 treatment may in fact be negligent, and worthy of further scrutiny. Prepare exit strategy to explain why sub optimal is not criminal. Consider the case law test for gross negligence." (HCO000640, p32)

D27 In respect of the Category 3 cases:

> "In these cases further work will need to be taken to determine whether there is a demonstrable causative link between the negligence and the ensuing outcome including an analysis of the hastening effect of treatment. Further expert opinion will be needed to understand the degree of negligence and to what extent it could be said to be criminal or otherwise." (HCO000640, p32)

D28 Mr Lohn also recommended that Dr Lawson and Dr Naysmith from the KCT produce a summary of their findings. He further advised that all the serious cases should be considered by a fresh team, including experts in palliative care and a consultant geriatrician with experience in caring for patients in a community nursing home (HCO000640, p32).

D29 On 24 September, Det Insp Niven and Detective Sergeant (Det Sgt) Owen Kenny met Mr Lohn in Manchester. During that meeting, it was noted:

> "… the Clinical Team had been employed to provide an analysis of case notes and provide a filtering system. This process will continue … They will continue to be employed as the key team, but if any case was later considered to be appropriate for any form of proceedings, then a separate team of experts will be used. Teams will be referred to as 'Key Clinical team' and 'Clinical Review Team'." (HCO000638, p103)

D30 It was also noted during the meeting that Mr Lohn would *"review cases using medical records, clinical team comments and Officers Reports and will devise questions for Dr Lawson and Dr Naysmith who were going to 'refine' certain cases".* Mr Lohn would review the cases falling within Categories 1A and 2A as a priority (HCO000638, p104).

D31 On 7 October, members of the Hampshire Constabulary Investigation Team met Robert Drybrough-Smith and Mr Close, both of the CPS. Mr Drybrough-Smith asked about the role of Mr Lohn and commented that he was not a prosecution lawyer, but the police were going to him for advice rather than the CPS. Det Insp Niven stated that Mr Lohn was assisting the police in the investigative phase, not the prosecution, as *"that will always be a matter for the CPS"*. The CPS asked to be copied into any advice provided by Mr Lohn (HCO005249, pp2–3).

D32 The Panel has seen no document to confirm that this happened.

D33 On 9 November, Dr Naysmith produced her *Report Concerning the Screening Assessment of First 61 Cases Analysed*. She stated at the start of the report:

> "This report is compiled from the annotations made during the initial screening of each case. No subsequent editing or amendment is included in this report. However, it should be noted that only the first 20 cases were screened truly blind. In assessing the first 20, I applied the same standard as I would to my own practice, i.e. that of an experienced medical practitioner in the speciality of palliative medicine. It is my personal belief that excellent clinical practice, i.e. the best possible decision making given the clinical information available and the patient's preferences, should be the same in all settings, whether specialist or generalist. However, during the conference after the screening of the first 20 cases it was made clear to me that I was setting an unrealistically high standard for practice in a rehabilitation/continuing care setting. My assessments of all subsequent cases were influenced, therefore, by the views of the other members of all the clinical team. There will not be complete consistency in my assessment between the first 20 case and the subsequent ones." (HCO003793, p3)

D34 Dr Naysmith's report concluded that eight cases fell within Category 3B (negligent treatment where the cause of death was unclear). These were: Henry Aubrey, Walter Clissold, Elsie Lavender, Catherine Lee, Elizabeth Rogers, Jean Stevens, Robert Wilson and Patient H. One case fell within Category 3C (negligent treatment where the cause of death was unexplained by illness): Elizabeth Aubrey. One case fell within Category 4A (the treatment intended to cause harm but the patient died of natural causes): Edwin Carter. One case fell within Category 4B (the treatment intended to cause harm and the cause of death was unclear): Arthur Cunningham. One case fell within Category 4C (the treatment intended to cause harm and the cause of death was unexplained by illness): Elsie Devine.

D35 Dr Naysmith's report, and in particular her findings in relation to the first 20 cases she reviewed, serves as a good example of the divergence of opinion within the KCT when considering individual cases. It is clear from the notes prepared by individual members of the KCT that, while the team was able to reach a collective decision on the categorisation of cases, members often had very different views about the standard of care afforded to individual patients and whether their death resulted from natural or unknown causes.

D36 On 13 January 2004, a meeting took place between representatives of Hampshire Constabulary, Mr Lohn and representatives of the CPS. Mr Lohn explained that his role was to analyse *"medical records/expert reports and quality assurance"*. Speaking of the cases he had reviewed, he explained that while *"most*

… are clearly 1As, out of an abundance of caution any that leave … any doubt are upgraded" (HCO003768, p2).

D37 In an email dated 15 January 2004, Det Ch Supt Watts noted that Mr Lohn was engaged in a quality assurance review of the Category 2 cases the KCT had already considered. Hampshire Constabulary would soon be moving to the *"next phase"* of its investigation, *"which will be focused upon gathering evidence in those cases where there is the potential to establish criminal culpability"*. Mr Lohn was to complete the quality assurance task in respect of the cases categorised as 1A by *"mid-February"* (HCO000639, p79).

D38 Mr Lohn continued to review the cases considered by the KCT over the following months. On 20 July, he wrote to Det Sgt Kenny to confirm that he had completed his review of the Category 2 cases, and enclosed the summary reports. He noted concerns regarding Edith Aubrey, Henry Aubrey, Patient H, Geoffrey Packman, Gladys Richards, Elizabeth Rogers and Sylvia Tiller (HCO003051, p2). Mr Lohn had not, by that stage, completed his review of the Category 2 cases that Professor Baker had referred to the police, as he had not been provided with the KCT's notes on these cases.

D39 On 12 August, Det Supt Williams met Mr Lohn regarding *"Category 2 classifications"*, in particular those cases Mr Lohn had raised concerns about. It was agreed that those cases would be sent back to the KCT and *"their assessment reviewed through dialogue with Matthew Lohn"*. The reason for this was: *"Within the seven reports there are references to hastening death through inappropriately large doses of Diamorphine. + Disparity in grading process. Rationale for process by which KCT decisions made needs to be explored in the interest of the Investigations."* The notes of the meeting state:

> "Following further discussion it was decided that a final meeting would be held with the KCT to discuss the issues around the seven cases and any similar cases raised by Matthew Lohn following his completion of work around the remaining 31 category 2 cases. Mr Lohn will attend the meeting which should also be attended by 3 members of the KCT that are clinically authoritative to pass opinion, Lawson, Naysmith and Ferner." (HCO003033, p114)

The KCT meetings on 9 and 10 October 2004

D40 The KCT met over the course of 9 and 10 October 2004 to discuss a number of issues. On 9 October, KCT members considered the cases of Christina Town, Arthur Cousins, Lilian Taylor and Ruby Lake. The case of Mrs Lake was re-categorised as 3B. The cases of Mrs Town, Mr Cousins and Mrs Taylor were eventually removed from the police investigation, after the KCT determined that they fell outside Category 3 (HCO000642, p87).

D41 On 10 October, Matthew Lohn attended the meeting. The seven Category 2 cases that he had suggested should be upgraded to Category 3 were discussed. It was agreed that the cases of Edith Aubrey, Henry Aubrey, Patient H, Elizabeth Rogers and Sylvia Tiller would remain in Category 2. A gastroenterologist would be commissioned in respect of the case of Geoffrey Packman, and further work would be undertaken to consider the evidence in the case of Gladys Richards (HCO000641, p49).

D42 On 15 November, Mr Lohn wrote to Det Insp Niven after reviewing the statements of Gillian Mackenzie and Lesley Lack. Mr Lohn was of the opinion that the Gladys Richards case should be sent back to the KCT for further scrutiny, or that it could be reviewed by Dr Black and Dr Wilcock. Mr Lohn concluded:

> "Since the statements provide alleged insight into the thinking of Dr Barton, this may alter the classification. I am not optimistic that there will be a significant change since Mrs Richards was acknowledged to be very frail. It may lead to some criticism that GWMH did not give Mrs Richards a fair chance and effectively decided Mrs Richards was going to die and they would treat her as such." (HCO000641, p87)

D43 Dr Lawson considered that Geoffrey Packman had died of natural causes, but that his medical care was *"terrible"* and his gastrointestinal bleed was treatable. Dr Jonathan Marshall, a gastroenterologist, considered the case of Geoffrey Packman. He formed the opinion that Mr Packman was *"likely to have suffered a gastrointestinal bleed"* but that, given his morbid obesity, *"he would [have] represent[ed] a high risk for surgery"* and this would have been *"difficult to justify"*. The decision was made to refer the case of Geoffrey Packman to Dr Black and Dr Wilcock for their expert opinion (HCO000642, p80).

D44 The Key Clinical Team Table on this website reveals what the documents say about the assessment of patients by each of the members of the KCT.

KCT members' involvement with the inquests

D45 On 1 April 2009, Professor Forrest prepared a report in respect of Elsie Devine at the instruction of Mrs Devine's family. However, this report was never used as evidence at the inquest. At paragraph 9 of the report Professor Forrest said:

> "It was never intended that the product of our review would be suitable for evidential use. Rather it was a screening exercise designed to identify those cases that gave rise to particular concern. As I understand it, the plan was for those cases to then be reviewed by other experts who would produce reports on individual cases in detail that the CPS would eventually consider and which, absent prosecution, would eventually be passed on to HM Coroner." (TLE000118, pp3–4)

D46 He continued:

> "Our team report was an intelligence/screening exercise and, as such, was never intended to directly support consideration of a prosecution or a coronial inquiry. It was intended to provide a focus for further investigation. I do not even have a physical or electronic copy of the final assessments we made. All of our notes were, as I recall, collected by the Police after the exercise was completed." (TLE000118, p4)

Professor Forrest did not give evidence at the inquests.

D47 On 28 August 2012, Professor Ferner (Dr Ferner had become a professor by this date) prepared a report in respect of Gladys Richards, having been instructed by Mrs Richards' family (PCO001995). Professor Ferner subsequently gave evidence at the inquest into the death of Mrs Richards in 2013.

E Professor Robert Black and Dr Andrew Wilcock

The identification of Professor Black and Dr Wilcock as expert witnesses

E1 On 25 May 2004, Hampshire Constabulary decided to commission an expert in palliative care to provide a report as part of the ongoing Operation Rochester investigation (HCO000640, p15).

E2 In 2004, Dr Wilcock was a lecturer and reader in palliative care and medical oncology at Nottingham University. He was engaged by Hampshire Constabulary to provide evidence in relation to the cases that the KCT had classified as Category 3: those warranting further detailed investigation to determine whether unlawful activity could be identified. Dr Wilcock was instructed *"to provide independent evidence in respect of the standard of care afforded to Category 3 cases, in accordance with the standards of medical care of the day"* (HCO000640, p15). The purpose of obtaining expert evidence from Dr Wilcock was recorded as follows: *"Once Dr Wilcock's expert evidence is available then having regard to his professional opinion, healthcare professionals may be interviewed under caution in respect of allegations of gross negligence manslaughter"* (HCO000640, p37).

E3 In addition to obtaining evidence from Dr Wilcock, Hampshire Constabulary identified the need to obtain further expert evidence:

> "Research is currently being conducted in order to identify and recruit a suitable geriatrician to work in conjunction with Andrew Wilcock (palliative care expert) as our Clinical Review Team. Ten eminent geriatricians are currently being researched by DC Tenison." (HCO000640, p63)

E4 Hampshire Constabulary decided to instruct Dr Andrew Black as part of its investigation. At the time, Dr Black was a consultant geriatrician. (During the

investigation he became a professor, and for ease of reference is hereafter referred to as Professor Black.) In July 2004, Professor Black was provided with papers in relation to the case of Elsie Devine, which comprised Mrs Devine's clinical notes and a legal briefing document prepared by Hampshire Constabulary.

E5 The Panel has been unable to locate any correspondence between Professor Black and the police in relation to these papers.

E6 On 5 August, Professor Black met representatives of Hampshire Constabulary in order to confirm the structure of the reports commissioned and the timescales for delivery (HCO000640, p111). Professor Black was asked to consider *"all four initial cases"* (Elsie Devine, Elsie Lavender, Patient M and Helena Service) and *"identify whether there are any recurring themes in respect of lack of patient care"*. Professor Black agreed to review the statements *"together"*. He *"stated that he hadn't initially realised the size of the task that was before him with regards to the amount of work that was now being generated. He was aware of the Police's timescales and would do his best to meet them."*

The basis of the instruction of Professor Black and Dr Wilcock

E7 Hampshire Constabulary met the CPS on 6 July 2004 and expressed the view that the CPS should be actively involved in briefing the expert witnesses on the legal issues around homicide. The police produced an initial briefing note that they proposed to send to the experts (CPS000860, p3), while the CPS provided two notes on the law for the experts.

E8 On 12 August, Mr Drybrough-Smith of the CPS wrote to Det Supt Williams stating that it was *"inappropriate to ask experts to given an opinion on* [*criminal culpability*]*"*. Mr Drybrough-Smith also said that it was *"not admissible for the expert to give an opinion as to whether the defendant 'intended to hasten or end life'"* (CPS000858, p2).

E9 Between August and September 2004, Hampshire Constabulary produced a briefing document entitled *Guidance for Medical Experts*. This explained:

> "Nine cases [are the subject of ongoing investigation by the Police]. The brief to medical experts … is to examine the medical records and to comment upon the standard of care afforded to those patients in the days leading up to their death. If the care falls below what were then the acceptable standards of the day, the opinion sought would be, how far below the acceptable standards of practice did the care fall. It may be the case however that the experts determine that the standard of care afforded was acceptable. Any opinion should be limited to for example, stating that it would have been obvious to the reasonably prudent and skilful doctor in the defendant's position that their actions would hasten or end life." (HCO000640, p143)

E10 The document also provided legal guidance on manslaughter, murder, causation, hastening and/or accelerating death, the *de minimis* principle and multifactorial deaths. It stated that the *"experts should have an understanding of the terms Criminal Gross Negligence, and Unlawful Act within the context of Homicide"* (HCO000640, p143).

E11 The Panel observes that expert witnesses in criminal cases are not ordinarily required to comment on the 'ultimate issue'; that is, a person's culpability for an offence and how the law does or does not apply to what they are alleged to have done.

E12 Later it was confirmed that the *"product of the interviews [under caution]"* with Dr Barton would also be provided to Professor Black and Dr Wilcock, to *"enable their analysis against the material currently under examination"* (HCO000640, p154).

Category 3B cases: The findings of the experts for the purposes of the Hampshire Constabulary investigation

Professor Black's preliminary findings: Elsie Devine, Elsie Lavender and Patient M

E13 On 15 September 2004, following the request made by Hampshire Constabulary at the meeting on 5 August, Professor Black produced his preliminary findings. These set out the themes that were emerging from his review of the cases of Elsie Devine, Elsie Lavender and Patient M. Professor Black stated:

> "They [the cases] represent a selection of some of the most complex cases managed in geriatric medicine … Consultant assessment and supervision in the cases appears poor. It is not clear what direction or supervision, if any, are given to the clinical assistants working at the Gosport War Memorial Hospital … Medical assessment is very poor … The medical note taking is inadequate … However I am clear that in all three patients, at the time a decision was made that they were for palliative care, they were indeed terminally ill and that their problems were irreversible by that stage … In all three cases there was a large step to a subcutaneous management containing significantly higher than expected (or in my view needed) doses of Diamorphine and Midazolam than expected or needed … Despite this none of the patients died within a very short period of time of the subcutaneous doses and it is my belief that in all three cases any shortening of life is likely to have been more than a few days at most." (HCO002028, pp1–2)

Professor Black's findings: Helena Service

E14 On 6 November 2004, Professor Black produced a report entitled *The Care and Death of Helena Service.* This comprised a timeline, a drug chart analysis and Professor Black's opinion as to the cause of death. The report concluded:

> "The cause of death in Mrs Service was multifactorial. In my view the dose of 20mg Diamorphine combined with the 40mg dose of Midazolam was higher than necessary in this very elderly and frail lady's terminal care and the medication may have slightly shortened life, although this opinion does not reach the standard of proof of 'beyond reasonable doubt'. However, I would have expected a difference of, at most, no more than a few hours to days, if a lower dose of either or both the drugs had been used instead." (LAA000170, p7)

E15 On 10 November, Det Sgt Grocott emailed Det Supt Williams and others. He reported that, in respect of Mrs Service, Professor Black *"cannot state beyond all reasonable doubt that there are any issues of culpability in respect of criminal offences, particularly in relation to the care of Mrs Service whilst a patient at GWMH"* (HCO000641, p85).

E16 Det Sgt Grocott's summary of Professor Black's conclusion is more wide-ranging than Professor Black's opinion.

E17 Later, Professor Black considered 19 witness statements relating to the hospital care and death of Helena Service, in order to determine whether they impacted on his report. His review of these witness statements led him to make one change to the report: that Mrs Service was *"continually breathless"* and *"needed to be nursed upright all night"* (LAA000171, p1).

Dr Wilcock's findings: Helena Service

E18 On 19 June 2006, Dr Wilcock prepared a report in relation to the treatment of Mrs Service. He concluded:

> "… Mrs Service had significant medical problems. Although her cardiac failure appeared to be better controlled by the time of her transfer from F1 ward, she was becoming progressively frailer, increasingly dependent on others and her blood tests had deteriorated again. In this regard, it would not have been unusual if Mrs Service had naturally entered a terminal decline. As such it is difficult to say with any certainty that the dose of Midazolam or Diamorphine she received would have contributed more than minimally, negligibly or trivially to her death." (GMC100096, p197)

Professor Black's findings: Elsie Devine

E19 Professor Black originally produced a document titled *Report on the Care and Death of Elsie Devine*. This report contained a timeline and Professor Black's expert opinion. Professor Black stated that *"by the 19th November, [Mrs Devine] was terminally ill"* and that it would have been *"inappropriate not to provide high quality palliative care"*. He considered that, while midazolam was widely used in this respect, the use of diamorphine was more contentious. Professor Black also said:

> "… it is possible that the medication did shorten her life by a short period of time but she was also out of distress for the last 58 hours. I am therefore not able to say that the use of Fentanyl, Diamorphine and Midazolam were prescribed with the intention of deliberately shortening her life or indeed, that they had the definite effect of shortening her life in more than a minor fashion." (HCO003049, pp10–11)

E20 On 4 January 2005, Professor Black produced a second version of his report on Mrs Devine. His conclusion was:

> "… the major problem in deciding whether this lady's care was sub-optimal is the lack of documentation … However by itself [the lack of documentation] does not prove that the care received by Mrs Devine was sub-optimal, negligent or criminally culpable. In my view the drug management at Gosport was sub-optimal … The effect of a higher than standard dosage of Diamorphine and Midazolam may have shortened her life by a short period of time. However, she was already terminally ill and appeared to receive good palliation of her symptoms. Whilst her care was sub-optimal I cannot prove it negligent or criminally culpable." (PCO001183, p1)

E21 Professor Black produced a third version of his report on 16 January. However, the main conclusions remained the same (HCO001840, pp1–26).

E22 On 16 April, Professor Black produced a further report regarding Mrs Devine, in which he addressed Dr Barton's statement and job description. In this report, he disagreed with Dr Barton's diagnosis of myeloma. He expressed the view that, although there were two apparently minor misunderstandings of the medical complications arising in Mrs Devine's case on the part of Dr Barton, *"they might also indicate a doctor who did not have a full understanding of the medical conditions that they were managing in a patient with complex medical problems"*. As a result of reading Dr Barton's statement, Professor Black commented that *"the only change I would wish to make to my export report is in paragraphs 5.19, 6.10. 7.3 in the summary on page 1, the patient was prescribed Oramorphine and not Diamorphine as written in the report"* (CPS000543, p5).

Dr Wilcock's findings: Elsie Devine

E23 On 29 September 2004, Det Supt Williams met Dr Wilcock, who had written the first draft of his report in respect of Mrs Devine. Dr Wilcock had identified the following issues:

> "Elsie Devine had been incorrectly recorded in her notes as suffering myeloma (terminal bone cancer). The deceased had been suffering a number of problems but essentially did not appear to have been terminally dying. The reported renal failure would not necessarily have led to death. The patient had suffered a marked deterioration through dementia. She was effectively knocked out through the drug regime applied, and then syringe driver Diamorphine applied. This course did not give her an opportunity to recover. The patient reacted as a result of opiate naivety. Dr Wilcock commented that the medical notes were not sufficiently detailed to demonstrate that all analgesia options had been considered, there was no mention of pain in the notes. Devine's deterioration appeared to be mental as opposed to physical. Drugs appeared to have been prescribed without sufficient safeguards. Dr Barton's prescription of Diamorphine appears unjustified and excessive. There was inappropriate use of and doses of Diamorphine and Midazolam prescribed." (HCO000641, p28)

E24 On 10 December, Dr Wilcock produced his report in respect of Mrs Devine. In it, he examined the medical records and commented on the standard of care afforded to the patient in the days leading up to her death, comparing it with the accepted standard of the day. Concluding that there had been a number of failings in the care and treatment of Mrs Devine, Dr Wilcock said:

> "… in my opinion, based on the medical and nursing records, there is reasonable doubt that she had definitely entered her terminal stage. Given this doubt, at worst, Dr Barton could be seen as a doctor who breached the duty of care she owed to Mrs Devine by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Devine by unnecessarily exposing her to inappropriate and excessive doses of medications as with the Fentanyl transdermal patch, which could have resulted in a worsening of her agitation and confusion. Dr Barton's response to this was to further expose Mrs Devine to inappropriate and/or excessive doses of Midazolam and Diamorphine that could have contributed more than minimally, negligibly or trivially to her death. As a result, Dr Barton leaves herself open to the accusation of gross negligence." (CPS100290, pp3–4)

Professor Black's findings: Patient M

E25 On 14 September 2004, Professor Black produced his *Report on the Care and Death of Patient M*. He stated that by the time Patient M was first seen by Dr Barton on 9 January 1996, *"he had come to the end point of a series of mental and physical conditions and that his problems were now irreversible"*. Professor Black said that he would not criticise the use of morphine oral solution and that *"the decision that he was now terminally ill and for symptomatic relief appears to have been made appropriately"*. However, Professor Black noted that Patient M had been started on three times the dose of diamorphine that could be medically argued for, and that *"the medication is very likely (on the balance of probabilities) to have shortened life"* (HCO002027, pp2–9).

E26 On 31 January 2005, Professor Black produced a second report on Patient M. He again concluded that there was a *"major problem in assessing Patient M's care due to the lack of documentation"*. Professor Black stated:

> "In my view the drug management as Gosport was sub-optimal. There was no justification at any stage for the high doses of Diamorphine and Midazolam written up in the drugs charts and subsequently prescribed to Patient M … Combinations of the higher than standard doses of Diamorphine and Midazolam, together with the Nozinan were very likely to have caused excessive sedation and may have shortened his life by a short period of time, that in my view would have been no more than hours to days. However, this was a dying man … while his care was sub-optimal I cannot prove it beyond reasonable doubt to be negligent or criminally culpable." (CPS000439, p1)

E27 On 22 April, Professor Black produced a further report in relation to Patient M. This included a response to Dr Barton's witness statements (provided by Hampshire Constabulary) and also examined the job description for the clinical assistant post at the hospital (CPS000440, pp1–4). Professor Black observed that Dr Barton had conducted no physical examination, save for an examination of pressure points. He also raised questions regarding systemic issues within the hospital and Portsmouth HealthCare NHS Trust.

Dr Wilcock's findings: Patient M

E28 On 25 April 2005, Dr Wilcock produced a report in respect of the treatment of Patient M. He concluded that the care provided by Dr Barton fell short of a good standard of clinical care, and that she had provided treatment in excess of the patient's needs. In Dr Wilcock's view:

> "Dr Barton could be seen as a doctor who breached the duty of care she owed to Patient M by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Patient M by unnecessarily exposing him to excessive doses

> of Diamorphine that could have resulted in a worsening of his agitation. Dr Barton's response to this was to further increase Patient M's dose of Diamorphine. Despite the fact that Patient M was dying 'naturally', it is difficult to exclude completely the possibility that a dose of Diamorphine that was excessive to his needs may have contributed more than minimally, negligibly or trivially to his death. As a result, Dr Barton leaves herself open to the accusation of gross negligence." (GMC100096, p647)

Professor Black's findings: Elsie Lavender

E29 On 14 September 2004, Professor Black produced his *Report on the Care and Death of Elsie Lavender*. In it, he concluded:

> "… the medical assessment of Mrs Lavender was inadequate … and negligently poor … she certainly had serious illnesses which were probably unlikely to be reversible and therefore was entering the terminal phase of her various illnesses around the time of admission … the initial symptomatic management of her terminal illness was appropriate, but in the final 36 hours excessive doses of medication were used that would on the balance of probabilities hasten death by a short period of time." (HCO002026, p9)

E30 On 14 March, Professor Black produced a third version of his report in respect of Mrs Lavender (HCO000413, pp1–22), followed shortly by a fourth version on 19 March (CPS000485, pp1–21). It is not clear to the Panel what was contained in the second version. In both the third and fourth versions, Professor Black concluded:

> "The initial symptomatic management of her terminal illness was appropriate. The prescription of the Diamorphine on the 26 February (never given) and the excessive doses of medication used in the final 36 hours was, in my view, sub optimal drug management. These may have been given with the intention of shortening life at the final phase of her terminal illness. However, I am unable to satisfy myself beyond reasonable doubt this did hasten death by anything other than a short period of time (hours to a few days)." (HCO000413, p21; CPS000485, p20)

Dr Wilcock's findings: Elsie Lavender

E31 On 1 May 2005, Dr Wilcock produced a report on Mrs Lavender. He concluded that the care provided by Dr Barton was sub-optimal. He also concluded that the prescription of morphine may have been inappropriate or excessive. Dr Wilcock stated that he could not be sure that the patient had entered the terminal stage. As a result of the treatment given to Mrs Lavender, Dr Wilcock concluded:

"… Dr Barton leaves herself open to the accusation of gross negligence" (PCO001108, p4).

Professor Black's findings: Enid Spurgin

E32 On 27 June 2005, Professor Black produced a second version of a report into the treatment and death of Mrs Spurgin. The Panel has not seen the first version of this report. Professor Black stated that there were:

> "… a number of areas of poor clinical practice … The lack of a medical assessment, or documentation of that assessment on admission to Gosport. The failure to address the cause of this lady's pain, consider any other actions from 2nd March until 7th April. The use of Oramorphine on a regular basis from admission without considering other possible analgesic regimes … The starting does of Diamorphine at 80mg in the syringe drive is at best poor clinical judgment. However, I am unable to satisfy myself beyond reasonable doubt that this high dose of Diamorphine hastened death by anything other than a very short period of time (hours)." (HCO006629, pp1–2)

E33 On 22 August, Professor Black produced a further report in respect of Mrs Spurgin. He concluded:

> "I believe there are a number of areas of poor clinical practice in this case of the standards set by the General Medical Council. The lack of medical assessment, or documentation of that assessment on admission to Gosport. The use of Oramorphine on a regular basis from admission without considering other possible analgesic regimes. The recording of Cerebrovascular Accident as the cause of death with no evidence, or history, or of any examination to support this conclusion." (HCO110945, p2)

Dr Wilcock's findings: Enid Spurgin

E34 On 5 March 2006, Dr Wilcock produced a report into the treatment of Mrs Spurgin. In it, he concluded:

> "In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breach the duty of care they owed to Mrs Spurgin by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Spurgin by failing to adequately assess her condition and taking suitable and prompt action when she complained of pain that appeared excessive to a situation and when a physical state deteriorated in what was a potentially reversible way. Instead the actions of Dr Barton and Dr Reid exposed Mrs Spurgin to the use of inappropriate doses of Diamorphine and Midazolam that would have contributed more than minimally, negligibly

or trivially to death. As a result, Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence." (GMC100096, p898)

Professor Black's findings: Arthur Cunningham

E35 On 19 November 2004, Professor Black produced his *Report on the care and Death of Arthur Cunningham*. He could find *"no justification"* for the increase in the doses of diamorphine and midazolam on 25 and 26 September 1998. He considered this to be *"excessive … and that medication may have slightly shortened his life. This opinion does not meet the standard of 'beyond reasonable doubt'"* (HCO001918, p12).

E36 On 11 July 2005, Professor Black produced a second version of his report on Mr Cunningham. He stated that *"Mr Cunningham was managed appropriately, including an appropriate decision to start a syringe driver for managing his symptoms and agitation as part of his terminal illness in September 1998"*. Professor Black also repeated his concern about the increased dose of diamorphine in the syringe driver, stating that, while this may have shortened Mr Cunningham's life *"for at most no more than a few hours to days"*, he could not say this *"beyond reasonable doubt"* (CPS001801, p1).

Dr Wilcock's findings: Arthur Cunningham

E37 On 27 September 2005, Dr Wilcock produced a report on the medical care provided to Mr Cunningham (GMC100096, p295). Dr Wilcock noted in his report that Mr Cunningham's prognosis was poor, but that his nursing home had been asked to keep open his bed for three weeks. The medical care provided by Dr Barton fell short of a good standard of clinical care. In addition, the prescription of a larger dose range of diamorphine was likely to be excessive for Mr Cunningham's needs and he was unnecessarily exposed to risk (although the diamorphine was not administered in large doses). However, Dr Wilcock acknowledged that, although alternative treatments existed that would have better managed the patient's pain on turning, other practitioners might well have followed a similar course to Dr Barton.

Professor Black's findings: Ruby Lake

E38 On 29 August 2005, Professor Black produced the second version of his report into the treatment of Mrs Lake. The Panel has not seen the first version of this report. Professor Black concluded:

> "Without a proven diagnosis, it is possible that the combination of Diamorphine and Midazolam together with the Hyoscine in a syringe driver contributed in part to Mrs Lake's death. However, I am unable to satisfy myself to the standard of beyond reasonable doubt that it made more than a minimal contribution." (LAA000181, p1)

Dr Wilcock's findings: Ruby Lake

E39 On 23 August 2005, Dr Wilcock produced a report in respect of the treatment of Mrs Lake (HCO006624, pp1–35). He was of the view that reasonable doubt existed as to whether or not Mrs Lake had entered the terminal stage. He also concluded that Mrs Lake's medical care, as provided by Dr Barton, left Dr Barton open to the accusation of gross negligence.

Professor Black's findings: Geoffrey Packman

E40 On 30 October 2005, Professor Black produced a report concerning the treatment of Mr Packman. This report is described as the second version, although the Panel has been unable to locate the first version. Despite recognising a number of weaknesses in the clinical care provided to Mr Packman, it was Professor Black's opinion that Mr Packman *"died of natural causes and these deficiencies probably made very little difference to the eventual outcome"* (HCO006637, p1).

E41 Professor Black was subsequently provided with a number of witness statements in relation to Mr Packman's treatment at the hospital. This led him to produce an updated version of his report on 20 June 2006 (GMC100096, p379). The report included amendments relating to the dose of diamorphine used but also concluded that, despite the deficiencies in treatment, these made very little difference to the eventual outcome.

Dr Wilcock's findings: Geoffrey Packman

E42 On 28 March 2006, Dr Wilcock produced a report concerning the treatment of Mr Packman. He concluded:

> "It is the inappropriate management of Mr Packman's gastrointestinal haemorrhage together with exposure to unjustified and inappropriate doses of Diamorphine and Midazolam that contributed more than minimally, negligibly or trivially to his death. As a result, Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence." (GMC100096, p402)

Professor Black's findings: Sheila Gregory

E43 On 1 November 2005, Professor Black produced the second version of a report into the treatment of Mrs Gregory. The Panel has not seen the first version of this report. Professor Black commented:

> "The lack of clinical examination both on admission and more important [as] Mrs Gregory['s] care deteriorated represents poor clinical practice … Despite [this] I am satisfied that Mrs Gregory's death was of natural causes and that her overall clinical management in Gosport was just adequate." (HCO004404, p1)

Dr Wilcock's findings: Sheila Gregory

E44 On 22 December 2005, Dr Wilcock produced a report concerning the treatment of Mrs Gregory. Dr Wilcock considered that the administration of diamorphine was possibly excessive, to the point of rendering the patient unresponsive or depressing her respiration. Considering Mrs Gregory's apparent lack of pain, there was no obvious justification for the diamorphine, midazolam and hyoscine being given in a syringe driver on the day she was transferred to Dryad Ward. Dr Wilcock recommended that a cardiologist be consulted to comment on the case. He concluded that the patient's:

> "… decline was noted over a number of weeks and this would be in keeping with a natural decline into a terminal phase. Further, whatever the reason was for the use of Diamorphine, the physical findings on the day of Mrs Gregory's death would suggest that the dose she was receiving was unlikely to have been excessive to the degree that it rendered her unresponsive with respiratory depression." (GMC100096, p259)

E45 In a later report dated 30 July 2006, Dr Wilcock said:

> "Mrs Gregory was elderly, frail and had significant medical problems. In this regard, it would not have been unusual if Mrs Gregory had naturally entered a terminal decline. Dr Barton could then be seen as a doctor who, whilst failing to keep clear, accurate and contemporaneous patient records, had been attempting to allow Mrs Gregory a peaceful death, albeit with what appears to be an apparent lack of sufficient knowledge … However, the lack of documented thorough medical assessment does make it difficult to exclude with any certainty that Mrs Gregory did not have a potentially reversible medical problem, which if identified and promptly treated with appropriate therapy may have led to an improvement … In this regard Dr Barton could be seen as a doctor who breached the duty of care she owed Mrs Gregory by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Gregory by inadequately assessing her situation in order to identify (or exclude) potentially reversible causes of her symptoms that were appropriate to treat. It is the combination of the lack of appropriate treatment together with unnecessarily exposing Mrs Gregory to doses of morphine and Diamorphine that were difficult to justify that could be viewed as contributing more than minimally, negligibly or trivially to her Mrs Gregory's death." (HCO000285, pp5–6)

Professor Black's findings: Robert Wilson

E46 On 19 November 2005, Professor Black produced the second version of a report concerning the treatment of Mr Wilson. The Panel has not seen the first version of this report. Professor Black concluded:

> "It is my belief that the prescription of a total of 50 mg of Oramorphine on 15 October following the 20 mg that were given on 14 October was not an appropriate clinical response to the pain in Mr Wilson's left arm. In my view this dose of analgesia formed a major contribution to the clinical deterioration that occurred over the 15th to 16th October, in particular his rapid mental state deterioration. In my view this treatment was negligent, and more than minimally contributed to the death of Mr Robert Wilson on 19th October." (LAA000092, p1)

Dr Wilcock's findings: Robert Wilson

E47 On 21 May 2006, Dr Wilcock produced a report concerning the treatment of Mr Wilson. He concluded that it was:

> "… difficult to say with any certainty that the dose of morphine he received contributed more than minimally, negligibly or trivially to his death because the heart and liver failure could also have done this. Similarly … it is difficult to say with any certainty that the dose of Diamorphine … contributed more than minimally, negligibly or trivially to his death because drowsiness / unconsciousness, the one feature of excess opioid seen in this case is also a feature of the terminal stage of heart failure and liver failure." (GMC100096, p697)

Further statements and transcripts of interviews

E48 For a number of the Category 3B cases, Dr Wilcock and Professor Black were provided with the witness statements produced by Dr Barton and other witnesses (including Dr Richard Ian Reid) who were questioned during the police investigation. Unless specifically mentioned above, this information did not cause the two experts to alter their opinions.

Non-Category 3 cases: Professor Black's findings on Gladys Richards

E49 Professor Black was asked to produce a report into the treatment of Mrs Richards, although Dr Wilcock was not. On 10 August 2005, Professor Black produced a fourth version of his report concerning Mrs Richards (HCO006635, pp1–18). The Panel notes that the second (HCO006626, pp1–8) and third (HCO006634, pp1–18) versions do not differ in respect of the main conclusions reached. The Panel has been unable to locate the first version of the report. In the fourth version, Professor Black expressed concern at the:

> "… anticipatory prescription of Opioid analgesia on [Mrs Richards'] admission to Gosport War Memorial Hospital. If no justification for this can be identified or proven, then I believe that this was negligent practice and may have contributed to her fall on the ward. I also believe that the dose of Diamorphine, in particular prescribed on the 17th August, was sub optimally high. However I do not believe this contributed in any significant way to Mrs Richards death and that her death was by natural causes." (HCO006635, p1)

E50 On 17 August 2005, a decision was made to remove the death of Mrs Richards from the remit of the police investigation (HCO000642, p117).

Hampshire Constabulary's concerns in relation to Professor Black's reports

E51 During the early stages of the production of Professor Black's reports, the police raised concerns over the structure and format of his work. On 19 November 2004, Det Sgt Grocott recommended to Det Supt Williams that Professor Black adopt a different format for his reports, to cover *"his instructions, issues, CV, documentation received/reviewed in preparation of the report etc"*. Det Sgt Grocott stated that, in his view, Professor Black *"has failed to specifically answer the point (a) in all the circumstances did the individual identified receive the proper standard of care/treatment from the medical/nursing staff?"*. Det Sgt Grocott was concerned that *"Professor Black appears to centre his reports on whether the individual was terminally ill and was the treatment then appropriate"* (HCO000641, p95).

E52 In a letter to Professor Black, Det Supt Williams noted:

> "It is observed that you appear to centre your reports upon whether an individual was terminally ill and consider then whether the treatment/care was appropriate. It would be beneficial to the investigation if you were also to comment upon the standard of care afforded to these patients by healthcare professionals prior to your determination of the point where the condition became terminal. This approach will enable the investigation team and ultimately the Crown Prosecution Service to consider wider issues of culpability, particularly at Consultant and Primary Care Trust levels. Detective Sergeant Grocott has raised further issues in respect of the Devine case to which you have responded within a document separate to your initial draft report. These points should be incorporated within the body of your report so that they can be read in context." (HCO000641, p118)

E53 Had Professor Black considered the issues of care and treatment first, his findings may have fed into investigations of other offences, such as those that might have been committed under the Health and Safety at Work Act 1974.

E54 Det Sgt Grocott emailed Det Supt Williams on 2 March 2005 to raise concerns about Professor Black's report on Patient M. Det Sgt Grocott commented that, in his view, *"Professor Black either misunderstands his brief or is operating outside of what is required"*. He raised concerns about Professor Black's use of the phrase *"beyond reasonable doubt"*, stating that he applied the term in *"inappropriate contexts"* (HCO002699, pp2–3).

E55 In his response the following day, Det Supt Williams confirmed that *"it is entirely appropriate to raise these issues with Professor Black"*. However, he assured Det Sgt Grocott: *"We are not seeking to influence the evidence that he produces, we simply need to provide focus ensuring that the key evidential elements are addressed"* (HCO002699, p2).

Category 3A cases

E56 On 25 April 2006, Detective Sergeant (Det Sgt) Roy Stephenson was asked to compile *"detailed overview reports in respect of the four category 3A cases of Windsor, Houghton, Jarman, Carter".* It was noted: *"Whilst cause of death had been determined as 'Natural Causes' but care had been assessed by the KCT as 'Negligent'"* (HCO000643, p100). Professor Black had already been tasked with producing reports into the Category 3A cases as part of a quality assurance procedure.

E57 On 19 January 2006, Professor Black produced a report into the treatment of Clifford Houghton. In it, he concluded that the *"symptomatic response to his terminal illness was appropriate and that his death was by natural causes"* (HCO000211, p2).

E58 On 29 January, Professor Black produced a report concerning the treatment of Thomas Jarman. He concluded that the failure to record the change of doses in drugs represented poor clinical practice, and that a dose of diamorphine administered on 10 November 1999 was sub-optimally high. However, Professor Black also stated his belief that *"any excess prescription of Diamorphine made a negligible contribution to the death of Thomas Jarman which was due to natural causes"* (HCO000196, p2).

E59 On 30 April, Professor Black produced a report in respect of Edwin Carter. It concluded: *"The dose of Diamorphine and Midazolam in the syringe driver on 22nd December might be considered to have been excessive; however, I believe that this made a negligible contribution to the death of Edwin Carter"* (HCO110964, p1).

E60 On 9 May, Professor Black produced a report in respect of Norma Windsor (HCO110965, pp1–11). He commented on the lack of medical record keeping, but concluded that Mrs Windsor had died from natural causes.

Other experts

E61 Throughout the period in which Professor Black and Dr Wilcock prepared their reports, it became clear that additional expert evidence would be required to address matters outside their areas of expertise. Det Sgt Grocott confirmed:

> "Independent of one another both experts have stated that we need to seek evidence from other experts in specific fields to address certain issues. The additional experts can be specifically focused in certain areas of work and therefore the additional costs will be reduced as will the time taken to complete the work." (HCO002617, p4)

E62 On 23 December 2004, Det Supt Williams recorded a decision to instruct a renal expert in respect of the Elsie Devine case. It appeared that Professor Black and Dr Wilcock held different views as to whether Mrs Devine's renal condition was terminal. It was noted that *"this issue goes directly towards causation, it must be clarified"* (HCO000641, p125). Dr Christopher Dudley, a consultant nephrologist, prepared a report on this matter (BLC001640, pp1–13).

E63 Det Sgt Grocott had also been advised to instruct a consultant haematologist. He noted that there were *"outstanding issues in respect of certain aspects of the treatment proffered to Elsie Devine. Detective Sergeant Grocott also noted that each expert had provided a full report."* However, *"in light of counsels initial views that Mrs Devine's case does not merit a criminal prosecution",* he did *"not see the need to incur unnecessary expense"* in appointing such an expert.

E64 On 24 December, Det Supt Williams recorded a decision to instruct a radiologist in respect of Mrs Lavender's *"cervical spine & chest x rays"* after Dr Wilcock raised issues with them (HCO000641, p128). Dr James Gillespie, a consultant neuroradiologist, prepared a report on this matter (HCO000452, pp1–8).

E65 On 25 October 2005, Dr Wilcock recommended that the views of an orthopaedic expert be sought on the case of Mrs Spurgin (HCO000643, p12). Det Sgt Grocott was tasked with finding an expert, who was to comment *"upon care delivered & other options for care that may have been available"*. Mr D R M Redfern, a consultant orthopaedic and trauma surgeon, prepared a report on this matter (HCO000200, pp1–16).

E66 It was also recommended that a *"General Practitioner – Clinical Assistant"* be tasked to *"report on the anticipated and accepted level of work, including supervision and management, of a clinical assistant working in a stand alone localised hospital"* (HCO002617, p4). Hampshire Constabulary was *"looking to task Dr Holden in relation to Clinical Assistant/GP workloads & supervision"* (HCO002490, p3). The Panel has seen no report on this matter.

E67 It was recommended that a *"Toxicologist – Diamorphine specialist"* be consulted, to *"review and report on the specific circumstances of each case. Determine the combined toxicity of the administered drugs and comment on whether*

or not the dosages were causative to the death of an individual patient." Det Sgt Grocott was *"actively seeking suitable experts in the above fields to progress the investigation"* at the time of his report (HCO002617, p4). He had *"sought to appoint a Toxicologist regarding the levels of toxicity brought on by the combination of prescribed medicines"*. The advice from Dr Stephen Elliot, a toxicologist consulted by Det Sgt Grocott (HCO000643, p37), was that the questions Hampshire Constabulary *"needed answers to are better addressed by a Forensic Pharmacologist"* (HCO002490, p3).

E68 Professor Henry John McQuay produced a report in relation to the therapeutic use of controlled drugs (HCO006884, pp1–12). However, this did not address the specific circumstances of each case, as had been envisaged.

E69 The Panel notes that this was a missed opportunity. At the subsequent inquests in 2009 and 2013, the lack of any specific evidence in relation to the toxicity of the drugs administered to patients at the hospital would be a cause of significant concern. Further, from an early stage in the police investigation there was a concern that this matter had not been properly addressed through expert evidence. Despite this, in both hearings the Coroners initially took the view that Professor Black, and to a lesser extent Dr Wilcock, could provide sufficient evidence on this topic. Professor McQuay's report does not appear in any of the papers held by the Coroner's office.

E70 A consultant hepatologist, Dr Jonathan Marshall, produced a report in respect of Mr Wilson and Mr Packman (HCO000518, pp1–12).

E71 Dr Robert Baker, Head of the Department of Health Sciences at the University of Leicester, was instructed to prepare a report into the certified cause of death and the prescription of opioids and sedatives in the case of Robert Wilson (BLC001151, pp1–20).

E72 Dr Michael Petch, a consultant cardiologist, was commissioned to prepare a report in respect of Helena Service (HCO000095, pp1–6).

Professor Black's reports for the GMC

E73 The GMC instructed Professor Black to provide expert reports in relation to the disciplinary proceedings involving Dr Barton (FMC000024, p3). Dr Wilcock was also approached by the GMC, but was unable to assist because of other work commitments (HCO002458, p2). Professor Black had already prepared reports in respect of eight of the cases that the GMC was considering (Patient M, Mrs Lavender, Mrs Richards, Mr Cunningham, Mr Wilson, Mrs Spurgin, Mr Packman and Mrs Devine). He was also instructed to prepare reports on the cases of Patient L, Alice Wilkie, Jean Stevens and Patient N.

E74 On 22 February 2008, Professor Black completed a report in respect of Patient L. He stated:

> "In my view a dose of Diamorphine and Midazolam was on the high side but within clinical guidelines such as the British National Formulary. However, if the Fentanyl patch was continued there would have been a risk of over sedation for example causing unnecessary respiratory depression. The medical notes are inadequate to make an assessment as to whether the doses that were given were appropriate to her condition or excessive." (GMC100947, p259)

E75 Professor Black was also critical of a number of aspects of the use of drug charts in the treatment of Patient L, which he considered to be *"seriously deficient"*, and a number of failures to adequately document medical reviews of the patient.

E76 On 21 March 2008, Professor Black produced a report on the case of Alice Wilkie for the GMC (GMC100947, pp267–75). This is described as the third version of the report (there are few differences of any substance between this and the fourth version). Professor Black highlighted a number of failings in the clinical care provided. He stated:

> "In my view this is an unnecessarily high dose for someone who has received no previous opiate analgesia or indeed any other analgesia … There is nothing in the notes to explain why it was thought that both Midazolam and a high dose of Diamorphine were required in this patient. In my view the doses of Diamorphine and Midazolam were unacceptably high as a starting dose from the evidence available in the notes. There would have been a very significant risk of over sedation, for example causing respiratory depression impaired consciousness and a possibility of shortening her life by some hours or days." (GMC100947, p273)

E77 Professor Black also stated that there were a number of aspects of *"The documentation of [Mrs Wilkie's] medical care [that were] inadequate and in my mind [were] unacceptable medical practice"*, and that *"the use of the drug chart [was] seriously deficient"* (GMC100947, p267).

E78 On 27 March, Professor Black produced a report on Patient N for the GMC. This was described as the third version of the report (GMC100101, p14), although the Panel has not seen the first and second versions. Professor Black considered that there was evidence of poor clinical practice in the treatment of Patient N, including a lack of documentation in relation to examinations and choice of drugs, poor assessment of Patient N's pain, and a failure to use regular weaker analgesia. Professor Black was also critical of the use of the drug chart. He concluded that he was *"certain this lady was terminally ill"*.

E79 On 1 April, Professor Black produced the third version of his report on the treatment of Jean Stevens for the GMC. The Panel has not seen the first and second versions of this report. Professor Black commented:

> "There is nothing in the notes to explain why it was thought that both Midazolam and Diamorphine were required in this patient. In my view, the regular doses of Oramorphine and then the syringe driver together with the 20mgs of Midazolam would have given a risk of over sedation for example causing respiratory depression in this lady who already had severe heart, lung and neurological disease." (GMC100947, p358)

Professor Black also considered that the documentation of Mrs Stevens' medical care was inadequate and that the use of the drug chart was deficient.

E80 On 8 May 2008, Professor Black produced the fourth version of his report on Robert Wilson for the GMC. He noted a number of failings in the clinical care provided. He said:

> "While it is possible that Mr Wilson has gone into heart failure due to his salt and water retention documented previously, his unresponsiveness is almost certainly, in my view, to be because of a direct surreal effect of the morphine or that he is being precipitated again into hepatic encephalopathy … The situation may or may not have been still reversible on 16th October but he was probably now entering a period of irreversible terminal decline." (GMC100947, p310)

E81 Professor Black continued:

> "It is my view the regular prescription and dosage of Oramorphine was unnecessary and inappropriate on the 14th and 15th October and in a patient with serious hepatocellular dysfunction was likely the major cause of the deterioration, in particular in mental state, on the 15th and the 16th October. In my view it is beyond reasonable doubt that these actions more than minimally contributed to the death of Mr Wilson." (GMC100947, p319)

E82 Professor Black considered that there was evidence of poor medical practice in a number of areas related to Mr Wilson's treatment, including *"The decision to use strong opiate based analgesic on the 14th October … In my view a negligent decision that formed a major contribution to the clinical [deterioration] that occurred over 15th-16th October."* He was also critical of the failure to investigate the cause of Mr Wilson's deterioration and the failure to document decisions, as well as the use of the drug chart (GMC100947, p320).

E83 On 15 May, Professor Black produced the fourth version of his report on Ruby Lake for the GMC. He expressed the view that the medical care provided by the hospital was negligent, and listed a number of failures in the diagnosis and treatment of Mrs Lake. He was also critical of the use of the drug chart. He concluded that it was *"impossible from the notes to determine the cause of death and a Coroner's Post Mortem should have been held"* (GMC100947, p285).

E84 On 21 May, Professor Black produced the third version of his report on Arthur Cunningham for the GMC. He found there to be a *"number of areas of poor medical practice"*, including repeated failures to record in the clinical notes decisions and reasons for the use and increase in doses of certain drugs. He was also critical of the use of the drug chart. He concluded:

> "In my view from the information available in the notes, the dose of Midazolam was excessive on 25th and 26th and the medication may have slightly shortened life. However, I cannot find evidence to satisfy myself to the standard of 'beyond reasonable doubt'. I would have expected a difference of at most, no more than a few hours to days if a lower dose of either or both of the drugs had been used instead during the last few days." (GMC100947, p296)

E85 On 26 May, Professor Black produced the sixth version of his report on Elsie Lavender for the GMC. The Panel has not seen all the versions of this report. Professor Black expressed *"significant concerns about the medical management of Mrs Lavender, including failure in her medical assessments, examinations and the use of Diamorphine"*. In his view:

> "The doses of Diamorphine used, in conjunction with a significant dose of Midazolam, was in my opinion excessively high. However, I cannot find evidence to satisfy myself the standard of 'beyond reasonable doubt', they had the definite effect of shortening her life in more than a minor fashion of a few hours to a few days." (GMC100947, p248)

He was also critical of the use of the drug chart.

E86 On 2 June, Professor Black produced the third version of his report on Elsie Devine. He stated:

> "There is no explanation in the notes for the apparently high doses of drugs used to relieve her symptoms considering her age of 88 years and her previous lack of use of analgesia. It is possible that the medication did shorten her life by a short period of time but she was also out of distress for the last 58 hours." (GMC100947, p341)

E87 Professor Black also noted *"significant failings in the medical care provided to Mrs Devine"*. These included failings in the examination of Mrs Devine, failings in the recording of her condition and a failure to explain the use of an apparently high starting dose of diamorphine. He was also critical of the use of the drug chart.

E88 On 4 June 2008, Professor Black produced a report in relation to Geoffrey Packman for the GMC. He stated that the cause of Mr Packman's death was a *"massive gastro-intestinal haemorrhage"*, but considered that there were failings in the medical care provided. These included the failure to assess Mr Packman's

condition, the failure to ask for a senior medical opinion in relation to his condition, and the failure to document reasons for the increase in midazolam and the use of morphine oral solution and the syringe driver (GMC100947, p331).

E89 On 5 June, Professor Black produced the fourth version of his report on Enid Spurgin for the GMC. He was critical of the use of the drug chart and noted a number of failings in the medical care provided to Mrs Spurgin, including failings in her clinical assessment and diagnosis and the use of certain drugs. He concluded:

> "In my view the dose of Diamorphine used on 11th was inappropriately high, however, I cannot satisfy myself to the standard of 'beyond reasonable doubt' that this had the definite effect of shortening her life in more than a minor fashion of a few hours. I understand the cause of death on the death certificate was Cerebrovascular Accident. There is nothing in the medical notes to substantiate this diagnosis which is misleading and probably inaccurate." (GMC100947, p322)

E90 On 5 June 2008, Professor Black produced the fifth version of his report on Gladys Richards for the GMC. He noted that there were *"significant failings in the medical care provided to Gladys Richards"*, including the prescription and use of strong analgesia without either explanation or consideration of the use of milder analgesia, and failures to medically review Mrs Richards' condition. Professor Black expressed the view that *"Mrs Richards was prescribed 40 mgs, which in my view is just within prescribing guidelines yet seem high for someone who had been identified as 'sensitive to Oramorph' by Dr Barton on the 14th August"*. He was also critical of the use of the drug chart (GMC100947, p276).

E91 Professor Black also produced a report in respect of Patient M. In this report, he commented on *"significant failings in the medical care provided to Patient M"*. These included the failure to undertake assessments or examinations of Patient M, the prescription of a high dose of diamorphine, and *"the use of approximately three times the usual expected daily dose of Diamorphine when starting the syringe driver, together with a dose of 60 mg of Midazolam, without any explanation in the notes, in my view negligent criminal practice"* (GMC100947, p238).

The inquests into the ten Category 3B cases

E92 On 24 March 2009, Professor Black gave evidence at the inquests into the ten Category 3B deaths: those of Arthur Cunningham (CPS000012, pp49–79), Elsie Devine (CPS000014, pp21–54), Sheila Gregory (CPS000014, pp55–57), Ruby Lake (CPS000012, pp285–95), Elsie Lavender (CPS000012, pp38–42), Geoffrey Packman (CPS000014, pp3–20), Patient M (CPS000012, pp6–9; p18), Helena Service (CPS000012, pp47–49), Enid Spurgin (CPS000014, pp78–80) and Robert Wilson (CPS000014, pp57–77).

E93 In respect of Mrs Gregory, Professor Black had previously said that the administration of diamorphine was possibly excessive, to the point of rendering her

unresponsive or depressing her respiration. However, at the inquest he gave evidence that the dose *"could be at the upper limit of normal, and clearly there would need to be justification, but I do not think [the opiates administered were] exceptional"* (CPS000014, p55).

E94 In respect of each of the other cases, there were no significant departures in Professor Black's oral evidence from the conclusions he expressed in his reports.

E95 On 6 and 7 April 2009, Dr Wilcock gave evidence at the inquests in respect of Arthur Cunningham (CPS000029, pp28–41), Elsie Devine (CPS000031, pp3–36), Sheila Gregory (CPS000029, pp68–73), Ruby Lake (CPS000029, p27), Elsie Lavender (CPS000029, pp13–18), Geoffrey Packman (CPS000029, pp46–48), Patient M (CPS000029, pp3–13), Helena Service (CPS000029, pp18–27), Enid Spurgin (CPS000029, pp41–46) and Robert Wilson (CPS000031, pp37–70). There was no significant deviation from the views expressed in his earlier reports.

E96 On 2 March 2011, Professor Black produced the sixth version of his report in relation to Gladys Richards as part of the preparations for the inquest into her death (BLC004237, pp1–9). A number of changes were made between the fifth and sixth versions of this report. However, Professor Black maintained his criticism of the prescribing regime.

E97 At the inquest into the death of Mrs Richards, Professor Black gave oral evidence that Mrs Richards' death had been multifactorial. However, he did state that the analgesics and sedatives prescribed to Mrs Richards had made a difference (PCO001859, p11).

F Other experts

Overview

F1 The other experts involved in investigations into deaths at the hospital were:

- Bridie Castle
- Nurse Barbara Davis
- Dr Christopher Dudley
- Professor Flora Finlay
- Dr James Gillespie
- Dr David Jarrett
- Dr Althea Lord
- Dr Jonathan Marshall
- Professor John Henry McQuay
- Dr Ann Naylor

- Dr Julian Neal
- Dr Michael Petch
- Daniel Redfern
- Professor Karol Sikora
- Dr Rodney Taylor
- Dr Gill Turner
- Jeffrey Watling
- Dr Andrew White.

F2 During the course of investigations into the deaths of patients at the hospital, a number of medical professionals and experts were consulted by Hampshire Constabulary and others. Some were involved only briefly in the investigation, while others were involved throughout.

F3 The experts referred to in this section played a smaller part in the investigations. No discourtesy is intended to these medical professionals and experts, and their contributions were no doubt of use to those who engaged them. However, their involvement was limited compared with that of the experts discussed in sections A to E above.

F4 The following is a summary of each expert and their involvement.

Bridie Castle

F5 Mrs Castle, Clinical Services Manager for BHB Community Healthcare NHS Trust, was involved with the Independent Review Panel established by Portsmouth HealthCare NHS Trust to investigate a complaint made by Ann Reeves, the daughter of Elsie Devine (DOH604090, p1). The Panel's remit was to consider the care and treatment of Mrs Devine. Mrs Castle was engaged as a nursing assessor to review the case independently and provide a report to the Panel.

F6 Dr Jane Orr and Dr Andrew White were also involved in the preparation of this report.

F7 On 12 June 2001, Mrs Castle produced her report. She concluded that *"the drugs, doses and devices used to make Mrs. Devine comfortable on 19th November were an appropriate and necessary response to an urgent medical situation"* (DOH604091, p8).

F8 The *Report of the Independent Review Panel Established by Portsmouth Healthcare NHS Trust to Investigate a Complaint of Ann Reeves* was published on 10 August 2001 (DOH604090, pp1–19).

Nurse Barbara Davis

F9 During the first police investigation, Nurse Davis provided a witness statement to Hampshire Constabulary. It confirmed that she was a *"State Registered Nurse"* and her speciality was *"Palliative Care".* Her statement read:

> "The normal practice of caring for an individual within a life threatening situation would be to have a discussion with the relatives, if the patient was not deemed to be able to be involved. Pain control is of great importance and the best way to effect this would be the use of a syringe driver. The use of intravenous fluids at this stage may be considered to be of no benefit, as they can often create more difficulties. Regular mouth care would ensure that the patient would not suffer from dryness of the mouth. The lack of intravenous infusion would not make a difference to the eventual outcome of their situation." (HCO007012, p1)

Dr Christopher Dudley

F10 Dr Dudley, Consultant Nephrologist and Senior Clinical Lecturer at the Richard Bright Renal Unit, Southmead Hospital, North Bristol NHS Trust, prepared a report on Elsie Devine for Hampshire Constabulary on 20 March 2005. The report's *"Summary of Conclusions"* stated:

> "Although it may have been possible to stabilise her condition with relatively simple measures, this would not have materially changed her prognosis as death was inevitable. She was treated appropriately in the terminal phase of her illness with strong opioids to ensure comfort and calm, to enable nursing care and to maintain her dignity." (GMC000777, pp129–46)

F11 Both the CPS and Mr Perry considered this report. Dr Dudley's conclusions would not have supported a prosecution of Dr Barton for gross negligence manslaughter (CPS000201, p29).

F12 On 16 April 2009, the Coroner read out Dr Dudley's statement at the inquests into the deaths of the ten patients (CPS000035, pp56–63).

Professor Flora Finlay

F13 In a Policy File entry dated 3 April 2004, Professor Finlay was named in an Officer's Report by Det Insp Niven (HCO000639, p160). Professor Finlay was recommended to Hampshire Constabulary, but was unable to assist due to work commitments. In turn she *"strongly recommended Dr Andrew Wilcox"* and other experts to the police.

Dr James Gillespie

F14 Dr Gillespie, a radiologist, provided a report in respect of Elsie Lavender to Hampshire Constabulary in February 2005 (HCO000452, pp1–8). Answers to *"specific radiological questions"* were provided *"to assist other experts involved in this case"*.

F15 Dr Gillespie's opinion was: *"The issues concerning possible clinical diagnoses are beyond the area of my specific expertise and are best answered by a Consultant Physician or similar clinical expert"* (HCO000452, p7).

F16 The Panel notes that one of the difficulties during the police investigations was that, due to the complex medical condition of many of the patients, a single expert was often unable to answer the central questions in full.

Dr David Jarrett

F17 Dr Jarrett was a lead consultant at Portsmouth HealthCare NHS Trust. On 8 January 2002, he produced a report on events at the hospital. He said that he was *"Not convinced that what was happening at GWMH was in anyway different to what happening elsewhere"*. He also said that he felt the care at the hospital was good and that, if he had a relative there, he would have *"no worries".* Dr Jarrett's usefulness as a witness is questionable given his position within the Trust, which may have led to a perception of bias.

Dr Althea Lord

F18 On 22 December 1998, Dr Lord prepared a report on the treatment of Mrs Richards. She said: *"The … analgesia and sedation was considered necessary for Mrs Richards to keep her comfortable and aimed at addressing pain, anxiety and agitation."* She stated: *"I do not feel that the lack of intravenous fluids for the 4 days that Mrs. Richards was on a syringe driver significantly altered the outcome"* (CPS001876, p2).

F19 The Panel notes the potential, or perceived, lack of independence Dr Lord may have had from the investigation. For that reason, her report was of limited evidential value.

Dr Jonathan Marshall

F20 On 1 April 2005, Dr Marshall prepared a report on Geoffrey Packman at the request of Hampshire Constabulary (HCO000518, pp2–12). His conclusion was: *"Mr Packman is likely to have suffered a significant GI bleed while an in-patient at GWMH. Medical assessment at that time was limited and he was managed with escalating doses of opiate analgesia before he died on 3-9-99"* (HCO000518, p3).

F21 On 1 June 2005, it was noted that Dr Marshall, Dr Lawson and Dr Lohn had raised concerns in respect of the care given to Geoffrey Packman (HCO000642,

p79). As a result, it was noted that the case would be referred to Dr Black and Dr Wilcock.

F22 On 28 April 2006, Dr Marshall prepared a report for Hampshire Constabulary in respect of Robert Wilson (HCO116215, pp1–13). He concluded that *"The management of Mr Wilson's liver condition following the time of initial admission was not perfect but reasonable".* He continued:

> "Mr Wilson was clearly an unwell man whose life expectancy was short … The administration of high doses of morphine while an in-patient on Drylands however must be considered reckless … There also does not appear to have been any attention paid to appropriate dose reduction and/or monitoring in Mr Wilson's case. The outcome was predictable in the clinical context of cirrhosis and escalating opiate dosage that Mr Wilson could not have survived." (HCO116215, p12)

F23 On 2 August 2006, Det Supt Williams noted his views in an email:

> "Spurgin/Packman /Wilson and Lake are the stronger cases … Supported by additional medical experts … Particularly Marshall and Redfern … These witness give additional weight to premise that care for simple medical condition not applied … Experts use stronger language in these cases … Evidence could also be heard by GMC and Coroner …" (HCO000643, p188)

Professor John Henry McQuay

F24 In a Situation Report dated 31 July 2006, Professor McQuay's involvement was referenced as follows: *"All principal statements now taken and submitted to CPS with case files (other than Dr McQuay effects of Diamorphine, being chased by DI Grocott)."* It was also noted that he was a professor of toxicology (HCO000643, pp177–178).

F25 Professor McQuay prepared a report for the GMC on the therapeutic use of controlled drugs. It was a generic report in that it dealt with the therapeutic use of drugs in a hospital setting, without addressing specific issues arising out of any of the patients' cases or the treatment provided by Dr Barton (GMC101094, pp518–539).

F26 On 14 September 2006, Hampshire Constabulary made its final submission of papers to the CPS (HCO000643, pp196–203). Referring to Professor McQuay's evidence, Det Supt Williams wrote:

> "Professor McQuay comments that administration of 30mg of Diamorphine intravenously over 5 minutes to a less than fit normal person would make them sleep and stop breathing, the effect might be less dramatic if they were in severe pain. The older the patient the

> greater the effect of the dose. In terms of the doctrine of double effect the aim of using strong opioids in palliative care is to relieve pain. There is no quality evidence to show effective pain relief shortens life." (HCO000643, p198)

Dr Ann Naylor

F27 Dr Naylor was the Health Ombudsman's medical adviser and a consultant anaesthetist with experience in acute pain and palliative medicine. The records show that she commented:

> "Having reviewed the clinical and nursing records on the complaints file, I consider that the choice of pain relieving drugs for [Patient N] was appropriate in terms of the type of drug, doses, methods of administration and frequency of administration. Staff were correct in their judgment that [Patient N] required palliative care …" (DOH604078, p9)

F28 Dr Naylor said that the same comments could be made about the management of Patient N's hydration. She concluded: *"[Patient N] received medical management entirely appropriate to her condition and prognosis and this was supported by the nursing care plan"* (GMC100092, pp104–6).

Dr Julian Neal

F29 On 5 July 2009, Dr Neal prepared a *General Conclusions Report* for the GMC in respect of multiple patients (GMC101076, pp11–32). At the time of the report, Dr Neal was a senior partner at the Portsdown Group Practice.

F30 He concluded that Dr Barton's note keeping in *"all 12 cases was poor"* (GMC101076, p14), but acknowledged the time pressures she said she was under. He also noted that while Dr Barton was working at the hospital, doctors in similar positions, including her colleagues, also kept poor notes.

F31 Dr Neal noted that Dr Barton reviewed patients regularly, and when asked to do so. He said: *"I believe that her efforts to help all twelve cases were genuine and that despite time pressures she never failed in her obligation to visit and assess"* (GMC101076, p16).

F32 He said in relation to proactive prescribing: *"Dr Barton's adoption of proactive prescribing was based on a fundamental desire to relieve distressing symptoms in all 12 cases"* (GMC101076, p16).

F33 Dr Neal concluded that Dr Barton did not receive adequate consultant supervision during the period 1996 to 1999. In addition, none of the consultants who acted in a supervisory capacity saw fit to change her prescribing practice.

F34 Dr Neal concluded that Dr Barton was a *"very busy and dedicated doctor who was struggling to balance all her commitments"*. He stated it was unsurprising that an *"excessive workload led to some suboptimal practice"* (GMC101076, p18).

F35 Dr Neal attacked the credibility of Professor Ford, whose evidence he said *"at times, borders on the intemperate".* Dr Neal described Professor Ford's evidence as *"questionable for a number of specific reasons"*, which he outlined (GMC101076, p19).

F36 Dr Neal concluded: *"From my detailed examination of all the evidence presented to me regarding the 12 cases in question, I can understand the actions taken by Dr Barton in all 12 cases"* (GMC101076, p21).

F37 Dr Neal's conclusions gave rise to lines of enquiry on the question of corporate liability and health and safety offences.

Dr Jane Orr

F38 Dr Orr was a clinical assessor involved in the preparation of a report by the Independent Review Panel in respect of Elsie Devine, published on 10 August 2001, along with Mrs Castle and Dr White (CPS001601, pp1–19).

Dr Michael Petch

F39 On 5 April 2006, Dr Petch prepared an expert report for Hampshire Constabulary in respect of Helena Service. He concluded:

> "… Mrs Service's terminal decline in 1997 was not unexpected. Once the decision had been made that she was not for resuscitation, as it was in the Queen Alexandra Hospital in May 1997, then palliative care with increasing doses of Diamorphine and Midazolam was appropriate. These drugs were administered in accordance with cardiological practice in 1997." (HCO006803, p2)

F40 On 23 March 2009, Dr Petch's report of 5 April 2006 was read in the inquests into the deaths of ten patients (CPS000010, pp36–40).

Dr Daniel Redfern

F41 Dr Redfern was a consultant orthopaedic surgeon who was appointed to address the issues raised in the case of Enid Spurgin.

F42 On 22 January 2006, Dr Redfern produced an expert report for Hampshire Constabulary in respect of Mrs Spurgin (HCO000200, pp2–15). He concluded that he could not comment on the quality of the treatment of her hip fracture. He also concluded that it was not possible to confirm from the medical records that Mrs Spurgin had compartment syndrome. He said:

> "Due consideration of the significance of her symptoms of pain and her inability to mobilise was not given consistently at either Haslar of at Gosport War Memorial Hospital. Specifically she did not undergo a further x-ray examination at either hospital, and she was not referred back to Haslar from Gosport War Memorial Hospital. The differential diagnosis should have included implant failure and uncontrolled infection. These complications would have been reversible." (HCO000200, p3)

F43 On 10 March 2006, it was noted in an Expert Witness Update that Dr Redfern had completed his work. His report had been *"signed off and disclosed and discussed with Dr Wilcock"* (HCO000643, p87).

F44 In a letter to Kim O'Neill at the CPS on 14 September 2006, it was noted in respect of Mrs Spurgin that *"Drs Wilcock & Redfearn point to cause of death as Septicaemia or toximaemia arising from infection"*. The letter stated that Dr Redfern felt Mrs Spurgin's *"condition was reversible"*. In addition: *"All agree that cause of death as CVA was incorrect"* (HCO000643, p201).

F45 On 30 June 2009, Dr Redfern gave evidence at the GMC's fitness to practise hearing (CPS000087, pp5–29). He did not deviate from the evidence he had given previously.

F46 Dr Redfern's report was considered by the CPS and Mr Perry.

Professor Karol Sikora

F47 Professor Sikora's area of expertise was cancer medicine (GMC100124, p191).

F48 On 1 June 2009, Professor Sikora prepared an expert report on multiple patients for the GMC (GMC100124, pp190–96). He concluded: *"At no time do I believe Dr Barton was prescribing drugs to hasten a patients' demise but to relieve pain and suffering."* Professor Sikora continued:

> "Although Dr Barton was very much part of this process of anticipatory prescribing, I do not believe she was its cause. In fact she did her best to implement policies to reduce the level of suffering in the patients under her case." (GMC100124, p196)

F49 Professor Sikora also said:

> "Dr Barton was only a small cog working part-time in a large machine … She was the victim of circumstances in a very isolated and vulnerable part of the National Health Service. I believe she is simply a convenient scapegoat for a more widespread system failure that resulted in inadequate numbers of medical and nursing staff to ensure optimal

care being delivered to patients at Gosport during the period of her tenure." (GMC100124, p196)

F50 On 29 July 2009, Professor Sikora gave evidence at the GMC fitness to practise hearing (CPS000129, pp1–61). He accepted that he had not examined the individual cases of the patients, nor the statements of relatives, nor the prescriptions. His evidence did not deviate significantly from his statement. He was asked:

> "One of the consequences of anticipatory prescribing of a syringe driver where there is no start date on it, inevitably is that there is at least the risk that nursing staff, of their own volition, will make that judgment, no doubt with the best of intention, but that is a risk, is it not?" (CPS000129, p51)

F51 Professor Sikora accepted that it was a risk, and continued:

> "I think for the period of time and the location in terms of the structure, it was an acceptable risk. I cannot see any other way of getting appropriate symptom control. These are not well patients, the ones who are being written up for the syringe driver. They are not people who are ever likely to go out of hospital, so the decision is made to give them the best palliative care as quickly as possible if they do develop symptoms and the person on the spot, in this case the nurses, make the final decision and then it is reviewed the next day by the doctor." (CPS000129, p51)

F52 Professor Sikora's evidence did give rise to further lines of enquiry in respect of corporate liability and health and safety offences.

Dr Rodney Taylor

F53 On 7 September 2005, Dr Taylor, a consultant physician and gastroenterologist, provided a witness statement to Hampshire Constabulary in respect of Elsie Lavender. He concluded: *"We stabilised her medically and accepted that she would not be able to go home from us. She was referred for continuing care and transferred from the care of my team to Daedalus Ward, Gosport War Memorial Hospital"* (MRE000605, p7).

F54 On 19 March 2009, Dr Taylor gave evidence in the inquests into the deaths of ten patients (CPS000006, p60). His written evidence regarding Mrs Lavender was read.

Dr Gill Turner

F55 On 16 September 1999, Dr Turner wrote to Max Millett of Portsmouth HealthCare NHS Trust to comment on complaints regarding the care of Patient N.

Dr Turner criticised records and fortnightly ward rounds (following comments made by Dr Lord). Dr Turner also said:

> "… writing Morphine up for a subcutaneous pump with doses ranging from between 20 and 200 mgs a day is poor practice and could indeed lead to a serious problem … I think it unlikely that the jump from 20 to 40 mgs made any real contribution to Patient N's management, but I think it is still a large jump and steps need to be taken to consider limiting the flexibility of dosage regime." (MRE000365, p3)

Jeffrey Watling

F56 Mr Watling was the Pharmacy Services Manager for Portsmouth Hospitals NHS Trust. He explained in a witness statement how medicines were ordered, supplied and recorded. He also produced a handbook on palliative care (HCO004181, p2).

Dr Andrew White

F57 Dr White was a clinical assessor involved in the preparation of a report by the Independent Review Panel in respect of Elsie Devine, published on 10 August 2001, along with Mrs Castle and Dr Orr (DOH604090, pp1–19).