POLICE: CIRCULATION. INQUESTS. APRIL 2009

OPERATION ROCHESTER

BRIEFING DOCUMENT

BACKGROUND

The Gosport War Memorial Hospital (GWMH) is a community hospital which is managed by the Portsmouth Health Care (NHS) Trust. It is operated on a day-to-day basis by nursing and support staff, employed by the Trust. Clinical expertise is provided by way of visiting general practitioners and clinical assistants, consultant cover is provided in the same way.

Elderly patients are usually admitted to GWMH through referrals from local hospitals or general practitioners for palliative, rehabilitative or respite care.

Doctor Jane BARTON is a registered Medical Practitioner who, in 1988, took up a part-time position at GWMH as Clinical Assistant in Elderly Medicine. She retired from that position in 2000, but continues to work as a General Practitioner in private practice in Gosport.

Dr. Anthea LORD is a Consultant Physician within the Department of Elderly Medicine of Portsmouth Health Care (NHS) Trust and she is responsible for patients at GWMH.

POLICE INVESTIGATIONS

Operation ROCHESTER is an investigation by Hampshire Police Major Crime Investigation Team into the deaths of a large number of elderly patients at GWMH. It is alleged that elderly patients who were admitted to the GWMH from as far back as 1989 for rehabilitative or respite care, were inappropriately administered Diamorphine by use of syringe drivers, resulting in their deaths.

Most of the allegations involve a particular General Practitioner, Doctor Jane BARTON. Death certificates of patients who died at the GWMH between 1995 and 2000 total 954, of which 456 were certified by Doctor Jane BARTON.

This matter has been investigated by Hampshire Police on three separate occasions.

First Police Investigation

Hampshire Police investigations commenced in 1998 following the death of Gladys RICHARDS, aged 91 years.

Mrs. Richards died at the GWMH on Friday 21st August 1998 whilst recovering from a surgical operation carried out at the nearby Royal Haslar Hospital to address a broken neck of femur on her right side.

Following the death of Mrs. RICHARDS her daughters complained to the Hampshire Police about the treatment that had been given to their mother at the GWMH, alleging that she had been unlawfully killed.

Officers from Gosport C.I.D. carried out an investigation and in due course, a file was submitted to the Crown Prosecution Service.

In March 1999 the Reviewing CPS Lawyer gave the opinion that on the evidence available, he did not consider a criminal prosecution was justified.

On hearing of this decision, one of Mrs RICHARDS' daughters expressed her dissatisfaction with the quality of the police investigation and made a formal complaint against the officers involved. The complaint was upheld and a review of the police investigation was carried out.

Second Police Investigation

A team of detectives from the Major Crime Investigation Team commenced the re-investigation on Monday 17th April, 2000. A lengthy re-investigation was conducted during which nursing and medical staff were interviewed.

Medical opinion was obtained from an expert who provided a report on his findings. He made the following conclusions:

- "Doctor Jane BARTON prescribed the drugs Diamorphine, Haloperidol, Midazolam and Hyoscine for Mrs. Gladys RICHARDS in a manner as to cause her death."
- "Mr. Philip James BEED, Ms. Margaret COUCHMAN and Ms. Christine JOICE were also knowingly responsible for the administration of these drugs."
- "As a result of being given these drugs, Mrs. RICHARDS was unlawfully killed."

The expert provided a further report which added:

- "It is my opinion that as a result of being given these drugs, Mrs. Richards death occurred earlier than it would have done from natural causes."

As a result of these expert reports a meeting took place between senior police officers, the CPS, Treasury Counsel and the medical expert. During that meeting, Treasury Counsel came to the view that the experts assertions that Mrs. RICHARDS had been unlawfully killed were flawed in respect of his analysis of the law. He was not entirely clear of the legal ingredients of gross negligence/manslaughter.

In August, 2001 the Crown Prosecution Service advised that their was insufficient evidence to provide a realistic prospect of a conviction against any person.

Local media coverage of the case of Mrs. Gladys RICHARDS resulted in other families raising concerns about the circumstances of their relatives' deaths at the GWMH. As a result of this four more cases were randomly selected for review by medical experts.

Reports from the medical experts were reviewed and a decision was taken not to forward them to th CPS as they were all of a familiar nature to the RICHARDS case and would therefore attract a simila reply. A decision was then made that there would be no further police investigations at that time.

Copies of the expert witness reports were forwarded to the General Medical Council, the Nursing and Midwifery Council and the Commission for Health Improvement for appropriate action.

Intervening Developments between Second and Third Investigations

On 22nd October, 2001 the Commission for Health Improvement (CHI) launched an investigation into the management, provision and quality of health care for which Portsmouth Health Care (NHS) Trust was responsible in GWMH. During the investigation 59 staff from GWMH were interviewed.

A report of the findings of the CHI investigation was published in May 2002. The report concluded that a number of factors (detailed in the report) contributed to a failure of the Trust systems to ensure good quality patient care. However, the Trust now has adequate policies and guidelines in place that are being adhered to, governing the prescription and administration of pain relieving medicines to older patients.

Following the CHI Report, the Chief Medical Officer, Sir Liam DONALDSON, commissioned Professor Richard BAKER to conduct a statistical analysis of the mortality rates at GWMH, including an audit/review of the use of opiate drugs.

On Monday 16th September, 2002 staff at GWMH were assembled in order to be informed of the intended audit at the hospital by Professor BAKER. Immediately after the meeting concluded a nurse, who had been employed at GWMH since the late 1980s, handed over to the hospital management a bundle of documents. These documents were copies of memos, letters and minutes all relating to the concerns of nursing staff which were raised at a series of meetings held in 1991 and early 1992 about the increased mortality rate of elderly patients at the hospital, the sudden introduction of syringe drivers and their use by untrained staff and the use of Diamorphine unnecessarily or without consideration of the sliding scale of analgesia (Wessex Protocol). Concerns raised by nursing staff in relation to the prescribed Diamorphine involved Doctor Jane BARTON.

The existence of the documents was reported to the police and a meeting of senior police and NHS staf was subsequently held on 19th September, 2002 at Hampshire Police Support Headquarters. Th following decisions were made at that meeting:

Further police enquiries were necessary in light of the new information and an enquiry team would b assembled and based at Hulse Road, Southampton. The enquiry team would:

- Examine the new documentation and investigate the events of 1991;
- Review existing evidence and new material in order to identify any additional viable lines of enquiry;
- Submit the new material to the experts and subsequently to CPS;
- Examine individual and corporate liability.

It was decided that a press release was necessary, which would include a free phone telephone numbe for concerned relatives to contact police. It was also decided that a Police Family Liaisons Office needed to be appointed.

Third Police Investigation

On 23rd September, 2002 Hampshire Major Crime Investigation Team commenced enquiries. To date relatives of 90 elderly patients have contacted police with regards to the deaths of the patients a GWMH. A number of these relatives are part of a family group being represented by a firm o solicitors, namely ALEXANDER HARRIS of Manchester. Others contacted police through an NH direct free phone number or directly, as a result of publicity. Sixteen of these cases were identified b Professor BAKER during his research on behalf of the CMO.

The current police investigation is being conducted in stages, as follows:

Stage One

Enquiries into the documents and events of 1991. (Now completed)

In summary, the events of 1991 were as follows:

- A number of night-nursing staff at GWMH had concerns as earlier stated and held a private meeting to discuss the issues. They were conscious of an on-going case within the NHS of GRAHAM PINK, a Charge Nurse working in the care of elderly patients in Stockport, who was dismissed for "whistle blowing".

- It was decided that three of the nurses would approach the hospital management and raise their concerns. The nurses raised their concerns with the Patient Care Manager.

- A series of meetings took place between management, medical and nursing staff.

- A final meeting took place in which the nursing staff were informed by both the hospital management and medical staff, that the problems raised were due to a lack of understanding by nursing staff concerning the use of Diamorphine. In addition, there was also a training issue in relation to syringe drivers.

- Although the nursing staff were not entirely happy with the outcome of the meetings, they felt that they had done everything they could in raising the issues, but in light of the PINK case, felt there was no more they could do, apart from retaining the documentation.

Stage Two

Obtaining further expert medical opinions for screening purposes (now completed).

This stage involved a team of medical experts in various areas of elderly patient care i.e. Palli Geriatric, General Medicine and Nursing, providing their individual and holistic opinions or treatment of the 90 GWMH, based entirely on information from medical records.

The screening process enabled the medical experts to put the cases into 3 categories as follows:

1. Patient received optimal care and died of natural causes or cause of death unclear.
2. Patient received sub-optimal care and died of natural causes or cause of death unclear.
3. Patient received negligent care and died of natural causes or cause of death unclear.

Cases in category 1 are no longer under investigation. Cases in category 2 are currently being reviewe on a medical/legal bases in order to establish whether Police investigations should continue or whethe they should be referred to other regulatory bodies i.e. GMC, NMC.

There are 13 cases in category 3, 9 of which are cause of death unclear. Investigations are continuing i respect of all 13 with a view to the submission of files to CPS.

In respect of the 9 cases where death is unclear, 4 of these cases have been prioritized in order seriousness and will be fast tracked to CPS.

Stage Three

This stage is the gathering of evidence in respect of the cases in category 3 and the submission of a file of evidence to the CPS in respect of the first 4 cases.

A Clinical Review Team consisting of experts in Palliative and Geriatric medicine have been appointed with a view to initially reviewing all information regarding the treatment of the four patients and providing their expert opinion as to whether or not any of these patients have been unlawfully killed.

Code A
Detective Sergeant