Draft verdict responses

What do you say to the families?
I would like to extend my sympathies to the families for the uncertainty they have experienced over the last ten years concerning their loved ones' deaths. I sincerely hope that these inquests have provided an opportunity for the families to hear more about the care their relative received and that these verdicts have provided answers for all the families regarding the circumstances of their loved ones' deaths.

What's your response to the verdicts?
The local NHS welcomes these verdicts and the insight they provide into the deaths of these ten patients.
Previous police investigations found no evidence of criminal wrongdoing and it is important for everyone involved in the care of these patients that X verdicts indicate that the patients were cared for appropriately/and that the medication used to treat and relieve their symptoms was correct.

It is a matter of regret to the NHS that X verdicts suggest that in the mid/late 1990s the organisations responsible for care at the time did not provide the highest quality care for these patients. (We would like to apologise unreservedly to the families concerned and assure local people that all these issues have been addressed and this was confirmed by CHI in 2000).
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These verdicts have highlighted some serious problems with the NHS…what's your response to this?
See above.

Who is to blame/has anyone taken responsibility?
An inquest is not a trial and the purpose of an inquest is not to apportion blame – so it is not appropriate to talk about who's resposible. These inquests were to determine how these ten individuals met their deaths.
Internal investigations and the CHI review concluded that there was no evidence to suggest that any individual should be disciplined. Furthermore three police investigations found that there was no evidence of any criminal wrong-doing. We await the outcome of the GMC investigation and reconsider our position when the outcome of this investigation is known.

We've heard a whole catalogue of problems/errors/poor care at GWMH how do you explain/justify this?
We know from the thorough investigation conducted in 2002 by the then health watchdog, the Commission for Health Improvement, that predecessor organisations did not have adequate policies and procedures in place and this has been further demonstrated by the evidence heard in court.

It is a matter of regret that the organisations responsible for care at the time had not done everything possible to ensure high quality care. However we are confident that the quality of care provided at Gosport War Memorial Hospital today is of the highest standard – the Healthcare Commission has rated the care provided by us as excellent and good in the last year.

The way the NHS monitors patient safety and the quality of care has changed considerably since the early 1990s. Staff are now required to report all incidents and 'near misses' and these are immediately logged and reviewed at the local integrated governance group, if appropriate a detailed action plan is developed and monitored.

We've heard about people being discharged too early from QAH because of bed blocking…is this the case/explain why this happened?
(DN: needs clinical input) There are always pressures on large acute hospitals – that was the case in the late 1990s and it remains the case today. Sometimes this does mean that patients are transferred to other hospitals. However patients should always undergo a clinical assessment of their fitness to travel and receiving hospitals must confirm that they can meet the care needs of the patient. Today all transfers are subject to strict assessments to ensure that patients are only transferred if it is in their best interests to do so……

Dr Barton says that she was overworked and unsupported and this meant she had to cut corners…why did the NHS put her in this position?
(DN: did CHI review make recommendations about clinical cover?)
(?We believe that everyone involved in the care of patients at GWMH has always put patient care foremost, however)…We know from the CHI review and the verdicts today that in the late 1990s the organisations responsible for care at the time did not have adequate resource and policies in place to provide the highest quality care for patients at GWMH. This is a matter of regret and in 2000 the NHS took steps to provide more cover at GWMH. We are confident that there is more than sufficient clinical cover at GWMH today with X doctors providing cover on the five wards at GWMH.

What are you going to do about Dr Barton now?
The GMC will consider Dr Barton's case in June. Until then she continues to practice although the GMC have imposed some restrictions on her prescribing. Once we know the outcome of the GMC hearing we will take appropriate action.

Why were the families told that their relatives would receive rehabilitation at GWMH when this clearly wasn't the case?
Good communication between doctors, nurses, patients and their relatives is at the heart of good quality care and is a major factor in determining a positive patient experience. One of the enduring challenges in healthcare is establishing the right point of contact and ensuring that they get timely and accurate information which they can disseminate to other family members. The evidence heard over the last few weeks suggests that back in the 1990s this process did not always happen. Today this is what we do…….

The consultants at QAH were meant to supervise Dr Barton…why didn't they do this properly?
Supervision was in lines with procedures at the time. Prescriptions were reviewed by the pharmacist weekly and regularly reviewed by consultants.

Why did the NHS allow Dr Barton to write prescriptions for patients before assessing them properly?
?Was this standard practice at the time and does it happen now?

Why was Dr Barton allowed to prescribe such high doses of diamorphine? Why was diamorphine given for minor medical problems like a broken arm or bed sores?
There are now much tighter governance arrangements in place in relation to the prescribing and administration of medicines than there were in the early 1990s. For example reviews of prescribing practices and all medicines related incidents are reported on the national risk learning database and analysed by the Trust. Action plans developed, where appropriate.

How does the NHS check the care provided by clinical assistants like Dr Barton?

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Medical experts in court and also other experts (Ford report, Baker report etc) have said that the levels of diamorphine contributed to the deaths of these patients…how did the NHS allow this to happen?
It is a matter of regret to the NHS that X verdicts suggest that in the late 1990s the organisations responsible for care at the time did not have adequate resource and policies in place to provide the highest quality care for these patients. (We would like to apologise unreservedly to the families concerned and assure local people that all these issues have been addressed and this was confirmed by CHI in 2000).

We would like to apologise to the families concerned that the NHS at the time did not have adequate policies and procedures in place to ensure that their relatives were cared for appropriately. All issues highlighted by CHI were addressed as early as 2002 and we are confident that care at the Hospital today is of the highest standard.