Mike Gill
16/10/2001 07:00 PM

Sent by: Mike Gill/SERO

To:
cc: **Code A**

Subject: Re: PMQs: Gosport War Memorial Hospital

sorry - I've been out all day. There are one or two errors in your note. I attach a note I sent to CMO last week

Gospbr. Gosport.

To: Chief Medical Officer

From: Dr. Mike Gill
Copies: Dr. Sheila Adam
Date: 5th October 2001

Gosport War Memorial Hospital (GWMH)

1. You have asked for reassurance that in the context of an allegation of a 'culture of euthanasia' apparently made in relation to care delivered at GWMH, and since the CHI investigation will not be complete until next year, the hospital is providing safe care.

2. Para.s 3- 10 of this note summarise some key points in the background, most already the subject of previous briefings. Para.s 11-12 describe the actions taken locally.

3. Gladys Richards (GR) died in GWMH in Aug 1998. Dr Jane Barton, local GP and clinical assistant at Portsmouth Healthcare Trust (PCHT) was involved in her care. GR's daughters complained about the standard of care their mother had received. The local resolution route was not completed as the daughters contacted the Police. Three issues have been reported as giving cause for concern:

   - The degree of discretion given to nursing staff administering diamorphine (e.g. 20mg midazolam and **40 – 200mg** diamorphine in 24 hours via a syringe driver. In the event, Mrs Richards received only 40mg in 24 hours).

   - An allegation of a 'culture of euthanasia' (apparently reported to the Police by a member of the nursing staff, but it is not known which one)

   - Poor communication between the medical staff and relatives

4. The initial Police investigation found that there was no criminal case to answer. GR's daughters complained about the conduct of the Police investigation. The complaint against the Police was upheld and the investigation re-opened.

5. Early in 2001, GR's daughter complained to the media about the lack of progress with the Police case. Immediately following this publicity, nine sets of relatives contacted the Police with concerns.

6. Subsequently the Police reported Dr Barton to the GMC. She appeared before the Interim Orders Committee in June 2001. No action was taken. Similarly, the Police also reported three nurses to the UKCC. I understand that the UKCC do not intend to take any action.

7. In July 2001, the Crown Prosecution Service decided that in the case of Gladys Richards 'there is insufficient evidence to proceed.'

8. The Police subsequently confidentially reported the fact, and some of the content, of their investigation to CHI.

9. The Police have recently requested four sets of case notes related to patients who had died at GWMH between March and September 1998. Dr Barton has been involved in care of all four of these patients. The Police are still awaiting a view from their experts. DCI John James, who is leading the Inquiry, expects that no decision about these cases will be made for at least two to three weeks. The GMC await the outcome and receipt of any new information before taking any further action

10. In the last two years, PHCT has dealt with two serious complaints about GWMH. Neither have been the subject of any Police involvement:

    - A complaint about the care of Mrs P. This was taken through the complaints process and a 'paper review' by the Ombudsman. One of the issues in this case was the inappropriate use of diamorphine. The Ombudsman did not criticise the clinical care given to Mrs Pl. Dr Barton's involvement in this case was peripheral.

    - The other complaint concerned Mrs D. This went to an Independent Review Panel, which upheld a complaint about poor communication that was acknowledged by PHCT. The Panel did not criticise the clinical care given to Mrs D. Dr Barton was closely connected to this case.

Local Action

11. PHCT have taken the following action:

    - A 'whistle-blowing' policy was introduced in 1998.

    - The medicines management policy (operated jointly with Portsmouth Hospitals NHST) was reviewed and revised this year.

    - A pain management policy, which includes the policy for the use of syringe drivers, was introduced last year. This formalised changes in diamorphine prescribing policy already initiated by the medical director. It has clearly been tested: variations from it have led to nurses successfully querying such variation with senior Trust management.

    - Dr Barton resigned as Clinical Assistant in 2000. Following this a staff grade doctor was employed to work at GWMH during the day. Out of hours Dr Barton and her partners continue to provide cover.

12. The Health Authority has taken the following action:

    - In view of the serious nature of the allegations made against Dr Barton, her general practice work was reviewed according to the local procedure for the *identification and support of doctors whose performance is giving cause for concern.* The Screening Group found no evidence of possible poor professional performance.

    - In June 2001, Dr Barton was asked to 'stand aside' as Chair of Gosport PCG while the Police investigations continue. She continues to be paid. At the time of writing it is unclear if the Vice Chair will assume the role of Chair during the PCT consultation process.

- An attempt to analyse death rates among patients treated on the ward was inconclusive

Conclusion

13. There clearly was a period when prescribing policy was lax. On whether this in fact led to abuse there is conflicting evidence. Without wishing to prejudge the outcome of the CHI investigation, I and the DPH are satisfied that the care being provided is now safe, and that there are governance systems in place to ensure that. My sense is that a significant trigger to relatives going to the Police has been the brusque know-it all- style of the GP. Having had to review and overturn their own initial response to first complaint, the Police may feel under unusual pressure to leave no stone unturned.

14. The CHI investigation may now begin before the police have completed theirs, and before the CPS have come to a view. This will require a very careful setting out of ground rules, for example those surrounding the use of statements already made to the Police, some of them under caution.

Mike Gill, SERO
Code A

DRAFT
16 October 2001: Briefing for Prime Minister's Questions

CHI INVESTIGATION OF GOSPORT WAR MEMORIAL HOSPITAL

1 Accusation

The Commission for Health Improvement (CHI) is to investigate allegations of a "culture of euthanasia"[Code A it's important to realise that this was a turn of phrase used we think by a member of the public when making a statement to the police, possibly under caution, and passed on to CHI and the HA on a confidential basis by the police. I'm anxious about it appearing in every minute on this subject, and suggest strongly either that it should be removed from this one, or that it is qualified] at Gosport War Memorial Hospital.

2 Facts

In August 1998 Portsmouth Healthcare NHS Trust received a complaint from the family of Mrs Gladys Richards who died at Gosport War Memorial Hospital. The complaint concerned the administration of diamorphine - the family believed Mrs Richards had been given excessive dosages. As well as receiving treatment at Gosport, Mrs Richards also received care at Royal Hospital Haslar. The complaint was fully investigated by the Trust and no evidence of inappropriate care was found.

In the Autumn of 1998 one of Mrs Richard's daughters alleged that her mother had been unlawfully killed. A police investigation followed and the papers were presented to the Crown Prosecution Service (CPS). The CPS recently decided there was no case to answer.

Following publicity about the case a number of other families approached the police with concerns about treatment of relatives at the hospital (9 cases in all). The police are now investigating these allegations and a decision on any prosecutions has still to be made by the CPS.

As part of the police case on Mrs Richards, papers on the role of a local GP, Dr Jane Barton, were submitted to the CPS. Dr Barton was acting as a clinical assistant in the hospital. Dr Barton's involvement is still part of the ongoing investigations in the other 9 cases. Dr Barton was, at the time, Chair of Gosport Primary Care Group but stepped down when the investigations began.

Dr Barton also appeared before the GMC's Interim Orders Committee (IOC). The IOC decided not to make an order against her and requested further information.

CHI was informed of the allegations of unlawful euthanasia by the police and decided to undertake an investigation. Although it has been suggested that the announcement of this investigation will be made on 18th October, no date has yet been set and the terms of reference for the investigation have still to be agreed.

3 Elephant Traps

Initially concerns were raised that this had the potential to be another Harold Shipman case but there is no evidence to support this. Police investigations are continuing on 4 of the other 9 cases and no decision has yet been made by the CPS on possible prosecutions.

Dr Barton is still suspended on full pay pending final outcome of enquiries. [NOT TRUE. She is a practising GP, whose performance has been formally assessed by the *local procedure for supporting and identifying general practitioners whose performance givers rise to concern.* The screening group found nothing to pursue. (See my note to CMO last week –attached)] ~~The GMC's Interim Orders Committee has requested an expert report on the case~~ The GMC awaits contact from the police before taking any further action.~~and continues to liase with police on their investigations.~~

4 Lines to take

- Police investigations have concluded that there is no criminal case to answer in the death of Mrs Richards. It would be inappropriate to comment on any other investigations at this time.

- It would be inappropriate to comment on Dr Barton's position while police investigations are underway and enquiries by the General Medial Council are not yet concluded.

- CHI – Sarah what would you like to say?

5 Political Context

None. This is a local matter, although potentially high profile.

6 Key quotes

N/A