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From: Gerard Hetherington
CMO's Office

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PUBLICATION OF REPORT OF REVIEW OFDEATHS OF PATIENTS AT GOSPORT WAR MEMORIAL HOSPITAL BETWEEN 1998 AND 2000 – THE BAKER REPORT

Issue

1. Whether to publish the report of the review into deaths at Gosport War Memorial Hospital (GWMH) which was commissioned in 2002 by the previous Chief Medical Officer Sir Liam Donaldson from Professor Richard Baker at Leicester University, now that legal proceedings into the deaths have been completed, how the report of the review (copy attached) might be made public, and whether to agree to requests for a public inquiry.

Recommendations

2. That you should agree to make the report of the review public, (a media handling plan is attached), but that you should not agree to requests for a public inquiry.

Timing

3. Urgent. While the events in the review took place some time ago, there continue to be demands for the report to be published, including from local MPs. There have also been a number of requests for publication under FoI and we are currently dealing with an outstanding complaint/investigation from the Information Commissioner's Office (ICO).

Background

Events at Gosport War Memorial Hospital

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

Professor Baker's Review

5. In 2002, the then CMO commissioned Professor Richard Baker of Leicester University (who undertook the audit of Dr Shipman's patients) to carry out a review of patient deaths at GWMH. Professor Baker concluded "…the findings tend to indicate that the finding of a statistical excess of deaths among patients admitted to Gosport would be unlikely".

6. He also concluded that "a practice of almost routine use of opiates before death had been followed in the care of patients at the Department of Medicine for Elderly People …" and that "The practice had almost certainly 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."

7. Professor Baker report made 5 recommendations:

    1) Investigations should continue into the deaths of individual patients

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

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

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

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

8. The recommendations have mainly been overtaken by events. The police investigations and inquests have been concluded. Procedures for the use of Controlled Drugs were addressed following Dame Janet's Smith's 4th report into the Shipman case; policies on palliative care have been addressed through the development of the End of Life Care strategy; and NICE issued guidelines on the use of opioids in 2012. Professor Baker's point on monitoring outcomes of clinical teams is being addressed by the development of the quality agenda which places increased emphasis on outcomes and increasing transparency.

<u>Investigations and legal proceedings</u>

9. There were further police investigations over the next few years but proceedings were never taken against Dr Barton or anyone else. Most recently, the Portsmouth coroner conducted inquests on ten patients who had died in the hospital. The verdicts, returned in April 2009, were that:

    a. all ten died from natural causes;
    b. in five cases prescribing did not contribute to death and was for therapeutic reasons;
    c. in two cases prescribing did contribute to the deaths but medication was appropriate for the condition and for therapeutic reasons;
    d. In three cases prescribing did contribute to the deaths and medication was not appropriate for the condition and for therapeutic reasons.

10. A General Medical Council (GMC) hearing into Dr Barton's fitness to practise ended early in 2010, deciding that she should not be struck off but that her continued registration should be subject to a series of conditions. The Council for Healthcare Regulatory Excellence, which can look at any Fitness to Practise decisions it thinks unduly lenient, considered the GMC's decision and concluded that, in its view, Dr Barton should have been struck off but that the decision not to strike her off, although lenient, was not so unreasonable that it could be referred to the High Court. Dr Barton has now retired and has, at her own request, had her name removed from the medical register.

11. The Portsmouth Coroner decided to hold an inquest into the death of another GWMH patient, Gladys Richards. However, the coroner first referred the case back to the Hampshire police as Mrs Richards' daughter had raised concerns about the death; after their investigation, the police passed the papers to the CPS, who decided (in August 2010) that there was insufficient evidence for a prosecution. This decision attracted some media attention. The inquest into the death of Mrs Richards concluded on 18 April 2013. The coroner gave the narrative verdict that painkillers and sedatives given to a 91-year-old woman after a hip operation "more than insignificantly" contributed to her death. He added there were a number of contributing factors including her age. There was local media interest at the beginning and end of the inquest.

Publication of Professor Baker's report

12. There have been many requests over the years for Professor Baker's report to be made public.

13. When the police conducted inquiries into events at GMWH Professor Baker's report was made available to them and to the coroner. We understand that the coroner made the Baker report available to some of the families. The police requested that Professor Baker's report should not be made more widely available while their investigations and any legal proceedings were in progress.

14. During the course of the legal and GMC/CHRE proceedings the Department received a number of requests for Professor Baker's report to be made public, including from the families of some of the patients who died at GWMH, from local MPs and the local media. We have also received a number of requests under the Freedom of Information legislation. Whilst the investigations and coroners' inquests were on-going we have claimed exemption from FoI requests under section 31 of the FoI Act on the grounds that publication would be "prejudicial to the administration of justice". However, this is in longer applicable. DH Legal colleagues advise that if Ministers were to decide not to publish the report, there is nothing within the FOIA to resist publication. If the DH does not publish, it is likely that the current outstanding complaint/investigation being undertaken by the ICO could mean that we are legally ordered to release the report under the FOIA.

15. Following the conclusion of the final inquest in April 2013 the Department has had to consider under the Data Protection legislation whether there had been any undertakings of confidentiality about personal data in the report. We contacted Professor Baker who confirmed that he had not given any undertakings about confidentiality to any of the people he had spoken to while conducting the review. While Professor Baker had not interviewed Dr Barton as part of his review, he recommended that Dr Barton should be given an opportunity to review the report and to comment. We have contacted Dr Barton through her solicitor to whom we sent a copy of the report. He has now replied having consulted Dr Barton. While Dr Barton does not welcome the prospect of publication of the report, she understands that DH may wish to publish it. She has not requested the removal of any of the content of the report.

16. Dr Barton's solicitor also commented: "Dr Barton understands the concern to be open and transparent in relation to the investigations undertaken concerning the Gosport War Memorial Hospital, and to that end she would not seek to stand in the way of provision of the report in relation to FOI Act requests if that is the wish of the department…it is Dr Barton's position that she found herself very much overworked in her role as clinical assistant. Together with the nursing staff, she strove to provide the best care possible, but she was effectively faced with the choice of attending to patients, but not

writing notes in detail, or writing notes but limiting care. She chose the former. The result has been that the rationale for properly instituted treatment is more difficult for Dr Barton to demonstrate, and for experts such as Professor Baker to see, at a remove of time."

17. There are no remaining legal or procedural barriers in the way of making the report public. As Sir Liam made clear that he intended that the report should be made public and that it was on this understanding that Professor Baker prepared it, there seems to be no legitimate argument for withholding the report any longer.

18. We have considered whether any part of the content of the report should be removed before publication. As the report contains no personal data about anyone other than Dr Barton, there is therefore no reason under the Data Protection Act not to publish the report in full. Advice from Legal Services is that there is no other reason in law not to publish the report in full.

19. We think it is possible that some of those requesting publication may have the impression that the content of report is something different from what Sir Liam commissioned. In his summary of the report Prof Baker makes clear that his audit "drew on documentary evidence only and did not involve seeking information or comment from patients or their families or staff at the hospital but that such information might be more appropriately considered by a different type of inquiry, for example that being undertaken by the police." The best way to respond to such speculation about what the report does or does not contain would be to make its content public.

Method of making the report public

20. If Ministers agree that the report should be made public, there are several ways in which this might be achieved:

    - through formal publication, possibly with a Written Ministerial Statement or press notice,
    - putting the text of Professor Baker's report on a website.
    - sending the report to those who have asked to see it.

21. There does not seem to be a case for formal publication of the report or a WMS. The events described in the report took place many years ago. The recommendations in the report have been acted upon or superseded. There is a case for sending the report to those who have asked to see it or informing them that the text is available on a website.

Requests for a Public Inquiry

22. There have been requests for a public inquiry into the events at GWMH, including from patients' families from individual MPs and in an Early Day Motion. The Department's response has been that it would not be appropriate

to have such an inquiry before police investigations and inquests had been concluded. We have also said, most recently in response to a PQ in February 2011, that it is not clear what purpose an inquiry would serve or what new information it would disclose. Publication of Professor Baker's report would reinforce this point.

Media Handling – Shareena Merzi ext 5477

23. Recent interest in the publication of this report has been primarily from local MPs and local media. However, there has been national media interest in the past, most recently in 2009 and 2010 when the GMC heard the case against Dr Jane Barton.

24. Although the report's recommendations have been acted upon or overtaken it is likely national media will pick up on the report following recent stories about poor or negligent care in the NHS (eg, Mid Staffs).

25. Media could focus on Baker's recommendations and try to suggest that the department could have prevented subsequent failings in hospital care or even deaths if we acted at the time the report was produced. For example, one of the recommendations says that hospitals should have explicit policies on the use of opiate medicines. Baker concluded that a routine use of opiates at Gosport hospital shortened the lives of some patients and said it cannot be ruled out that a small number of these would have been discharged from hospital. We can confidently rebut any accusation on this as the use of opiates has been considered in a number of contexts since the Baker report was commissioned. There have also been subsequent police and medical investigations. We have published a reactive statement below for clearance.

26. Media may also focus on Dr Barton herself. In January 2010, the Guardian ran a piece reporting that the "doctor who prescribed 'potentially hazardous' levels of drugs can still work" and in August 2010, the Telegraph reported that no criminal charges were to be brought "against doctor guilty of misconduct over deaths". We may face questions over whether any further action is to be taken against Dr Barton. This would be a matter for the police.

27. Media may also ask what action has been taken on Baker's fifth recommendation: Baker says that a more detailed set of codes to monitor the outcomes achieved by clinical teams is required than is available through Hospital Episode Statistics. We have a prepared a reactive statement which stresses the action that has been taken.

Regional Media

28. Regional media have followed this story and therefore the release of the report is likely to attract coverage. Press office will issue the cleared statements.

Timing of the report and risks

29. The legal advice is to publish the report immediately.

30. As local MPs have been interested in the publication we could be accused of trying to hide the report's findings by not addressing Parliament when they are sitting. There may also be more significant media coverage in recess.

31. However, from a communications perspective, on balance we recommend following the legal advice and taking an open and transparent approach. If we do receive accusations from MPs for not publishing when Parliament is sitting, we can rebut this accusation by saying that this report is of wider public interest hence the publication now. The Media Centre are in discussions with No10 and are suggesting that the report should be made public on Friday of this week, 2 August.

Lines to take

Overall statement:

A DH Spokesperson said:

"Professor Baker's report has been helpful in improving understanding of the events at Gosport War Memorial Hospital.

"Since the report was prepared there we have been changes to practices around end of life care and to legislation for the monitoring and audit of the use of Controlled Drugs, as well as better monitoring of death rates in hospitals. NICE have also published guidelines on the use of opioids in palliative care.

"We are already seeing changes that will mean systems are in place to detect and deal with any problems quickly so that patients can have confidence that they are getting the high quality care from the NHS that they deserve, including a new Chief Inspector of Hospitals, developing clear fundamental standards of care, and the legislation currently going through Parliament to bring in Ofsted-style ratings."

Background

The report presents an audit of the care at Gosport War Memorial Hospital and provided valuable information for the police, the coroner and local health services. Professor Baker also made valuable points about the use of opiates and the importance of helping clinical teams to focus on the outcomes of their work, which have been addressed in the development of policies since the report was written.

On why we have taken so long to publish

A DH Spokesperson said:

“The deaths at Gosport War Memorial Hospital have been the subject of police investigations and inquests have been held into 11 of the deaths. Professor Baker’s report was made available to the police and to the coroner and Hampshire Police requested that Professor Baker’s report should not be made public while investigations and legal proceedings were taking place. The last inquest was concluded in April and so we are now making the report public.”

On Dr Barton’s fitness to practise

A DH Spokesperson said:

“There was a General Medical Council (GMC) hearing in to Dr Barton’s fitness to practise in 2010 which decided she should not be struck off. Dr Barton has now retired and at her own request had her name removed from the medical register.”

On Doctors’ checks

A DH Spokesperson said:

“We have already announced a world-leading system of regular checks on doctors’ skills and abilities, called revalidation. From this year, doctors have started to have regular assessments to ensure that their training and expertise are up-to-date and that they remain fit to carry out their important role of providing high quality care for patients.”

"The UK is leading the way on this - we are the first to introduce such a rigorous system."

On use of opiates

A DH Spokesperson said:

“Since Professor Baker wrote his report, tighter controls on the availability and use of opiates have been introduced. Legislation was introduced in 2007 to tighten the monitoring and auditing of Controlled Drugs including the introduction of Controlled Drugs Accountable Officers. In May 2012 NICE produced guidelines on the use of strong opiates in end of life care.”

<u>Background</u>

Arrangements are place to investigate reports on deaths from the unsafe use of opiates through National Reporting and Learning Service (now part of NHS

England). A clinical subgroup to promote safer clinical use of Controlled Drugs has been established to report to the National CQC Accountable Officers for Controlled Drugs Group.

On Hospital Episode Statistics

A DH Spokesperson said:

"Hospital Episode Statistics are based on international standard classifications which are subject to periodic review and amendment. Since Professor Baker's report was written we have strengthened the clinical audit and there has been an emphasis on clinical outcomes.

"Since this review was prepared, a range of other data has become available, including two mortality measures and clinical outcomes data for a range of surgical specialities by individual surgeon. The new Chief Inspector of Hospitals will oversee new rigorous hospital inspections based on the Keogh reviews."

If asked why we didn't publish in April?

A DH spokesperson said:

"Following the conclusion of the final inquest in April 2013 the Department has checked that no promises around confidentiality were made to people involved in the report and that there are no restrictions under Data Protection legislation. There are no such issues which stand in the way of the text of Professor Baker's report being released and we have now published this in full."

Recommendations

32. I recommend:

a. That you agree to the release of Professor Baker's report
b. That you consider arrangements for release of the report in the media handling plan at paras 23-31 above
c. That you do not agree to holding a public inquiry

GERARD HETHERINGTON
Code A