Second Report to Hampshire Primary Care Trust and Portsmouth Hospital NHS Trust
Gosport Inquests

December 2008

Update on Current Position and Advice

1 Liaison with the Coroner.

I have written to the Coroner seeking confirmation of the venue for the inquest. In addition I have sought his view with regard to a further pre-inquest hearing. I am compiling a list of issues which could be considered at such a hearing. Unfortunately it would not be possible to meet the Coroner without the other Interested Parties being invited.

2 Liaisons with the Police.

I am chasing the police with regard to their list of 2000 exhibits. Some of these are mentioned in the witness statements provided by the Coroner. On the face of it, being as there is no continuing criminal investigation, there is no reason why these documents should not be returned to the NHS. I have requested their return although would not be optimistic of a positive response prior to the inquest taking place.

3. Medical Records

It has been agreed with the Coroner that the original medical records should be returned to the NHS. I am making arrangements for them to be returned to Mary Deaks for safekeeping. I anticipate receiving copies from Code A for our files and also for copies to be made available to staff for them to be able to 'refresh their memories' before attending the hearing.

4. Expert Evidence

The Coroner has released statements from 4 expert witnesses. The main experts are Dr Andrew Wilcock an expert in palliative medicine and medical oncology and Professor David Black a Consultant Physician and Geriatrician. These are the 2 witnesses who will attend to give evidence.

he hasn't he has had a summary produced by a Junior

I have reviewed their evidence and their reports reveal recurring critical themes many of which will not come as a surprise. The following points from the expert evidence are noteworthy.

- They regard elements of care as sub-optimal, a breach of duty and 'out-with the GMC Guidelines'. Interestingly Dr Ian Reid is criticised in at least 2 cases.
- There is no evidence of a criminal level of neglect.
- There is inadequate clinical and nurse note taking.
- There are inadequate clinical assessments and a lack of evidence of appropriate assessments.
- They are unclear as to how patients are assessed as in 'terminal decline' rather than having a potentially recoverable condition.
- They criticise a lack of basic observations.
- They suggest they cannot exclude the effect of the drug regime as a cause of death. They say that prescriptions of drugs may have 'shortened life'. By how much is unclear. They say it could have contributed to death more than is 'minimal or negligible'. On the other hand the experts conclude that any negative effect may only be for a few hours or days. They also confirm that the drugs may have the effect of shortening life although the intention may be to relieve distress.
- The prescription of drugs is excessive for the patients' needs.
- There is a lack of explanation or inappropriate explanations for the drugs used.
- There is a failure to follow the 'analgesic ladder'.
- It is suggested that drugs may have been prescribed *'intending'* to shorten life, but that there is no evidence to show that it had this effect. *(SPK note – I am not sure what is meant entirely by this statement nor am I clear on what evidence it is based. Considering the other criticisms made I am not sure how*

it adds to the evidence other than to raise the uncomfortable use of the concept of 'intention'. It will be a point to raise at the hearing).

- Inappropriate use of syringe drivers and inappropriate use of boosters causing excessive/erratic delivery.
- Lack of clarity on occasions as to the relevant consultant in charge.
- Poor communications with relatives.
- The lack of a post-mortem examination report is in some cases unhelpful.

It should be stressed that not all these criticisms apply to each and every patient but they are some of the main themes which I draw out of the various reports which they have produced. T a junior, not him

Clearly this evidence will need to be considered at the hearing and if necessary appropriate questions put to the experts to justify their position. We need to remember the experts were originally instructed by the police to consider any criminal actions and that is not the purpose of the inquest. They should be asked to be clearer in their view as to *how* these patients met their death. For example, can they say (on the balance of probability) whether a particular patient died from the natural disease process or was their death caused by the drug? If caused by the drug was it any more than the incidental effects of a dose of Diamorphine intended to relieve pain and stress?

5. Representation of Nursing and Medical Staff

As previously advised we would normally be in a position to assist nursing and medical staff in their preparation for the hearing and also their attendance at the Court. There is rarely a conflict between members of staff and the NHS employer. With the exception of Dr Barton I do not see a conflict with members of clinical staff and I have been approached by solicitors for the Medical Defence Union seeking clarification as to whether or not we will be prepared to assist Dr Logan. I am already assisting Dr Reid. but the nurses have their own case to answer with the NMC

The nursing staff pose a different problem for the NHS in this case. Very helpful discussions have been held with Betty Woodland (RCN rep). The RCN have been engaged in assisting their members for many years. The statements disclosed by the

This being the case, how can he think it is not relevant to the inquest??

Coroner indicate that 3 nursing staff have been critical of the management of the service and brought problems to the attention of management and clinical staff. More staff not involved in the hearing may have been critical. I have reviewed a file of papers held by Hants PCT which contains correspondence from nursing staff and minutes of meetings held between nursing staff, management and senior clinicians. Whilst it would appear that serious relevant concerns were raised by the nursing staff, I do not have evidence to show that these were properly managed or handled by the NHS at the time. – they weren't

There is theoretically potential for conflict here and I will liaise with the RCN lawyer as to the current position and his view.

It may be that the NHS would simply have to accept that it was appropriate for the nursing staff to air these concerns at the time and the management response simply has to be accepted by the NHS as probably inappropriate by modern standards. I cannot make a value judgment as to the appropriateness of the response in the early 1990's. Need opinion that this type of response was "normal" at that time.

We need to prepare our stance on this not just throw our hands in the air

I am keen to avoid 'over representation' before the Coroner with more barristers than absolutely necessary. Much would depend upon the view taken by the RCN and by the individual nursing staff involved. I would hope that we could consider jointly instructing Counsel and that we and the RCN act as a team – simply accepting that concerns were appropriately raised by staff in the early 1990s. ?

I will keep this under review and advise further.

6. Files Held by Hampshire PCT

I have held a productive meeting with Code A and reviewed a helpful list of documents which she has supplied to me. I am now aware of the documentation which the PCT is holding. Copies of some documents have been supplied to me primarily to forewarn of potential issues and problems which might arise at the inquest. In addition to the potential problems with nursing staff, these issues primarily concern the policies involved in the training of staff and the administration of drugs along with the job descriptions and roles of various grade of staff.

I will keep this documentation under review as the matter progresses and if further documentation is required then Code A has agreed to make this available.

7. Evidence from Lesley Humphrey

After a significant amount of work the witness statement from Lesley Humphrey is nearly in a final form. I anticipate having this signed imminently and distributed amongst members of the steering group. I will then consider whether it should be disclosed to the Coroner with a view to inviting him to hear her evidence at the inquest or whether to produce a version limited to the changes that have taken place in the service since the deaths in question.

8. Additional Witness Statements

I have noted the suggestion that it may be possible to take additional statements from other members of staff. — We were invited by M+R Secs to suggest names I put forward RS + FS (Not taken up)

I will keep this under review although my advice at the moment is that additional statements should not be taken unless there is some clear purpose and justifiable reason. It is my view that the evidence provided by Lesley Humphrey puts this matter into context and also makes clear the changes put in place since the CHI review and sets out the current governance and management arrangements (see further below). We cannot insist that the Coroner calls additional evidence and unless additional statements assist the Coroner in his understanding of this matter I do not anticipate suggesting that he call additional witnesses.

It should be noted that the Coroner has only called a limited number of staff in any event. It is my view that as far as possible we should keep the evidence at the inquest as short and as uncomplicated as possible. Unless there is good reason so to do, I do not propose suggesting to the Coroner that he should call witnesses whose statements have been disclosed but who he does not intend to hear from at the inquest. Having said that I will keep the evidential position under review at all times.

but we need to prepare for the coroner. extend up in case of questioning

9. 'CHI Response'

ie systems / processes / policies / procedures / staff training records.

Coroners right to investigate Who died, when where how + in what circs Wide-ranging Jury -

Lesley Humphrey has produced a very helpful table which I anticipate will be before the group at its next meeting. This outlines changes in the management of the service and its current governance arrangements along with confirmation that the CHI recommendations had been put into practice. I intend to table this as evidence exhibited to Lesley's statement.

I am aware that other PCTs may be producing similar documents in respect of their responsibilities.

We need as a matter of urgency to find out what he was to be done with GH's docs we may want to stop him - we have no safeguards at present

At this juncture I do not propose to send to the Coroner any further responses unless there is something important which is not covered in the table produced by Lesley. (or which can not be easily incorporated). Having said that it is clearly important that the relevant boards are given assurance about the current position in advance of the hearing and as such other responses should be finalised and considered by this group in due course. I am in liaison with Mary Deeks on this point. If it transpires there is something which has been omitted in Lesley's table then this can be forwarded to the Coroner.

I understand that the review table needs to be considered by this group and then forwarded to the relevant boards and the SHA. I am aware that the SHA have requested a particular format be used. It is my view that the format adopted by Lesley Humphrey is appropriate in the circumstances and for her report. I note that we are not in fact responding to the CHI recommendations (that was done many years ago) what we are seeking to achieve now is board assurance and assurance to the Coroner and to the public as to the current state of the service. Hopefully the format adopted will be acceptable but if changes need to be made then these can be considered shortly. Hopefully this will meet the SHA's requirements.

I am aware it has been suggested that we should consider instructing an expert to review our response. That would be a matter for this group and for the respective boards if they required further assurance. In the circumstances as they are I do not advise that we require an expert to review the response at this stage to assist the Coroner. - it is to assure ourselves and the SHA not the Coroner.

A copy to JE ES

If this group felt that there were potential difficulties in respect of the response(s) which might be exposed or where the Boards might demand further assurance then of course expert assistance may assist. The group will be aware it runs the risk that

the expert might be adversely critical of our response and that would certainly cause potential problems. Having said that forewarned of criticisms is of course 'forearmed'.

10 Staff Meetings

I have attended various staff meetings and briefings and outlined the inquest procedure and the current 'state of play'. I have dealt with a question and answer session at QA and at Gosport War Memorial.

I have advised that a support network be put in place for members of staff and I understand that this is being put in hand. It is important that members of staff have someone with whom they can discuss matters and possibly receive assistance or counselling. This may be appropriate in-house or from external sources/occupational health. It is vital that this service is well publicised and made available to members of staff on a confidential basis.

11. Trimedia

I have held a meeting with Trimedia and I am sure they will report on the action plan. I am liaising with Try Media in respect of the media response and preparations. I will assist as required and consider any written briefings if requested. A briefing in the staff news letters is a possibility.

12. Counsel

I anticipate contacting Counsel's Clerk in the next (Jan) month with a view to setting up a conference and meeting with Counsel for his advice and to take matters forward to the final hearing. ? Barrister to meet Steering Group members.

Activity £181,0766

I can advise that recorded hours on this matter currently total 150 with a recorded value of £27,161.50. The original estimate was in the sum of around £80,000.00. Activity at this stage has been slightly higher than anticipated. The main reason for this is the 88 witness statements produced by Counsel. These have taken around 10 days of careful review and to summarise by a member of staff. I will keep activity and costs under constant review and advise if I believe the estimate needs to be reviewed. A substantial amount of preparation work has now been undertaken and much will depend upon activity generated by the Coroner and any further evidence that may be required. I remind you that a brief fee has

M+R to provide itemised bill.

been suggested by Counsel in the sum of around £20,000.00 and in addition there will be daily 'refreshers'.

I will of course consider any way in which costs can be minimised and savings made.

Stuart Knowles

3 December 2008