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10.	'Help me son, they're killing me'; Investigation Nearly 100 deaths at a hospital in Gosport have provoked an outcry from many of the patients' families, who believe the cases are suspicious. Official investigations have established little. The Independent on Sunday was the first to make arguments for a public inquiry and continues to pressurise the authorities to find out what really happened. Beyond the headlines, the relatives are struggling to uncover the whole truth behind their parents' final days... Nina Lakhani hears their stories Ivestigation The New Review, May 24, 2009, FEATURE; Pg. 8, 2438 words, Nina Lakhani

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13.	92 dead. Who's to blame?; IoS investigation The betrayed Families hope unprecedented inquests will find answers Police inquiries have failed to throw light on what really happened at Gosport War Memorial Hospital. Now, a decade on, a coroner is to investigate 10 of the deaths - after Jack Straw, the Justice Secretary, gave his go-ahead. Nina Lakhani reports The Independent on Sunday, March 15, 2009, NEWS; Pg. 8, 2022 words, Nina Lakhani

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The Independent on Sunday

June 6, 2010
First Edition

Death by night shift;
Special report The caring killers For years, nurses illegally administered morphine and other powerful drugs. Hospital patients died. Now the story can be told. Nina Lakhani reports

BYLINE: Nina Lakhani

SECTION: NEWS; Pg. 10

LENGTH: 1583 words

A showcase hospital that won the Government's highest three-star rating allowed nurses to prescribe illegally and administer powerful drugs which police believe killed three patients and injured many more. A damning report into "systemic failures" at the Airedale NHS Trust reveals that night nurses at the hospital in Keighley, West Yorkshire, openly gave patients drugs such as morphine intravenously for many years, despite the practice being illegal and against hospital rules.

Nobody has ever faced trial or been struck off as a result. One nurse at the heart of the inquiry, Sister Anne Grigg-Booth, was charged with three murders, one attempted murder and more than a dozen lesser, related charges but died of an overdose in 2005 before the case came to trial. Her death meant the allegations against her were never tested. No motive has ever been suggested for her actions.

The report, by an independent panel, to be published next week, dismisses claims that the deaths were the work of one "rogue nurse". Grigg-Booth, it states, was no Beverley Allitt, the so-called "Angel of Mercy" who was jailed for life after being convicted of killing four children while working in a Lincolnshire hospital in 1991.

Airedale Trust hospital bosses, the report says, "failed to recognise or act upon the fact Sister Grigg-Booth was part, if not a symbol, of a system that was not working".

The report, a draft copy of which has been seen by The Independent on Sunday, says oversight systems at the hospital, which won national awards for quality, did not fail "overnight" but were "recurring". The trust's governing body was operating in a "parallel universe" completely unaware of what was happening in hospital wards overnight. Senior managers knew, or should have known, but did nothing, it says. "The management did not always reflect back the reality of what was actually taking place at the coalface," it states. Individual staff troubled by events were too frightened to challenge it, believing managers would not act.

The findings will add to mounting pressure on the new coalition government to examine how local NHS organisations are run and by whom, and force ministers to investigate how systemic safety breaches can take place under the noses of NHS bosses and safety watchdogs. It follows similar

critical reports of NHS failures at Mid-Staffordshire and Leeds Teaching Hospitals. There are calls for the second Mid-Staffordshire inquiry promised by the former health secretary, Andy Burnham, into the role and effectiveness of regulators in spotting such systemic failures.

Patient safety groups say the public will want to be assured that the impact of any spending cuts on the NHS will be monitored to ensure patient safety remains paramount. Former Keighley MP Ann Cryer said yesterday that it was unsafe for hospital managers to rely on external reports, and they must take a more hands-on approach to find out what is happening on the wards.

The inquiry said night nurse practitioners (NNPs) "ran" the hospital at night after the NHS introduced the New Deal in the early 1990s to comply with European regulations which insisted that junior doctors' working hours had to be reduced. The NNP posts were created to take some of the burden off doctors and ensure night nurses disturbed them as little as possible.

Grigg-Booth was one of them. London-born, she joined the hospital in 1977. Some colleagues described her as hard-working, committed, caring and good in a crisis, others as a "larger than life" person who was the stuff of hospital legend having once brought a parrot on to a ward. Some colleagues, including doctors, found her intimidating and overbearing and accused her of bullying. She rarely attended training sessions, didn't like filling out forms, and got away with both. The report suggests she possessed a cavalier attitude towards management and "seems to have regarded herself as above the rules". According to some staff, Grigg-Booth liked to be regarded as an old-style matron who carried ultimate authority at night.

NNPs took verbal orders for medicines from doctors over the phone to save them coming to the ward. They also administered morphine and other opiates intravenously. Neither was allowed under hospital or professional regulations. Grigg-Booth, and at times other NNPs, also prescribed opiates such as pethidine and diamorphine for patients. This was risky and unlawful as they can hasten or cause death.

Yet no one, not a pharmacist, a doctor or a manager, ever questioned what they were doing, so they carried on believing it was all right. They weren't trying to hide anything: clear, open records of the drugs issued on prescription charts, clinical notes and letters exist as far back as 1996. Opportunity after opportunity was missed because some people didn't notice, while others failed to act. Occasional complaints to the divisional manager went nowhere, and evidence of a "club culture" between key staff existed, according to the report. So the board remained unaware, no doubt reassured by the awards and accolades it was winning as its reputation soared. The inquiry found little evidence of the board debating protocols and policies, and external accolades blindly accepted without the healthy suspicion which is crucial for good management. By failing to find out how the New Deal target was being achieved, hospital bosses inadvertently put the needs of the organisation before the needs of patients, the report states.

The divide between what the board thought was going on and what was actually happening at night is described as a "striking failure". Apart from two visits by the director of nursing in 1995 and 2003, no senior boss visited the hospital at night. The chain of command between the trust board and the night nurses was "effectively broken", the report concluded.

Action was finally taken only after one senior nurse inadvertently spotted the suspicious drug prescriptions while carrying out an internal audit of patient notes in December 2002. The nurse noticed that diamorphine given to Annie Midgley, 96 - to alleviate her distress - was illegally prescribed by Grigg-Booth two hours before Mrs Midgley died. This triggered the police investigation and Grigg-Booth's suspension.

At that time, Grigg-Booth was preparing to return to work after six months off sick. She had been drinking heavily and using a lot of painkillers while ill. She came to A&E demanding drugs on several occasions and there were rumours, but no evidence, of her taking medication from the wards for herself. In August 2004 Grigg-Booth was charged with three counts of murder, including Mrs Midgley, one of attempted murder and 13 counts of administering noxious substances with intent to cause harm. Her case was listed for plea in Bradford Crown Court in March 2006. She died at home alone after taking an accidental overdose of antidepressants on 29 August 2005.

The divisional manager, a nurse by background, kept his job despite documents which strongly suggest he had known what was going on for several years. He resigned only when arrested by police in 2004 and refused to give evidence to the inquiry.

One nurse manager was eventually sacked. Two of the NNPs were downgraded and then left; another resigned. No one else was charged. None of the nurses has faced disciplinary action by the

Nursing and Midwifery Council.

The inquiry report praises management improvements at the Airedale Trust since 2005 but pointedly warns of the "enormous time and energy being expended on achieving foundation trust status". "This must not become an end unto itself," the report warns. "Unfortunately there are examples across the NHS where it would appear that the process has beguiled boards into losing sight of their overriding goal of serving patients in the best way possible."

Ms Cryer said yesterday: "If the chief executive of a small district hospital like Airedale had no idea about the things going on under his nose, this could certainly happen in a bigger hospital, unless the right checks are in place. The NHS is wonderful, but when it goes wrong, it can cost lives. Airedale must make sure the right systems are in place and stay in place, so that something like this can never happen again. They must make sure they know how targets are being met, and at what cost."

PAST INQUIRIES

How the health service has failed patients

Inquiries into NHS scandals have raised similar issues for years.

1998 Dr Jane Barton was found guilty earlier this year of gross professional misconduct for prescribing unjustifiably high doses of painkillers and sedatives to 12 elderly patients at **Gosport War Memorial** Hospital - nearly 12 years after the first death was investigated by Hampshire Police. Even then, she was not struck off. None of the nurses who administered the drugs has faced disciplinary action.

2002 Nurse Colin Norris killed five elderly patients with the diabetic drug insulin at a Leeds hospital. The subsequent inquiry found safety checks were not embedded in the city's hospitals, and systems to monitor the supply and use of drugs were insufficient, allowing Norris to continue undetected for months.

2008 A target-driven culture and huge spending cuts were crucial in Mid-Staffordshire becoming one of the country's first foundation trusts, but, it turned out, at the expense of safe, high-quality patient care. Positive external reports were accepted while complaints from patients, relatives and some staff never reached the trust board.

LOAD-DATE: June 5, 2010

LANGUAGE: ENGLISH

PUBLICATION-TYPE: Newspaper

JOURNAL-CODE: SU

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The Independent on Sunday

April 4, 2010
First Edition

Honourable members? There were some...;
Election 2010 MPs bow out While almost no one was spotless, not all of our MPs deserve to be remembered just for the expenses

scandal. Nina Lakhani salutes the hard-workers who won't be standing for re-election

BYLINE: Nina Lakhani

SECTION: NEWS; Pg. 30

LENGTH: 1503 words

Expense claims for duck ponds, tree surgery and DVD players, boasts about owning a "very, very large house, like Balmoral Castle" and widespread "flipping" between first and second homes to maximise mortgage payments at the taxpayer's expense have all left a bitter taste in the nation's collective mouth, and the reputation of our elected parliamentarians in tatters. But, would you believe, many of these Right Honourable ladies and gentlemen have been working incredibly hard on important, sometimes unpopular, issues for their constituents and the country, even refusing to toe the party line on controversial, politically divisive issues. With a record-breaking 130 MPs standing down at next month's election, here we pay tribute to 10 unsung heroes who, in our opinion, should leave Westminster with their heads held high.

Lynne Jones 1992

Birmingham Selly Oak (Labour)

More than any other MP, Lynne Jones, a seasoned backbench rebel, has worked to reduce the stigma surrounding mental illness and improve equal participation, especially in employment, for people with mental health problems. Motivated by her father's experience of mental illness, she has co-chaired the all-party group on mental health which managed to bring together about 70 disparate voluntary and professional organisations to form the Mental Health Alliance. The coalition campaigned successfully against some of the most draconian and controversial aspects of the Mental Health Act of 2007.

Brian Iddon 1997

Bolton South East (Labour)

Brian Iddon has spoken without restraint about the ineffectiveness of the ABC drug classification, which he believes should be abolished in favour of a scale showing levels of harm from various drugs, alcohol and tobacco. Mr Iddon, a former chemist, has been an outspoken critic of the "war on drugs" which he believes has criminalised young people while displacing the problem to alternative illegal and legal drugs. The all-party group on drug misuse produced a seminal report into the abuse of legal medications in 2009 under his chairmanship, which led to a new Department of Health unit to investigate the problem. His work on drug misuse is to be archived at the Wellcome Trust.

Peter Ainsworth 1992

East Surrey (Conservative)

A genuine Green Tory hiding among one or two sceptics, Peter Ainsworth recently steered his own Green Energy Bill, which makes it easier for people to install wind turbines and solar panels, on to the statute book. His sustainable livestock Private Member's Bill would, if implemented, help to reduce the environmental impact of meat and dairy consumption. He recently started the Conservative Environment Network to promote green thinking and offer solutions to issues such as climate change that are consistent with Conservative principles. He was the only member of the Shadow Cabinet to vote against the Iraq war.

Chris McCafferty 1997

Calder Valley (Labour)

Chris McCafferty has won a great deal of respect among human rights groups and other NGOs for her work on international development, sexual health and women's rights. Her political commitment to improve protection for victims of gender violence was integral in the passing of legislation that outlawed taking girls abroad for female genital mutilation and in the Forced Marriage Act 2008. She has been an active MP in the Council of Europe, contributing to committees that worked to improve equal opportunities and eradicate gender discrimination.

Chris Mullin 1987

Sunderland South (Labour)

As a journalist, he campaigned successfully for the release of the Birmingham Six. Since election to Parliament, Chris Mullin has continued to campaign for victims of injustice and against the curtailment of civil liberties in the UK and abroad. He was one of the first to speak out against the Government's support of the Khmer Rouge in Cambodia, and rebelled against its attempt to institute detention without trial for terrorist suspects for 90 days. His diaries, published last year, offered an entertaining insight into his colleagues as well as the tedious workings of Westminster.

Michael Clapham 1992

Barnsley West and Penistone (Labour)

A republican, former miner and trade unionist, Michael Clapham helped to secure better compensation for former miners and their families affected by industrial conditions such as emphysema, and for people with asbestos-related diseases. This has included helping miners to claim back thousands of pounds of unjust solicitors' fees. He has a well-deserved reputation for rebelling and has voted against many of Labour's controversial policies, including the Iraq **war,** student top-up fees and ID cards. He resigned as parliamentary private secretary to the then health secretary Alan Milburn after a few months because of a decision to cut benefits for lone parents.

Ann Cryer 1997

Keighley (Labour)

Ann Cryer's outspoken criticism of violence against women and forced marriage in her constituency led to accusations of racism from some Asian MPs and community leaders, and into a political battle with the BNP leader, Nick Griffin. She has continued to speak out for women's rights and developed a well-earned reputation for being a troublemaker. She can take some credit for the Forced Marriage Act 2008 which has already led to more than 100 civil protection orders. She has repeated politically incorrect calls for an end to marriages between cousins - prevalent in Muslim communities - because of the high number of disabled babies being born in her constituency.

Helen Southworth 1997

Warrington South (Labour)

Helen Southworth won MP of the Year in 2008 at the Women in Public Life Awards for her work on missing and runaway children, a cause never given high priority by government before. She established and became chair of the all-party parliamentary group for runaway and missing children in 2006 and has proposed Early Day Motions to improve child protection. Her campaigning led to the government Young Runaways Action Plan in 2008 and in March 2010 she presented Gordon Brown with recommendations from the taskforce for missing people.

Adam Price 2001

Carmarthen East and Dinefwr (Plaid Cymru)

A vocal critic of the Iraq **war,** Adam Price tried to impeach Prime Minister Tony Blair, something not seen in Parliament for 150 years. In 2006 he opened a debate on the Iraq **war.** Both actions eventually led to the Chilcot inquiry. In 2002 he exposed the links between Blair and steel magnate Lakshmi Mittal after obtaining a copy of a letter from Blair to the Romanian government which suggested the privatisation of its state steel and sale to Mittal might help Romania enter the EU. In 2003 Price helped thousands of workers from Allied Steel and Wire to recover 90 per cent of their lost pensions.

Tony Wright 1992

Cannock Chase (Labour)

As co-chair of the Campaign for Freedom of Information, Tony Wright was instrumental in the passing of the FOI Act in 2000, without which we would still be none the wiser about MPs' expenses or the conflicting legal advice given to the Government in the run-up to the Iraq **war.** He has campaigned for constitutional reform and to increase the transparency and accountability of all public bodies, especially within government and the Civil Service. He has chaired the Public Administration Select Committee for more than 10 years and led inquiries into ethics and standards in public life.

'We must find a way to harness the commitment of the young'

LEADING ARTICLE, PAGE 43

ROLL OF DISHONOUR

But good riddance to ...

* **Gosport** MP and garden-proud Peter Viggers whose expense claims included £1,645 for a floating duck house for his pond, more than £3,000 for gardening over three years and £500 for manure. His failure to make representations for the families seeking answers about the deaths of elderly patients at **Gosport War Memorial** Hospital has impeded their long fight for justice.

* Derek Conway, pictured, who was way ahead of the field in 2008 when his improper use of parliamentary allowances to pay his son, a full-time student, £1,000 a month for office work of which there was "no record" came to light. Mr Conway, who has one of the worst voting records in Parliament, had the whip withdrawn as a result.

* Former transport secretary Stephen Byers, aka Mr "Cab for Hire", whose reputation was well and truly shattered after he was caught on camera offering his services to a fake lobbying company.

* Former armed forces minister Adam Ingram who was another "victim" of the recent lobbying sting operation. He had plenty of non-political skills to offer as he already earns £170,000 a year from consultancy work and non-executive directorships. Nice work if you can get it.

* Margaret Moran, a serial big-claimer, who was banned from standing for the Labour Party again after it was revealed she claimed £22,500 to treat dry rot in a second home 100 miles from her Luton South constituency. Moran claimed 10 times more than the MP for the neighbouring constituency, even though they live on the same street. Goodbye and, dare we say, good riddance.

LOAD-DATE: April 3, 2010

LANGUAGE: ENGLISH

PUBLICATION-TYPE: Newspaper

JOURNAL-CODE: SU

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The Independent on Sunday

January 31, 2010
First Edition

A continuing risk to patients;
An IoS investigation Yet Gosport doctor allowed to practise Outraged families will ask the High Court to rule on the General Medical Council's refusal to strike off Dr Jane Barton. Nina Lakhani reports

BYLINE: **Nina Lakhani**

SECTION: NEWS; Pg. 8

LENGTH: 1696 words

The General Medical Council's decision to allow a doctor found guilty of serious professional misconduct to continue to practise is likely to be challenged. A health watchdog, prompted by anger among the relatives of 12 of the doctor's patients who died while under her care in the infamous **Gosport War Memorial** Hospital case, is now expected to take the matter to the High Court.

The saga of Dr Jane Barton, found guilty of multiple counts of misconduct last week, has outraged relatives, MPs, lawyers and patients groups alike. Several medical experts described the decision not to strike her off as "illogical and inconsistent".

The Council for Healthcare Regulatory Excellence is examining transcripts from the hearing, which began last June. The GMC's imposition of 11 sanctions on Dr Barton did little to curb the widespread concern.

The GMC's five-person panel said: "There have been instances when Dr Barton's acts and omissions have put patients at increased risk of premature death ... the panel was unable to accept that she no longer posed any risk to patients." However, the panel decided that she had proven her safety in the past 10 years during which she continued working as a GP while several police investigations, an inquest and NHS report were carried out.

Relatives of the deceased were particularly angry at the credence given to the 187 testimonials gathered from some of her patients and colleagues, which led the panel to conclude that "preserving Dr Barton's services as a GP is in the public interest".

She prescribed high doses of powerful drugs delivered through an intra-muscular syringe driver without properly assessing or investigating the patients. The panel concluded that she showed a "worrying lack of insight". Dr Barton worked as a part-time clinical assistant at the community hospital between 1989 and 2000.

Few of the 92 families who complained to Hampshire Police and triggered a massive investigation were permitted to give an opinion at the hearing. These families pointed out that the Shipman inquiry, into the deaths of elderly patients at the hands of their GP Harold Shipman, found that he too had been popular with his victims and their families.

Many of the 108 recommendations made in 2005 by Lady Janet Smith to tighten the system to prevent other murders have still to be fully implemented. A senior medical legal source admitted last night it is "universally accepted" that the current system of death certification and regulation "is a mess" and would not prevent another Shipman.

Ten years after the conviction of Shipman, the eminent toxicologist involved in his prosecution warns that a similarly murderous doctor could still escape detection for years.

Robert Forrest, professor of forensic chemistry at Sheffield University and one of Britain's foremost experts on murders committed by healthcare professionals, has told The Independent on Sunday that a "Dr Shipman who is careful and who used drugs not readily available could probably still get away with it for a considerable length of time."

He added: "Dr Barton and others who have sailed close to the harsh wind of the law of homicide no doubt have had in mind the rule of dual-effect that gives a doctor an exemption from the general law of murder. This, in effect, gives a practitioner the option to prescribe what they know to be life-shortening doses of pain and anxiety-relieving medicines if their primary intention is not to shorten life, even if they know that is likely. To deliberately prescribe such doses with the intention of ending life is, of course, murder, provided the CPS prosecutes and a jury convicts.

"The cases of [nurse] Beverley Allitt and Harold Shipman have removed any vestiges of disbelief investigators may have had that doctors and nurses can deliberately kill patients in large numbers and get away with it for, sometimes, many years."

The IoS has learnt that the Nursing Midwifery Council is likely to face an unprecedented second investigation in the space of two years amid allegations of failing properly to investigate the nurses who worked with Dr Barton. The new chief executive last night promised to start investigations immediately, but it is some 19 years after the whistle was first blown by night nurses about what they

claimed was unnecessary prescription of morphine to elderly patients.

The **Gosport** case has rung alarm bells about substandard or even negligent care given to elderly patients and the difficulties relatives face when trying find out how things went wrong.

Katherine Murphy from the Patients' Association said many relatives were frightened to leave loved ones alone in hospital in case they were neglected, maltreated or overmedicated.

Peter Walsh, the chief executive of the patient safety charity AvMA, said: "This scandal is another systematic example of older people's care and safety being severely compromised. Frankly, when there is an adverse outcome or death of an older person, there is a tendency for the health service to simply assume that it is natural causes, it could not be avoided, or decide it isn't worth investigating because they did not have long to go anyway.

"Access to justice in these cases is so difficult to achieve. This means that we only get to hear about a fraction of the cases where older people have suffered or even died prematurely as result of sub-standard care or errors."

Norman Lamb, the Liberal Democrat health spokesman, who last week tabled an Early Day Motion calling for an independent public inquiry into the **Gosport** deaths, said last night: "The failure of the system to deal with the Dr Barton case speedily has helped her to convince the panel she is safe to practise and should stay on; it beggars belief that she has been permitted to do so. There is real concern about the inconsistency of decisions made at these hearings, which completely undermines faith in the system's ability to protect patients."

The Labour MP Jeremy Corbyn, who signed the motion, said: "Part of the reason we are calling for a public inquiry is that it would send out a message to all health workers and services that NHS patients should get the best possible care regardless of age."

The Tory MP for **Gosport**, Peter Viggers, has repeatedly rejected calls for a public inquiry.

MISSED OPPORTUNITIES

In December 1991, a Royal College of Nursing union representative wrote to a senior colleague on behalf of night nurses at **Gosport** hospital complaining about the overuse of strong painkillers:

"I am seeking your advice on how best to resolve a problem which was brought to my attention in April 1991 but apparently has been present for the last two years.

"I was contacted by a staff nurse [Sylvia Griffin] who is ... employed on night duty in Redclyffe Annexe. Her concern was that patients within Redclyffe were being prescribed diamorphine who she felt did not always require it, the outcome being that the patient died. The drug was always being administered via 'syringe drivers'. It is fair to say that this member of staff was speaking on behalf of a group of her colleagues."

In 1999 Hampshire Police asked Professor Brian Livesley, an expert on medical care for the elderly, to look into the death of 91-year-old Gladys Richards in 1998. He concluded:

"Doctor Jane Barton prescribed the drugs diamorphine, haloperidol, midazolam and hyoscine for Mrs Gladys Richards in a manner as to cause her death.

"Mr Phillip 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."

A meeting took place between senior police officers, the CPS, Treasury Counsel and Professor Livesley. During that meeting, Treasury Counsel came to the view that his assertions were "flawed in respect of his analysis of the law".

In August 2001 the CPS advised that there was insufficient evidence for a successful prosecution.

FROM FIRST SUSPICIONS TO A VERDICT

1991: Night shift nurses raise concerns with the Royal College of Nursing about numbers of elderly patients given diamorphine at **Gosport**. The matter is dealt with internally at the Hampshire hospital.

August 1998: Gillian Mackenzie reports the death of her mother, Gladys Richards, to Hampshire

Police, which launches an investigation. Two complaints are upheld by the Police Complaints Commission. No charges are brought.

1999: Another police investigation is launched into five deaths. Dr Jane Barton is interviewed. No charges.

April 2000: Dr Barton leaves the hospital, but continues as a GP. She agrees to stop prescribing opiates such as morphine. She says she raised concerns about her high workload.

July 2002: The Commission for Health Inspection finds systemic failings in the monitoring and prescribing of medication for elderly patients at **Gosport**. The NHS Trust doesn't issue an action plan until November.

September 2002: The chief medical officer orders an independent audit into the deaths. This report has never been made public. A nurse reveals complaints dating back to 1991. Police begin an investigation into 92 deaths at the hospital.

October 2007: Crown Prosecution Service concludes there is insufficient evidence to prosecute any health professionals. Police reports are passed to the Portsmouth coroner, David Horsley, in early 2008. His call for a public inquiry is dismissed by the Government.

March 2009: Inquests into 10 deaths begin. A jury decides that in the cases of Robert Wilson, 74, Geoffrey Packman, 66, and Elsa Devine, 88, the use of painkillers had been inappropriate for their conditions. In two other cases, Arthur Cunningham, 79, and Elsie Lavender, 83, the medication doses contributed to their deaths. HowThe IoS first broke the story, inset.

July 2009: GMC fitness-to-practise hearing opens eight years after Dr Barton was first referred. She tells the panel: "I was aiming to ensure the maximum comfort and dignity for my patients."

January 2010: Dr Barton is found guilty of serious professional misconduct but allowed to continue working under certain conditions. The Nursing & Midwifery Council promises an investigation into nurses working with Dr Barton.

Richard Osley

LOAD-DATE: January 30, 2010

LANGUAGE: ENGLISH

PUBLICATION-TYPE: Newspaper

JOURNAL-CODE: SU

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The Independent on Sunday

January 24, 2010
First Edition

Gosport doctor's fate in the balance at medical hearing; Lib Dems call for Shipman-style inquiry after 'abject failure' of the system to address suspicious deaths

BYLINE: **Nina Lakhani**

SECTION: NEWS; Pg. 12

LENGTH: 596 words

MPs will demand this week a public inquiry into the suspicious deaths of scores of elderly patients at **Gosport War Memorial** Hospital.

An early-day motion calling for an independent inquiry "with equivalent powers to the Shipman inquiry" into the treatment of patients at the Hampshire hospital between 1989 and 2000 was tabled by Liberal Democrat health spokesman, Norman Lamb, on Friday; MPs can register support for the motion from tomorrow. It comes days before the fate of Jane Barton, the doctor at centre of the allegations, is decided at a General Medical Council hearing.

The disciplinary hearing which began in June 2009 - eight years after the case was referred to the GMC by Hampshire police and relatives of the dead - reconvened last Monday. GMC lawyers said the findings against Dr Barton were so serious, as was her failure to show any insight or remorse into these findings, that she must be found guilty of serious professional misconduct and struck off the register.

Lawyers acting for Dr Barton dismissed these arguments as completely unjustified and described her as a "good, experienced, conscientious and caring family doctor who continues to provide an important and vital service for her community".

But MPs and patient safety campaigners argue that a public inquiry is essential regardless of the GMC outcome. They argue an independent investigation into allegations of incompetence and damaging delays by several public bodies, including government departments, is essential to learn lessons from the case. Previous calls for an inquiry have been rejected.

Mr Lamb said yesterday: "There has been an abject failure by the system to address concerns of the utmost seriousness in this case and lessons must be learnt. It is fundamental that relatives who have legitimate concerns about the circumstances surrounding the deaths of their loved ones need to be respected and listened to by the system, and not treated with a degree of high-handedness which has been the hallmark of this case."

Nurses at **Gosport** first raised concerns about the increasing use of syringe drivers to administer powerful painkillers and sedatives for elderly patients, many of whom died within days, in 1991. No further action was taken by hospital management or nurses apart from a few training sessions about end-of-life care. Police investigated after a complaint by Gillian McKenzie in 1998 following the death of her mother, Gladys Richards, 91. Complaints about the initial police investigation were later upheld by the Police Complaints Authority.

A subsequent, wider investigation into 92 deaths did not result in a prosecution. The Crown Prosecution Service is re-examining the case.

Dr Barton voluntarily agreed to stop prescribing opiates and to stop working in hospitals in 2002. She continued as a **Gosport** GP and has an unblemished record, her lawyers say. Last week 184 testimonials were presented to the hearing to demonstrate her popularity and respect among patients and colleagues, her lawyers said. The panel previously concluded that Dr Barton prescribed doses which were inappropriate, potentially hazardous and not in patients' best interests. The panel must decide whether her failings are serious enough to justify greater sanctions. Tom Kark, counsel for the GMC, said: "The panel has a duty to assure the public that they are safe when their care is entrusted to a doctor.... The failings demonstrated in the case were so serious that, despite the passage of time, the only sanction that will protect the public is one of erasure [from the medical register]."

LOAD-DATE: January 23, 2010

LANGUAGE: ENGLISH

PUBLICATION-TYPE: Newspaper

JOURNAL-CODE: SU

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The Independent on Sunday

December 27, 2009
First Edition

The news as the IoS reported it;
The year in review We broke firsthand accounts of foreign news, dissected the state of Britain and campaigned to help our children. What happened next?

SECTION: NEWS WEEKLY; Pg. 42

LENGTH: 1332 words

'In the footsteps of Abraham Lincoln'

18 January

Last January Rupert Cornwell, in a special report shortly before Barack Obama's inauguration, captured the feelings of hope and excitement that surged through America - and swept the rest of the world - as it prepared to swear in the country's first black president. Cornwell noted that the President-elect enjoyed an unprecedented approval rating of 75 per cent, which he attributed both to Obama's intelligence and charisma, and to the fact that he represented the end of the Bush era. Almost 12 months on, and his prediction that Obama - saddled with a legacy of **wars** in Iraq and Afghanistan, millions unemployed at home, and the ever-present threats of terrorism and climate change - would fail to live up to these sky-high expectations have proved pertinent, with the President struggling to get his health-care reform passed.

'The Betrayed'

15 March

Nina Lakhani's investigation revealed the mysterious circumstances surrounding 92 deaths at **Gosport War Memorial** Hospital, Hampshire. An inquest into 10 of the deaths later ruled that the powerful drugs given to five of the patients had contributed to their deaths. We revealed how the Government had refused requests from the coroner, Hampshire Police and council to hold a public inquiry into all the deaths and the subsequent investigations; opposition MPs, lawyers and patient safety campaigners have since joined relatives and the IoS in calls for an inquiry. The doctor at the heart of the case - Dr Jane Barton - later faced a disciplinary hearing at the General Medical Council which found against her in the majority of charges relating to the inappropriate and unjustified use of medication. Dr Barton will learn whether she will be struck off in January.

'The Apprentice: Britain's army of young trainees'

22 March

In stark contrast to the pantomime indiscretions of TV's cut-throat world of The Apprentice, in March the IoS uncovered the hard graft facing young people trying to get into the workplace. With real-life trainee apprentices more likely to be trying to avoid the dole queue than survive the glitz and glamour of Sir Alan Sugar's "job interview", the Government pledged to spend £140m to open up 35,000 new schemes over the year.

'The Uplifting Truth about Britain's youth'

12 April

Feral youth, violent gang members and hoodies are all too commonly used to describe young people in Britain today. In April the IoS investigated the truth behind Britain's youth and found scores of uplifting stories of teenage volunteers, carers, charity workers and campaigners. Among them was Sisco Augusto, who went off the rails after the murder of his friend, Damilola Taylor. This former gang-member has turned his life around, swapping street violence for voluntary work after meeting a youth worker who helped him to change. Sisco is now studying for his A-levels, mentors troubled kids and has ambitions of opening youth centres in the UK and his country of birth - Angola. The story drew attention to the positive work being done at Stewart's Road Adventure Playground in south London, which has since received funding to secure its future.

'Let Children Grow'

26 April

Since the IoS began its Let Children Grow Gardening Campaign with the Royal Horticultural Society last April, more than 250,000 pupils around Britain have benefited from the scheme. Our aim was to get children learning about and eating fresh fruit and vegetables - that they had grown themselves. The campaign attracted the support of celebrities including Kim Wilde and Boris Johnson, and exhibited at the Chelsea Flower Show and Hampton Court. Liam Jackson, headteacher at the IoS's beacon school, Kingsway Primary School at Goole, East Yorkshire, said the children were getting ready to start again next spring. "We know to be more organised in our planting now, and we can start earlier as we have poly tunnels," he said. "It's a credit to the IoS in starting the campaign and getting so many children and schools interested."

'Defence minister glossed over Nimrod safety fears'

26 April

Andrew Johnson exposed the safety fears surrounding Britain's Nimrod spy planes following the mid-air explosion that killed 14 crew members in Afghanistan in 2006. He revealed that a mechanical report based on an inspection on one aircraft alone had shown up almost 1,500 problems, 26 of which were defined as having "potential airworthiness implications" despite a previous statement by the Defence Secretary, Bob Ainsworth, that the report had not raised any "significant airworthiness issues". In May we revealed that the Ministry of Defence (MoD) would lose a landmark court case into whether the Human Rights Act protected soldiers on duty - with profound implications for the supply of equipment.

In November we revealed how the MoD planned further cost cuts, just days after the devastating report by Charles Haddon Cave QC into the Nimrod crash was published. It condemned the MoD for putting savings ahead of air safety and revealed a 30-year history of safety breaches. This month the MoD has announced a new military aviation authority will be established and that some of those named in the Haddon Cave report could face court martial.

'Terror in Tehran'

14 June

Robert Fisk wrote a first-hand account of the suppression of the Iranian protests over the controversial re-election of President Mahmoud Ahmadinejad. Fisk witnessed widespread violence by Iranian police and militias. Despite the attacks, which resulted in scores of deaths, protests continue to be mounted - the most recent last week following the death of Grand Ayatollah Hossein Ali Montazeri - and the legitimacy of the elections is still called into question.

'Is Rachel Christie the first black Miss England?'

19 July

The day after the IoS tipped her for success, Rachel Christie was crowned Miss England. The aspiring athlete was the first black woman to receive the spangled tiara and her victory dominated news headlines. But before the niece of the Olympic gold medalist Linford Christie had the chance to strut her stuff in the Miss World final, she was in the headlines for rather less savoury reasons. While attending a porn-themed party last month she got into a fight with Sara Jones, the reigning Miss Manchester. The scandal cost Christie her Miss England crown and she is now awaiting a court hearing next month.

'Britain stalls on new deal to rescue Africa'

20 September

Jane Merrick revealed divisions between leading governments over the currency transaction tax (CTT) proposal at the G20 meeting in Pittsburgh. The IoS reported that the German Chancellor, Angela Merkel, would lobby US and British governments on the so-called "Tobin tax", worth some £30bn for developing countries. Although the Foreign Secretary, David Miliband, was sympathetic, the UK was accused of stalling on the plan. The issue shot up the agenda in November when Gordon Brown signalled Britain's backing at the G20 summit in St Andrews - only for the US Treasury Secretary, Tim Geithner, to dismiss it. The issue has since featured prominently at international summits, with Mr Brown - and President Nicolas Sarkozy of France - earning praise for promoting a CTT targeted at helping poor countries adapt to the effects of climate change, but the Americans remain fiercely opposed.

'The Missing'

11 October

Our investigation into the hundreds of thousands of Brits reported missing each year - now at record levels - unlocked the mysteries of why people disappear. It also looked at why, when found, many missing people don't return home or even make contact with those who are searching for them. Martin Houghton-Brown, of the charity Missing People, said: "The impact of the IoS investigation was significant in helping the Government to examine the UK's response to missing people." In December the Prime Minster announced a task force to deal with the issue. The charity reported that there have since been several sightings of missing people mentioned in the piece.

LOAD-DATE: December 26, 2009

LANGUAGE: ENGLISH

PUBLICATION-TYPE: Newspaper

JOURNAL-CODE: SU

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The Independent on Sunday

November 1, 2009
First Edition

Families call for hospital inquiry

BYLINE: Nina Lakhani

SECTION: NEWS; Pg. 6

LENGTH: 123 words

The Government will this week come under further pressure to hold a public inquiry into deaths of elderly patients at **Gosport War Memorial** Hospital in the 1990s, as relatives and lawyers meet Norman Lamb MP, the Lib Dem health spokesman.

Failures by the policeand health regulators can be exposed only if there is an open and transparent inquiry, Mr Lamb said.

Relatives have spent years trying to access reports about hundreds of deaths at the Hampshire community hospital, which they believe may hold the key into what happened when Dr Jane Barton worked there from 1989- 2000.

Having received transcripts from Dr Barton's eight-week disciplinary hearing, officers are reinvestigating at least 12 deaths that occurred between 1996 and 1998.

LOAD-DATE: November 1, 2009

LANGUAGE: ENGLISH

PUBLICATION-TYPE: Newspaper

JOURNAL-CODE: SU

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The Independent on Sunday

August 23, 2009
First Edition

Calls for inquiry as GMC 'runs out of time' in GP probe; Relatives of 12 elderly patients who died in a Hampshire hospital are left waiting for answers

BYLINE: Nina Lakhani

SECTION: NEWS; Pg. 14

LENGTH: 571 words

The General Medical Council faced growing condemnation last night after relatives of 12 elderly patients who died at a Hampshire hospital more than 10 years ago were told that they must wait until next year to find out whether the doctor in question will be struck off.

Dr Jane Barton was last week found guilty of widely prescribing powerful painkillers and sedatives to elderly patients under her care at **Gosport War Memorial** Hospital which were "inappropriate, hazardous and not in their best interests".

Relatives were aghast to discover that the Fitness to Practice panel had "run out of scheduled time" and would not decide whether or not Dr Barton is guilty of professional misconduct until January next year.

Dr Barton was first referred to the GMC by Hampshire Police in 2000, but no action was taken until last year when she was banned from prescribing morphine and diazepam.

Last Thursday, the doctor was condemned for routinely prescribing medication outside the

recommended safe limits and failing to consider the potentially lethal consequences of this for her elderly patients.

The panel said there was no excuse for her poor note-keeping, which had hampered its ability to judge beyond reasonable doubt whether her assessments of patients were unsafe. Nor was the inadequate supervision she received an excuse because "as a medical practitioner you retained ultimate responsibility for your own actions".

Norman Lamb, the Liberal Democrat health spokesman, said: "It is intolerable that the relatives now have to wait till January for justice. The GMC has to see what it can move in order to complete the process as soon as possible. These findings reinforce the need for a public inquiry. It is scandalous that this doctor was allowed to keep practising for so many years."

A public inquiry could identify exactly how many people died under Dr Barton's care, and who knew what and when. Hampshire Police supposedly looked into 92 deaths at the hospital but the IoS has learnt that some of those relatives have never been interviewed. The Nursing and Midwifery Council has failed to investigate nurses who worked alongside Dr Barton, despite receiving complaints in 2000.

Catherine Hopkins, the legal director of the patient safety charity Action against Medical Accidents, said: "It has now been established by the GMC and the inquest that she prescribed large doses of drugs, stepped back and left someone else to give it to patients in an NHS hospital. If this is not a suitable subject for a public inquiry then I don't know what is."

An inquest into the death of Gladys Richards, 91, which triggered police inquires in 1998, is still to be heard. Her daughter, Gillian Mackenzie, 75, wants the coroner to see the GMC transcripts to get the whole truth. This delay means the inquest is unlikely to be heard until next spring, 12 years after she first went to the police.

The GMC will not comment on individual cases but said the panel had taken longer than expected to examine the complex evidence. The Department of Health has repeatedly brushed aside calls for a public inquiry despite pleas from relatives and the Hampshire coroner.

Vicky Packman's father, Stan Packman, 67, died after Dr Barton prescribed him a cocktail of drugs instead of investigating an internal bleed. She said: "Dad didn't stand a chance. But it's disgusting that we'll have to go through another Christmas with this all hanging over our heads."

LOAD-DATE: August 22, 2009

LANGUAGE: ENGLISH

PUBLICATION-TYPE: Newspaper

JOURNAL-CODE: SU

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The Independent on Sunday

July 19, 2009
First Edition

Doctor defends drugs policy at deaths hospital; GMC Gosport hearing told: 'I was aiming to ensure the maximum

comfort and dignity for my patients'

BYLINE: Nina Lakhani

SECTION: NEWS; Pg. 14

LENGTH: 637 words

The doctor at the centre of almost 100 suspicious deaths at a Hampshire hospital said last week she routinely pres-cribed large doses of painkillers and sedatives because she "didn't want any of her patients to suffer unnecessarily".

Dr Jane Barton does not accept that the medication she prescribed to 12 patients at Gosport War Memorial Hospital between 1995 and 1999 contributed to their deaths, the General Medical Council was told. These patients came to Gosport either at the end or near the end of their lives, she said. They died because of their underlying medical problems, despite what relatives may have been told about the possibility of rehabilitation by other hospitals.

The GMC's Fitness to Practise Panel is investigating allegations of professional misconduct in relation to 12 elderly patients who died under Dr Barton's care between 1995 and 1999.

She rejected criticisms levelled at her during previous weeks of the hearing by a medical expert, Professor Gary Ford, some former colleagues, and relatives of the dead. The hearings heard she prescribed patients high doses of powerful painkillers and sedatives for no justified reason, contributing to their deaths - something she denies.

Dr Barton said: "It is quite inappropriate that a person should have to suffer. I was aiming to ensure the maximum comfort and dignity for my patients; this was not for my or the nurses' convenience."

When asked about her habit of anticipatorily prescribing diamorphine and the sedative midazolam, Dr Barton told the hearing: "Patients could have been with us a very short time when it became apparent to you clinically that they were reaching the end of their life ... this is not something you can measure or put into guidelines."

Dr Barton described oromorph [oral morphine] as a "very user-friendly drug" adding that in those days: "We were not as frightened of opiate use as we are now".

The Gosport GP said she'd felt "ideally suited to look after elderly patients at the end of their lives" when she took on the part-time hospital post in 1989, but by the time she resigned in April 2000 she was "sustaining an excessive and dangerous workload" because the patients they looked after were much sicker.

The panel saw copies of letters sent by Dr Barton to hospital managers at the beginning of 2000 about her concerns. By this point the police were already investigating deaths at the hospital as attempted murder.

After she resigned from Gosport, Dr Barton voluntarily agreed to stay away from the hospital and stopped prescribing opiates and benzodiazepines in her GP practice after she faced investigation by the NHS trust under the failing doctors' procedures, the panel was told. The trust would not confirm whether Dr Barton has ever faced any formal disciplinary investigations.

When asked about the death of Gladys Richards, 91, whose death triggered the first police inquiry, Dr Barton told the panel that there was nothing she would do differently.

Mrs Richards died in August 1998, three days after she was re-admitted from a neighbouring acute hospital where she was treated for a dislocated hip caused by falling from a chair whilst at Gosport.

Dr Barton claimed that the note on Mrs Richards' transfer letter which said the patient was "weight bearing" was "over optimistic" and that the morphine she prescribed "seemed a very appropriate starting dose for her symptoms", despite the fact she had written "no obvious signs of pain" in Mrs Richards' notes. She added: "I considered that there were potential hazards and side-effects to it but my over-riding priority was to make her as pain-free as possible."

Dr Barton insisted she saw all the patients being discussed every morning, but did not have the time to record what she did in the medical notes.

The hearing continues.

Additional reporting by Tim Persinko

LOAD-DATE: July 18, 2009

LANGUAGE: ENGLISH

PUBLICATION-TYPE: Newspaper

JOURNAL-CODE: SU

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The Independent on Sunday

July 12, 2009
First Edition

Doctor prescribed sedatives 'for no reason'; Five patients died after receiving lethal doses of painkillers that were administered 'without justification', General Medical Council told

BYLINE: Nina Lakhani

SECTION: NEWS; Pg. 24

LENGTH: 615 words

Elderly patients at Gosport War Memorial Hospital were prescribed potentially lethal doses of painkillers and sedatives for no obvious reason, the General Medical Council was told last week.

Professor Gary Ford - a medical expert in elderly care and drug interactions - told the GMC there was no clear justification for the high doses of morphine and midazolam given to elderly patients, many of whom did not appear to have been in any pain. Professor Ford was called as an expert witness by the GMC as part of its inquiry into allegations of professional misconduct against Dr Jane Barton related to the care of 12 patients in the 1990s. Professor Ford was also used as a medical expert by Hampshire Police in earlier criminal investigations.

The cocktail of drugs prescribed by Dr Barton "most likely contributed" to the deaths of Robert Wilson, 75, Edith Spurgin, 92, Elsie Devine, 88, Geoffrey Packman, 67 and Jean Stevens, 73, he told the five members of the Fitness to Practice Panel on Friday. But Professor Ford acknowledged that elderly patients with co-existing medical conditions can deteriorate unexpectedly.

The panel was told that the high doses of medication which patients were given soon after arriving at Gosport could not be justified, even if patients were dying.

"In good end-of-life care, the aim is to keep patients comfortable and alert. The only indication for sedating patients is if they are suffering intolerable pain, and even then they must still be monitored properly for adverse reactions to the medication. There is no justification for escalating sedatives and opiates even if the patient is getting end-of-life care," Professor Ford told the panel.

The serious side effects of the drugs, such as respiratory depression, were not considered to be relevant even though patients often went downhill soon after the drugs were started, the hearing was told.

Furthermore, the use of morphine to treat conditions other than pain was inappropriate and unjustified, and midazolam was only recommended for "terminal restlessness" - to treat physical and psychological agitation in dying patients - and was not justified for these patients.

He also told the panel that there was "no logic" in Dr Barton's decision not to transfer Mr Packman back to the acute hospital after he developed clear symptoms of a gastro-intestinal bleed. Instead, he was started on "very high" doses of diamorphine and midazolam for no apparent reason.

Mrs Spurgin was given increasing doses of morphine for severe pain after hip surgery, without the cause of the pain - which was unusual so long after surgery- being investigated. The medical notes suggest the X-ray ordered by a more senior doctor was not followed up by Dr Barton, nor was there any indication that even basic investigations were carried out before it was concluded that Mrs Spurgin died from a stroke. Dr Barton has already admitted to substandard note-keeping.

Professor Ford said it was inappropriate to deal with Mrs Devine's agitation and confusion with strong painkillers which could render a patient unconscious.

"Her deterioration was undoubtedly down to the drugs she received. As with the others, sudden death can occur in elderly, frail patients, but it is difficult not to conclude that the drugs contributed to her death," he said.

Professor Ford agreed that Dr Barton would have been under greater pressure after the ward's senior doctor was not replaced when she went on maternity leave in 1998, but said that staff shortages did not justify prescribing high starting doses of painkillers in case patients developed pain.

Concerns were first raised about Dr Barton's prescribing by nurses in 1991.

The hearing continues.

LOAD-DATE: July 11, 2009

LANGUAGE: ENGLISH

PUBLICATION-TYPE: Newspaper

JOURNAL-CODE: SU

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The New Review

May 24, 2009
First Edition

'Help me son, they're killing me';
Investigation Nearly 100 deaths at a hospital in Gosport have provoked an outcry from many of the patients' families, who believe the cases are suspicious. Official investigations have established

little. The Independent on Sunday was the first to make arguments for a public inquiry and continues to pressurise the authorities to find out what really happened. Beyond the headlines, the relatives are struggling to uncover the whole truth behind their parents' final days... Nina Lakhani hears their stories Ivestigation

BYLINE: Nina Lakhani

SECTION: FEATURE; Pg. 8

LENGTH: 2438 words

In 1991, nurses working night shifts at Gosport War Memorial Hospital in Hampshire were troubled. Over the previous few months, the number of elderly patients dying under their care had been mounting. Two nurses at the community hospital (which treats elderly patients in need of rehabilitation or sometimes terminal care, in collaboration with GPs) raised the alarm to senior hospital staff and the Royal College of Nursing. They believed the deaths started after patients were given diamorphine (a powerful painkiller) via a syringe driver (which delivers drugs via a tube and needle, and is traditionally used for very sick patients who need constant medication but find it difficult to swallow tablets). Giving these drugs, while sometimes necessary for chronic pain, can cause serious side-effects, such as difficulty breathing. These are more likely to occur in those patients not in pain: breathing can stop altogether.

Letters were written, internal meetings were held, but eventually the matter was closed by the hospital trust. A GP attached to Gosport, Dr Jane Barton, was responsible for prescribing drugs to many of the elderly patients. She continued working in the rehabilitation and terminal care wards.

The death at the hospital of 91-year-old Gladys Richards in 1998 triggered the first NHS, and two police, investigations after her daughter, Gillian Mackenzie, refused to accept she had died from natural causes. The police investigations were later found to have been incompetent and led to a third - lasting four years - into at least 92 deaths at the hospital. Thirteen were categorised as the "most serious" by an eminent team of medical experts led by Professor Robert ' Forrest, the forensic toxicologist who gave evidence at the Harold Shipman trial, but no charges were brought.

Eighteen years after the nurses' initial worries, on 17 March 2009, inquests into the deaths of 10 people who died at Gosport between 1996 and 1998 opened at Portsmouth Combined Court. The unprecedented concurrent inquests - to determine how, when and why the 10 patients aged between 68 and 99 had died - came after years of campaigning by relatives who believed their loved ones died in suspicious circumstances. The 10 were among almost 100 deaths at the hospital investigated by Hampshire police between 1998 and 2006, but why they were chosen for an inquest remains unclear. They were not the most straightforward cases, or the strongest, and family members point out that the mix diluted the strength of the evidence.

In April, an eight-strong jury decided diamorphine and other powerful drugs had "contributed more than minimally" to five of the deaths (including those of Robert Wilson and Arthur Cunningham). An inquest, however, has no authority to apportion blame to individuals. The verdict led to a moment of jubilation for a few, but calls for a public inquiry - a Shipman-type independent investigation into the deaths and handling of the complaints by authorities - resumed soon after.

The deaths at Gosport happened around the time of several scandals involving NHS doctors and nurses. In 1993, nurse Beverly Allitt was convicted of murdering four children at a Lincolnshire hospital. At least three babies died in the Bristol baby scandal between 1991 and 1995, and more than 2,000 organs were illegally harvested at Alder Hey Children's Hospital between 1988 and 1995. The GP Harold Shipman was convicted of 15 murders in 2000 but a public inquiry found evidence to say he killed at least 250 patients.

The consensus among the bereaved families who have spoken out is that there has been a cover-up about what happened at Gosport. They are unhappy with the way their complaints have been dismissed, delayed or inadequately investigated. Relatives believe the deaths were downplayed because another NHS scandal would cause public outrage and may have had political consequences.

Families of the dead have made a number of complaints against Dr Barton to the General Medical Council (GMC), but the council allowed her to work unrestricted until last year. In July 2008, they issued an interim order banning her from prescribing diamorphine and restricting her ability to prescribe the sedative drug diazepam. She will face allegations of serious professional misconduct at the GMC next month - at least seven years after police first passed on their files.

No one - apart from the Government and the GMC - has set eyes on a crucial study by Professor Richard Baker into whether the death rate at **Gosport** was abnormally high. Other highly critical medical opinions were withheld from the jury by the coroner at the inquests. And the Government rejected pleas from the coroner to hold a public inquiry into all of the deaths rather than inquests into just a few. The children of Arthur Cunningham, Stanley Carby, Robert Wilson and Norma Windsor, who died between 1998 and 2000, have all been advised by the authorities to "move on" and accept that their parents were old and sick - but none is prepared to. They feel let down: by the NHS, police, Crown Prosecution Service, GMC, coroner and the Government. They believe the public deserves the truth and that justice must be done, for their parents, but also for everyone else who has, or will have, an elderly relative in hospital. Because if things go wrong, horribly wrong, the truth should not be hidden - no matter how much it hurts. *

Arthur Cunningham

Arthur "Brian" Cunningham (above) could be a difficult man. In the 1940s, he had worked on the tea plantations in Sri Lanka, and his colonial attitudes rubbed many people up the wrong way. In the mid-1980s he developed Parkinson's disease, and a combination of symptoms, medication side-effects and his cantankerous personality meant that nursing-home staff could find him difficult.

However, he and his stepson, Charles Farthing (left), had always been on good terms. On the morning of 21 September 1998, Cunningham was admitted to **Gosport War Memorial** Hospital suffering from bed sores. "I rushed down to the **War Memorial** and someone on reception told me he was on Dryad Ward," says Farthing. "At that point a man, maybe a porter or cleaner, said to me, 'That's the death ward,' which seemed stupid because Brian was nowhere near death, but I didn't think too much of it."

Cunningham was sitting up in bed when his stepson arrived, alert and animated despite a "sore butt". Before Farthing left for work in London, he spoke to the nurse in charge, Sister Gill Hamblin. "She said Brian's bed sores were the worst she'd ever seen and he might not survive them, which completely astounded me. I asked to see a doctor, but no one was available."

By the time Farthing returned with his wife two days later, Cunningham was attached to a syringe driver for regular morphine and midazolam - a strong sedative - and was unconscious. He repeats now what he told the inquest, that his stepfather was "out of this world and I thought straight away they must be killing him, because my mum had been given a syringe driver just before she died of cancer in 1989."

He continues: "I demanded that it be removed so that I could talk to Brian and find out if this is what he wanted."

But Dr Barton, who had prescribed the drugs, said that he was dying from the "poisonous" sores. The driver remained in place. From that point, Farthing and his wife sat with Cunningham until he died on Saturday 26 September 1998, aged 79.

Over the years, Farthing has obtained dozens of documents and independent medical reports which he believes proves his stepfather's death was suspicious, but many were excluded from the inquest. "I believe they didn't like him because of his manner.

"Ever since Mr Blair stood up in the Commons and said there would never be another Shipman, we have been up against a brick wall. I've always been a law-abiding citizen, I believe in right and wrong, and that's what keeps me going: I still want justice."

Robert Wilson

"Help me son, they're killing me." These were the last words Robert Wilson (above), 74, said to his son the day before he died on Dryad Ward. His son, Iain Wilson (right), tried to reassure him. "No they're not, Dad, they're doing what they can to try to help you." He now believes his father was right.

Glasgow-born Robert Wilson fought in the Second World **War** and left the navy in 1965, already a drinker. He fractured his shoulder after falling at home in September 1998 and was admitted to Queen Alexander Hospital for almost three weeks. The doctors found alcohol-related problems with

his kidneys and liver but none were considered life-threatening, so he was transferred to **Gosport** to recover, as his wife couldn't cope with his broken shoulder at home. He was wearing a sling, but didn't even want paracetamol for pain.

"My younger brother and I visited Dad the night before he was transferred and he was in good spirits, joking around, eating and drinking, though he wasn't looking forward to the journey as he hated being driven anywhere," says Iain Wilson. "When I visited him in **Gosport** two days later, he was almost comatose, on a syringe driver, and Sister Hamblin told me he would be dead within four days. At that point I nearly got thrown out for kicking up a fuss, but how I wish now I'd trusted my instincts and got him out of there."

Robert Wilson died on 18 October 1998, four days after he was admitted for rehabilitation.

The experience of looking after his dying wife six years beforehand convinced Iain Wilson that his father was treated as is he were a dying man as soon as he arrived at **Gosport**. But his fight for justice has led to arguments with his seven siblings over the years.

At first he felt "ecstatic" when the jury decided his dad had died because of inappropriate medication, but within days the elation was gone. "I actually feel gutted now because it feels we're back at the beginning. But I have to keep going.

"Every time I'm told 'no' by the coroner or the police or the GMC, it just makes me more determined to keep searching for the truth. I have to get justice for him."

Norma Windsor

Norma Windsor (above) died on her 69th birthday after 10 days of "rest and recuperation" at **Gosport**. Windsor had a heart condition and was awaiting bypass surgery, which had been delayed by the onset of a blood disorder. She was poorly, she was tired, but there was nothing in her notes to suggest that she was dying.

At the end of April 2000, her GP, Dr Knapman (who also attended patients at **Gosport**), suggested a short hospital admission to give her husband time to pack for their imminent move to Sussex. Windsor baulked: "You go there to die," she told her youngest daughter Sheena, but she persuaded her mother to go in for a rest, so Windsor reluctantly walked into Sultan Ward.

She went downhill rapidly. Her daughter Maggie Ward (left) says: "Within days she went from being chatty, mobile, just normal really, to being spaced out, hardly able to talk or keep her eyes open. Her skin went from being plump to totally dry." As the family complained, Windsor got sicker. "Mum kept saying to us 'You don't know what they're doing to me,' but we felt helpless."

On 4 May 2000, Dr Knapman agreed to a second opinion and Windsor was transferred to St Mary's Hospital in Portsmouth. "When we got there, one of the doctors said they'd never received a patient from another hospital in such bad condition," says Ward. Windsor died from multiple organ failure on 7 May 2000.

A hospital doctor asked them to consider an autopsy, but the family, traumatised, refused, which they regret. The medical notes they've seen are incomplete and they have no idea what medication she was given. The police dismissed their initial complaint in 2002; said Windsor's death was one of the most serious cases being investigated in 2003; and dismissed it again in 2006. Requests for an inquest have been denied.

"We feel like Mum has been forgotten," says a tearful Ward. "Things are probably OK at **Gosport** now but what we feel was criminal neglect robbed us of time with Mum and for that, there should be justice. We don't understand why the deaths at **Gosport** aren't as important as the Shipman murders."

Stan Carby

Everybody knew Stan Carby (above). He was a larger-than-life former naval officer, whose subsequent career as an ice-cream vendor had made him a local legend. At 65, he suffered a series of mini-strokes that landed him in the army hospital, Royal Haslar, where his bad jokes and relentless flirting earned him the nickname "Stan the man". The mini-strokes had caused some weakness and drooping of his left side, so he needed a period of rehabilitation. His weight ruled out home rehab and despite being technically too young for **Gosport War Memorial** Hospital, he was eventually admitted to Daedalus ward at lunchtime on 26 April 1999.

"He picked out a horse for a bet at around 3.30pm, had a cup of tea and was generally fine," says his

daughter Debbie Mackay, the second eldest of five. "He was not in any pain and had been discharged from Haslar on nothing stronger than aspirin. But he was a bit agitated about staying in and his medical notes had still not arrived, so I made sure the nurses knew they should call me if he became upset or things got worse, whatever the time." The last relative left at 9pm and they all went to bed under the impression things were settled. But Mackay received a phone call the next morning telling her Stan had taken a "turn for the worse".

"Dad's eyes were shut, he was clammy, unresponsive and his breathing was heavy," says his daughter Cindy Grant (above with her brother). "We were devastated at the change; it was completely unexpected. We lifted him up to try to help him breathe, which is when I saw a tube in his back - what I now know was a syringe driver."

Around midday, the doctor came in and told the family she suspected a major stroke; she would make sure he wasn't in any pain but they would now "let nature take its course". Stan Carby took his last breath at 1pm, barely 24 hours after being admitted for rehabilitation.

The family have shown me his admission notes, written by Dr Barton, which state: "happy for nursing staff to confirm death". They also know he was given large doses of midazolam and morphine through the syringe driver, despite never complaining about pain. His medical notes from Haslar had not arrived.

Carby's death wasn't chosen for an inquest and his relatives' complaints to the GMC have led to nothing. "I want to knock on Barton's door and find out the truth," says Grant, close to tears. "Dad was taken from us and mum died in 2007 without knowing what happened. We have to see it through for her."

LOAD-DATE: May 28, 2009

LANGUAGE: ENGLISH

PUBLICATION-TYPE: Magazine

JOURNAL-CODE: SR

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The Independent on Sunday

May 17, 2009
First Edition

Relatives of Gosport dead demand new police inquiry; Families threaten to boycott General Medical Council probe into deaths of elderly patients at Hampshire hospital

BYLINE: Nina Lakhani

SECTION: NEWS; Pg. 28

LENGTH: 719 words

The Crown Prosecution Service (CPS) has been asked to reopen its investigation into a series of controversial deaths at **Gosport War Memorial** Hospital. Relatives are asking it to revive the inquiry after several pieces of new evidence emerged during recent inquests.

Norman Lamb, the Liberal Democrat health spokesman, last night became the most senior MP to call for a public inquiry into the 92 deaths, which were investigated by Hampshire police between 1998 and 2006.

Mr Lamb told The Independent on Sunday that he will this week write to Jack Straw, the Secretary of State for Justice, and Alan Johnson, the Health Secretary, supporting calls from relatives, the Portsmouth coroner, Hampshire police and lawyers for an independent investigation into the deaths at **Gosport**.

His move comes just weeks before the General Medical Council will hear an inquiry into Jane Barton, the doctor at the heart of many of the allegations about the deaths at **Gosport**. Several families are threatening to boycott the proceedings in a vote of no confidence after the GMC refused to allow them legal representation.

Mr Lamb added his voice to the mounting condemnation of the GMC, which stands accused of failing to deal properly and promptly with serious complaints of professional misconduct against Dr Barton.

John White, a solicitor from the law firm Blake Lapthorn, said: "The medical evidence in these cases and the GMC processes are all so complicated that legal representation would enable the relatives to participate fully. By saying no, the GMC is effectively shutting them, and all their vast knowledge, out, which poses a risk to achieving a successful prosecution."

He added: "We are in this for the long haul. If the CPS refuses to re-open the criminal case and the Government refuses calls for a public inquiry, then our only option will be to get all the evidence in front of a judge through a group clinical negligence claim. We will get the answers whatever it takes."

The GMC's disciplinary panel, to be convened on 8 June, will examine Dr Barton's role in 12 cases in which patients died. The hearing comes seven years after the GMC was first warned about the deaths of elderly patients under her care. Relatives are angry that the GMC allowed Dr Barton to continue working unrestricted as a GP until last July.

Several earlier dates for a disciplinary hearing, going back to 2002, were postponed while investigations continued. It was deferred last September after the GMC decided to wait for the inquests to take place.

But Gillian Mackenzie, who was the first to raise the alarm after the death of her mother, Gladys Richards, aged 91, in 1998, is outraged because her mother's inquest is still outstanding. Mrs Mackenzie believes the GMC's refusal to reschedule her mother's case could jeopardise the inquest.

Peter Walsh, from Action Against Medical Accidents, said: "First, why were the original concerns of patients' relatives dismissed? Second, why did it take so long until the GMC imposed an interim order to protect the public? If they were right to act to protect the public in 2008, this means that they have left the public at unnecessary risk for years when they already had the information they needed from relatives, if they would only listen.

"There should be a wholesale review of the procedures to refocus them on what should be the overriding priority - protection of the public."

The GMC would not comment on any aspect of the case against Dr Barton but insists all its decisions have been based on the evidence available to it and in the public's best interests.

A spokeswoman defended the decision to refuse relatives the right to legal representation. The relatives will face questions as witnesses but cannot make available information they have discovered through their own investigations.

Mr Lamb said: "This case raises fundamental concerns about the way the GMC operates and its apparent failure to protect patient safety. While it is absolutely right to follow the principle of innocent until proven guilty, this does not mean steps to protect the public from potential risks cannot be taken, something which has clearly not happened in this case.

"Given that lives were lost in circumstances which cause serious concern, it is truly extraordinary that this has dragged on for so many years."

LOAD-DATE: May 16, 2009

LANGUAGE: ENGLISH

PUBLICATION-TYPE: Newspaper

JOURNAL-CODE: SU

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The Independent on Sunday

April 26, 2009
First Edition

Gosport deaths 'not important enough' to justify public inquiry; Questions remain after 92 elderly people died unexpectedly at the same Hampshire hospital, a story first highlighted by The IoS on 15 March

BYLINE: Nina Lakhani

SECTION: NEWS; Pg. 8

LENGTH: 831 words

The Government rejected repeated calls for a public inquiry into the unexpected deaths of 92 elderly patients at a Hampshire hospital because it was not of "national importance".

Officials from the Ministry of Justice and the Department of Health refused petitions from a coroner and a senior police officer for a public inquiry in August 2007, according to confidential emails seen by The Independent on Sunday.

But the DoH claimed yesterday that a public inquiry into the deaths at **Gosport War Memorial** Hospital was refused on the grounds that it would duplicate work done, or under way, by the police and health regulators - a claim rejected by relatives and lawyers.

Several emails from the Portsmouth and South East Hampshire coroner reveal his concern at the Government's decision to refuse a public inquiry into all 92 deaths and instead authorise inquests into just 10.

Relatives maintain that the piecemeal investigations since 1998 by the police, the Crown Prosecution Service (CPS), the local NHS Trust, the General Medical Council and the Commission for Health Improvement have all failed adequately to explain the large number of deaths among patients who were given doses of painkillers and other sedative drugs usually associated with terminal care.

In an email last November to a relative of one of the dead, the coroner, David Horsely, wrote: "Hampshire Police, Hampshire County Council and I all tried to persuade the Government to hold a public inquiry into the deaths but there was no interest whatsoever. Neither was the Government prepared to assist with any additional funding for the inquests."

In another email, Mr Horsley said: "We did try very hard in the public inquiry direction but without any success, despite a face-to-face meeting at the Ministry of Justice in London. The reason for the

refusal was that there were no matters of national importance involved.

"Prior to that, I tried to pursue with the CPS why no prosecutions were being undertaken. I understand the CPS decided not to prosecute on the advice of leading counsel. I did ask the CPS for sight of counsel's advice on a number of occasions but they declined to let me see it."

A jury in Portsmouth last week ruled that powerful pain medication had been a factor in five out of 10 deaths at the hospital between 1996 and 1999. But relatives of some of those who died remain unhappy at the way the inquests were conducted. Thirteen deaths were categorised as the most serious by a team of eminent medical experts commissioned by Hampshire Police in 2002 but only some of these cases were included in the inquests. The reason for choosing the 10 deaths while rejecting 82 others has never been fully explained.

Andrew Bradley, the deputy assistant coroner who presided over the 10 inquests, has also been criticised for his refusal to allow damning medical evidence to be submitted. Documents showing concerns among nurses about the widespread use of morphine at **Gosport** dating back to 1991, as well as an inquiry by a health watchdog that found systemic failings in the prescribing and monitoring of powerful drugs, were excluded.

An independent review to establish whether the death rates at **Gosport** were abnormally high has been suppressed since 2002 despite repeated requests for it to be made public.

One of the excluded reports was by Professor Gary Ford in 2001, an expert in pharmacology. Writing about Arthur Cunningham, 79, who died on Dryad Ward in September 1998, he concluded: "The initial prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton was in my view reckless ... I consider the doses of these drugs most likely contributed to his death through pneumonia and/or respiratory distress."

Last Friday, Action against Medical Accidents (Avma), a charity representing some of the 92 families, made a formal application to Health minister Ann Keen to reconsider the decision not to hold a public inquiry.

Peter Walsh, chief executive of Avma, said: "Why also does the Department of Health continue to fuel conspiracy theories by not allowing access to key documents?"

John White, a solicitor from law firm Blake Lapthorn, is urging the other 82 families to come forward. He said: "Until the authorities really understand and acknowledge what went on in **Gosport**, the families are bound to be left with feelings of injustice, anger and mistrust. Public inquiries were held in the cases of Shipman, Beverley Allitt, Alder Hey and Bristol, which all happened around the time of **Gosport**. Why then does **Gosport** not merit a public inquiry?"

Gladys Richards No inquest yet

The death of Gladys Richards, 91, in 1998 triggered the first police and hospital inquiries after a campaign by her daughter. The Independent Police Complaints Authority upheld claims that inquiries had not been handled competently. Mrs Richards's case was not among the 10 inquests so far held, but permission for one was granted after lawyers intervened.

LOAD-DATE: April 25, 2009

LANGUAGE: ENGLISH

PUBLICATION-TYPE: Newspaper

JOURNAL-CODE: SU

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The Independent on Sunday

March 15, 2009
First Edition

92 dead. Who's to blame?; IoS investigation The betrayed Families hope unprecedented inquests will find answers Police inquiries have failed to throw light on what really happened at Gosport War Memorial Hospital. Now, a decade on, a coroner is to investigate 10 of the deaths - after Jack Straw, the Justice Secretary, gave his go-ahead. Nina Lakhani reports

BYLINE: Nina Lakhani

SECTION: NEWS; Pg. 8

LENGTH: 2022 words

An unprecedented inquest will this week begin to examine the suspicious deaths of 10 elderly patients who died unexpectedly after being given high doses of powerful painkillers and sedative drugs at a hospital in Hampshire.

The hearing, granted last year by the Justice Secretary Jack Straw, despite the fact that seven of the people concerned have already been cremated, highlights nearly 100 other cases at **Gosport War Memorial Hospital** which may be related.

Relatives of at least 92 patients involved in the case have fought for the past 10 years to have the matter investigated thoroughly. They believe the deaths have never been properly explained and want those involved to be held to account. They want to know whether their relatives died as a result of accidents, incompetence or what some fear might be something more sinister. They believe that there was a culture of treating patients with palliative care - as though they were dying - rather than rehabilitating them.

They point out that this week's jury hearing at Portsmouth Combined Court comes seven years after a damning report by the NHS watchdog which identified systemic failings in medication prescribing.

The Government has so far rejected relatives' calls for a public inquiry into the deaths, despite stinging criticisms about the way they were handled by the police and the General Medical Council (GMC). Three police investigations have failed to shed light on why the patients died. The GMC, in particular, has been lambasted by the relatives for its failure to act promptly and decisively.

Wednesday's inquest will examine the deaths of Code A 83; Elsie Lavender, 84; Helena Service, 99; Ruby Lake, 85; Arthur Cunningham, 79; Robert Wilson, 73; Enid Spurgeon, 92; Geoffrey Packman, 68; Elsie Devine, 88; and Sheila Gregory, 91. They all died while in-patients on Dryad and Daedalus wards between 1996 and 1999.

A separate inquest has now been granted into an 11th death, Gladys Richards. Her daughter, Gillian Mackenzie, 75, believes her mother died because she was unnecessarily prescribed high doses of morphine. Mrs Mackenzie's suspicions triggered an initial police investigation. She has spearheaded the campaign for years. It is not clear why her mother has not been included in the forthcoming inquest. As yet, no date has been set.

Mrs Mackenzie said: "I know my mother was 91, but she shouldn't have died when she did. She was not in pain, so why was she prescribed morphine? Since then, I have been fobbed off by the police time and time again; they closed the first inquiry without taking a statement or looking at my mother's medical notes. I'm 75 now but will not let this go because I know what happened to her, in law, was wrong."

At the time of deaths, **Gosport War Memorial Hospital** was run by Portsmouth Healthcare NHS Trust and provided long-term care and rehabilitation for elderly patients.

After Mrs Richards's case in 1998, a number of people contacted the police saying their relatives had died unexpectedly after being prescribed high doses of painkillers and sedatives including morphine. Police launched a second inquiry and reviewed a total of 92 deaths. I* July 2006, the police announced that after a third investigation they had found no criminal negligence in 80 of the 90 cases they examined. Ten deaths were referred to the Crown Prosecution Service (CPS) but no charges were brought.

The NHS watchdog at the time, Commission for Health Improvement (CHI), identified a number of systemic failings during their investigation into **Gosport** Hospital in 2002. High levels of powerful painkillers and sedatives were being prescribed without adequate supervision or checks in place. They also found a culture of "anticipatory prescribing", whereby patients were prescribed drugs before the patient displayed any symptoms.

The GMC has attracted bitter criticism for the way it has handled this case, particularly the length of time it took them to take action. Dr Jane Barton, the only doctor investigated in relation to the case, was ordered last July to stop prescribing morphine, many years after the matter was drawn to the GMC's attention.

At least one relative of the dead wrote to the GMC in 2002, expressing her concerns about Dr Barton and asking the GMC to investigate. In reply on 11 June 2002, the GMC said: "We do not consider that the actions of Dr Barton raise any issue which could be regarded so serious as to justify formal proceedings which may result in the restriction or removal of her registration." Yet two months after the inquest was announced last year, Dr Barton's practice was restricted by the GMC. A fitness to practice hearing will begin after the inquest.

In GMC correspondence seen by The Independent on Sunday, it admits it was aware of the case in 2000, but repeated attempts by GMC lawyers between 2000 and 2004 to persuade the Interim Orders Committee to take action against Dr Barton were unsuccessful. The committee was not convinced of the need to restrict Dr Barton's practice until the inquest was announced.

Peter Walsh, chief executive of Action Against Medical Accidents (AvMA), said: "This raises serious concerns about the rationale and consistency of the GMC's decision-making. This is another in a long line of cases which must lead the public to ask whether the GMC is fit for purpose."

Ann Alexander, the solicitor who represented families in the Harold Shipman inquiry and advised a number of relatives in the **Gosport** deaths, said: "The GMC has made few improvements since the publication of the Shipman inquiry. I do not understand why they failed to impose restrictions on the doctor until 2008. The GMC must remember that its role is to protect patients and not doctors."

According to the GMC, its actions were held back while other investigations took place, but says the necessary steps to investigate the case fully are being taken. A GMC spokeswoman said: "This is a difficult and complex case which has been investigated by various agencies. Criminal investigations always take precedence over any GMC procedures. It was necessary [for us] to wait for the outcome of the various investigations."

While relatives are pleased that an inquest has finally been granted, many believe a public inquiry is necessary, if all the relevant documents from earlier inquiries are to be uncovered.

The Chief Medical Officer, Sir Liam Donaldson, commissioned a clinical audit to examine death rates at the hospital in September 2002 - only the second time such a review has been carried out. But the report by Richard Baker, a professor of clinical governance at Leicester University who worked on the Shipman inquiry, has never been made public.

Professor Baker's investigation into Dr Harold Shipman found that he may have been responsible for 330 deaths. This persuaded ministers to hold a public inquiry into his crimes. His report in **Gosport War Memorial Hospital** has been requested under the Freedom of Information Act by AvMA.

Ms Alexander said: "A lack of openness breeds suspicion. Professor Baker's report about Harold Shipman was published so I have no idea why the **Gosport** families have been denied access to his findings. I think a public inquiry would have been much better in this case as it would have put the families on a level playing field with the health professionals. There is also much scope in a public inquiry to understand what went wrong and for lessons to be learnt."

A spokesperson for NHS Hampshire, which now runs **Gosport War Memorial Hospital**, said: "The

local NHS has been working closely with HM Coroner to ensure that all the relevant information is available to support his investigation. We co-operated fully with previous police investigations and with an earlier independent review by the Commission for Health Improvement. Procedures at **Gosport War Memorial Hospital** were revised as a result of the earlier inquiries. We are very confident that the hospital provides safe, high-quality care to all its patients."

Hampshire Constabulary declined to comment yesterday, but said it had previously defended its investigations.

Dr John White from Blake Lapthorn, a Hampshire-based law firm, is representing four of 10 families at this week's inquest. He said: "The inquest will try to establish in each individual case whether systemic or individual failings in prescribing caused them to die. The coroner is faced with a very difficult task and in my opinion a public inquiry would have been better."

THE CAMPAIGN

A decade of questions before inquest begins

1998: Gillian Mackenzie reports her mother's death to Hampshire Constabulary which launches an investigation. No charges.

1999: A second police investigation is launched after several families come forward with concerns. No charges.

July 2000: The General Medical Council first becomes aware of concerns relating to Dr Jane Barton (pictured below).

June 2002: Mrs Mackenzie asks the GMC formally to investigate Dr Barton; she is informed there are no grounds for any action.

July 2002: The Commission for Health Inspection finds systemic failings in the monitoring and prescribing of medication for elderly patients at **Gosport**. In November 2002, the NHS Trust which runs **Gosport** issues an action plan in response.

September 2002: Chief Medical Officer orders an independent audit into the deaths. This report has never been made public.

September 2002: Police begin a third investigation.

October 2007: CPS concludes there is insufficient evidence to prosecute any health professionals. Police reports are passed to the Portsmouth coroner, David Horsley, in early 2008.

May 2008: The Justice Minister, Jack Straw, announces an inquest into 10 of the deaths.

July 2008: GMC issues an interim order against Dr Barton which allows her to keep working with some restrictions.

18 March 2009: Inquests into 10 deaths begin. The jury will hear evidence from Dr Barton before 10 separate verdicts are returned after six weeks.

Breakdown of trust

'I want justice for my mother'

Elsie Devine died in **Gosport War Memorial Hospital** on 21 November 1998 at the age of 88. She had been recuperating after a urinary tract infection. Her daughter, Ann Reeves, has spent 10 years waiting to find out what happened to her mother.

"My mum was my rock. She had lived with my family for 25 years and had supported us all through my husband's illness [with cancer]. She was admitted to Queen Alexandra Hospital in Portsmouth for a urinary tract infection in October 1999. Ten days later she was ready to go home, but because I was staying with my husband at a London hospital, we agreed she would spend a few weeks at **Gosport**.

"Initially it was fine. But after a couple of weeks she became really distressed. She was crying and wanted to come home. When I look back, I'm so angry at myself for not bringing her home.

"Two weeks after my brother called me and said mum had kidney failure and had only hours to live. Just like that; totally out of the blue. I rushed to see her but she was unconscious. I never spoke to my mum again. She died two days later.

"I can't really explain it, but there were a few things her doctor - Dr Barton - said that made me feel uncomfortable, and so I asked to see her medical files. At this point I had no idea there was already a police investigation going on; the trust didn't tell me. I discovered that my mum had been prescribed strong painkillers and other sedatives. She had been prescribed fentanyl which is used to treat severe pain in cancer patients. She was also injected with chlorpromazine, an antipsychotic drug, and given midazolam, a sedative and diamorphine. I knew that something had gone wrong because my mum hadn't been in pain, so I started to write letters to the trust to try to find out what happened.

"I want justice for my mother. But I also want transparency, so we can find out what happened at **Gosport**. It has taken 10 years, but finally people are taking notice. We need a public inquiry. And the GMC is an absolute disgrace. I wrote to it about Dr Barton in 2002 and it fobbed off my concerns. Its motto should read 'Guiding doctors, silencing patients', not 'Protecting patients'."

LOAD-DATE: March 15, 2009

LANGUAGE: ENGLISH

PUBLICATION-TYPE: Newspaper

JOURNAL-CODE: SU

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