Code A

Dear MST

This correspondence needs to be dealt with as below, please.

1. **Business Group (please circle):**

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2. **Action required (please circle):**

ADR To note MC Treat Official Log and return to PS Send hard copy to official(s)

3. **To/cc (please list all names):**

TO: MCU.

CC:

Me, Code A

4. **With the following message:**

Lord McNally met Stephen Lloyd just before Christmas in what we had understood was a personal capacity.

5. **B/F date (please specify):**

/ / (dd/mm/yyyy)

Thanks

[Insert name here]

Code A

HOUSE OF COMMONS
LONDON SW1A 0AA

Rt Hon Lord McNally
Ministry of Justice
102 Petty France
London
SW1H 9AJ

Reference: Gosport/250111/SL

Date: 25/1/11

26 JAN 2011

Re: Gosport War Memorial Hospital deaths

I am writing further to our meeting just before Christmas. It is very important that I draw this matter to your attention and I would be very grateful if you can give consideration as to whether a judicial/ public enquiry would now be appropriate in all the circumstances.

You may already be aware of the background. Briefly this concerns the deaths of frail and elderly patients in the late 1990s who were under the care of Dr Jane Barton, clinical assistant, and her team of ward staff at the Gosport War Memorial Hospital, an NHS hospital. There have been various enquiries by public bodies but it is my deeply held concern that the overall effect of these is patchy and unsatisfactory without there having been proper accountability for actions by healthcare professionals within the NHS and without even the reassurance that such unfortunate circumstances might not occur again elsewhere.

It was in 1998 following a complaint to the Police by one of my constituents, Mrs Gillian Mackenzie, in respect of the death of her late mother that the first police enquiry took place. However this was not satisfactory and led to a complaint against the Police by Mrs Mackenzie in to the adequacy of the investigation and that complaint was upheld with further investigations taking place. A pattern emerged of evidence of excessive and inappropriate use of opiate (morphine like) drugs and tranquillizers in the patients. It seems that a routine and abnormal prescribing pattern and culture had developed between Dr Barton and the ward staff which went unchecked by the hospital management, clinical supervision and pharmacy procedures. All the patients involved were elderly and had concurrent illnesses. Therefore establishing a clear cut causal link between the inappropriate over prescribing and individual deaths was always going to be difficult. Nevertheless the sad fact is that as a result of these failures it is likely that some, possibly even many, patients died.

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By 2002 the Police investigation was inconclusive in terms of any prosecutions being brought and the Crown Prosecution Service (CPS) advised that it would not bring any criminal proceedings. The Police were however sufficiently concerned to refer the details to the Commission for Healthcare Improvement (CHI) and to the General Medical Council (GMC). It should be noted that the Nursing and Midwifery Council seems to have had no active role in these proceedings at all, although nurses were closely involved in the implementation of Dr Barton's prescribing regime..

By 2003 CHI had produced a detailed report which was damming in its conclusions about management procedures and clinical supervision. However that report did not seek to apportion any blame. Neither did it seek to determine the causes of death in individual cases. I am aware that a report, which I believe is an epidemiological study, was commissioned by Professor Baker. This looked at the overall death rates at the hospital but in spite of requests for its disclosure from the Coroner and requests under freedom of information requests it has never been made public.

It was Jack Straw at the Ministry of Justice who ordered that there should be ten Inquests into cases which were investigated by the Police. Those eventually took place before the North Hampshire Coroner acting for HM Coroner for Portsmouth and took place between March and April 2009. Only five of those families had legal representation. Of those five my understanding is that positive verdicts were obtained in four cases and in respect of the remaining case it was not unexpected that the verdict was negative. The latter may have been included as a sample case but the precise reason for its inclusion is just now known. Naturally of course it was outside of the Coroner's remit to seek to apportion blame for the deaths of the patients.

The GMC had adjourned its investigation into Dr Barton's actions pending the outcome of the Inquest hearings. This resumed in the summer of 2009 and by August 2009 the GMC made their determination as to the facts. There was then a further adjournment during which time Dr Barton had, very unfairly in the opinion of the victims' relatives, been given the opportunity to prepare additional representations as to what sanctions she might face. In January 2010 the outcome of the professional conduct proceedings into her actions led to multiple findings against her of serious professional misconduct. Incredibly however, much to my own surprise and that even of the GMC itself, the independent panel chose not to erase Dr Barton's name from the medical register. She had decided to cease practising and therefore avoided sanction.

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Following the conclusions of the GMC proceedings the CPS undertook a review and re-evaluation of the evidence both in light of the GMC's findings and also those of the Coroner. By summer 2010 the CPS confirmed that they did not intend to prosecute any person. It is this outcome which I find deeply disturbing and which is, of course, highly unacceptable to the relatives of the victims. The relatives had made attempts to make representations to the CPS. Clearly they are upset and disappointed that in spite of all the failings in this matter, it is the case that no doctor, nurse and or manager has been disciplined in any meaningful way let alone been prosecuted for anything. It really undermines the whole concept of accountability within the NHS.

Civil proceedings in negligence would of course be an option. However those proceedings would be directed against the Hospital Trust, rather than against the individuals responsible. Also many of these cases concern elderly patients without dependants. The likelihood is that damages awarded in the Civil Courts would be derisory and be of little or no value or meaning to the families concerned.

The CPS has made the point that the medical evidence is complex and I have no doubt also that the passage of time has done little to help there being a satisfactory resolution. That being said the injustice of the situation at Gosport War Memorial Hospital is a festering sore for all whose relatives who are caught up in it. I believe that professionals in the medical and legal fields locally would sympathise with that view and agree with the relatives but unfortunately there is just no forum to bring all these complicated proceedings and enquiries to a meaningful and helpful conclusion; one in which the relatives could participate fully and that would bring about closure and a constructive conclusion in the public interest.

I appreciate it greatly that you are able to look into this matter further, if you require any further information please do not hesitate to let me know.

With best wishes

Code A

Eastbourne and Willingdon Constituency.