Hampshire NHS
Primary Care Trust

Verdict responses

Overall response/lines to take (RS)

The care at GWM Hospital in the mid/late 1990s has been the subject of many investigations in the last ten years.

This included a thorough independent investigation in2002 by the then healthcare watchdog CHI.

The inquests have confirmed the findings of this review – and that means we can be confident that failings/shortcomings/challenges highlighted by the Inquests have already been addressed.

(CHI found that at GWMH in the mid-late 1990s there were failings in prescribing practice, inadequate supervision and appraisal systems and a lack of thorough multidisciplinary patient assessment).

We welcome these verdicts because they give us is the final piece of the jigsaw - whether the prescribing and practices at the time contributed to the deaths of any individual.

It is important for everyone involved in the care of these patients that X verdicts indicate that the patients were cared for appropriately/and that the medication used to treat and relieve their symptoms was correct.

However it is a matter of regret to the NHS that X verdicts indicate that in the mid/late 1990s the treatment or care of X, X and X has been found to have contributed to their deaths.

NHS Hampshire will be now be contacting these families but I would also like to take this opportunity to publicly apologise to the families concerned on behalf of the NHS for any treatment or care which has been found to have contributed to the deaths of their loved ones.

Since the late 1990s the systems and policies in place at GWMH have undergone a complete overhaul. I can assure the families and local people that all the issues highlighted by these inquests have been addressed and the care at GWMH today is of the highest standard.

Soundbite (RS)
Back in 2002 the NHS watchdog found a number of failings in care at GWMH. These inquests give us the final piece of the jigsaw – which is whether the prescribing and practices at the time contributed to the deaths of any individual. It is a matter of regret that X verdicts found that this was the case. The NHS will be contacting the families concerned but on behalf of the NHS I would like to apologise for any care which was found to have contributed to their loved ones' deaths.
Since the late 1990s the systems and policies in place at GWMH have undergone a complete overhaul. I can assure the families and local people that all these failings have been addressed and the care at GWMH today is of the highest standard.

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What do you say to the families? (RS)
I would like to extend my sympathy to the families for the uncertainty they have experienced over the last ten years concerning their loved ones' deaths. I sincerely hope that these inquests have provided an opportunity for the families to hear more about the care their relative received and that these verdicts have provided answers for all the families regarding the circumstances of their loved ones' deaths.

It is a matter of regret to the NHS that X verdicts indicate that in the mid/late 1990s the treatment or care of X, X and X has been found to have contributed to their deaths. We appreciate that it has taken those families in particular a number of years to get answers to questions raised over the preceding 10 years which despite a number of investigations by various bodies has not, understandably, allayed the concerns they have continually expressed.

I/NHS Hampshire will be now be contacting these families but I would also like to take this opportunity to publicly apologise to the families concerned on behalf of the NHS for any treatment or care which has been found to have contributed to the deaths of their loved ones.

What's your response to the verdicts? (RS)
The local NHS recognizes the importance of these verdicts and the insight they provide into the deaths of these ten patients.

Previous police investigations found no evidence of criminal wrongdoing and it is important for everyone involved in the care of these patients that X verdicts indicate that the patients were cared for appropriately/and that the medication used to treat and relieve their symptoms was correct.

However it is a matter of regret to the NHS that X verdicts indicate that in the mid/late 1990s the treatment or care of X, X and X has been found to have contributed to their deaths.

I will be now be contacting these families but would also like to take this opportunity to publicly apologise to the families concerned on behalf of the NHS for any treatment or care which has been found to have contributed to the deaths of their loved ones.

Who is to blame/has anyone taken responsibility? (RS)
It's natural to want to blame someone in circumstances such as this, but it's not that straightforward.

The NHS has investigated this, CHI have investigated this and the Police have investigated this thoroughly three times and none of these investigations have found any one individual responsible.

We're aware that referrals have been made to the professional regulatory bodies and that the GMC is undertaking a hearing in the summer into the practice of one doctor/Dr Barton.

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What has been indentified and is a matter of public record is that there were a number of challenges at the Hospital between 1996 and 1999 that meant that good quality patient care was not always provided.

It's important for every public body to ensure that we use inquests to improve our practice and it is my expectation that the NHS and the professional regulatory bodies (GMC/NMC) will consider the evidence presented in these inquests and determine the appropriate action to be taken.

What now? (RS)
I sincerely hope that these inquests have provided an opportunity for the families to hear more about the care their relative received and that these verdicts have provided answers for all the families regarding the circumstances of their loved ones' deaths.

NHS Hampshire will be contacting the families concerned to apologise for any care which was found to have contributed to their loved ones' deaths.

We await the outcome of Professional Bodies' investigations and will take any additional steps necessary, once the GMC hearing into Dr Barton's treatment of patients has been completed.

Since the late 1990s the systems and policies in place at GWMH have undergone a complete overhaul. I can assure the families and local people that the care at GWMH today is of the highest standard and will continue to be closely monitored to ensure that the Hospital continues to serve the community well in the future.

We've heard a whole catalogue of problems/errors/poor care at GWMH how do you explain/justify this? (RS)
The care at GWM Hospital in the mid/late 1990s has been the subject of many investigations in the last ten years.

This included a thorough independent investigation in2002 by the then healthcare watchdog CHI.

The inquests have confirmed the findings of this review – and that means we can be confident that failings/shortcomings/challenges highlighted by the Inquests have already been addressed.

It is a matter of regret that the organisations responsible for care at the time had not done everything possible to ensure high quality care. However we are confident that the quality of care provided at Gosport War Memorial Hospital today is of the highest standard.

We've heard about people being discharged too early from QAH because of bed blocking…is this the case/explain why this happened? (JD)
There are always pressures on large acute hospitals and sometimes this does mean that patients are transferred to other hospitals. However patients should always undergo a clinical assessment of their fitness to travel and receiving hospitals must confirm that they can meet the care needs of the patient.

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We now have a robust hospital transfer policy which means all transfers are subject to strict assessments to ensure that patients are only transferred if it is in their best interests to do so and that the transport provided is appropriate to their condition.

Our policy also includes a requirement for a proper conversation with patients and their family members regarding the reason for transfer.

Dr Barton says that she was overworked and unsupported and this meant she had to cut corners...why did the NHS put her in this position? (RS)
We know from the CHI review that in the late 1990s the organisations responsible for care at the time did not have adequate supervision policies in place to provide the highest quality care for patients at GWMH.

As a result of this review the Trust recognised that professional isolation and lack of support was an issue and took steps to address this. We are confident that there is more than sufficient clinical cover at GWMH today with a full time doctor providing cover on the wards.

What are you going to do about Dr Barton now? (RS)
The GMC will consider Dr Barton's case in June. Until then she continues to practice although the GMC have imposed some restrictions on her prescribing. Once the GMC hearing into Dr Barton's treatment of patients has been completed NHS Hampshire will take any additional steps necessary.

Why were the families told that their relatives would receive rehabilitation at GWMH when this clearly wasn't the case? (JD)
Good communication between doctors, nurses, patients and their relatives is at the heart of good quality care and is a major factor in determining a positive patient experience.

The evidence heard over the last few weeks suggests that back in the 1990s this did not always happen.

Today communications skills training is central to our training programme and we are regularly assessed on the quality of communications in the national patient survey to ensure that we are meeting patient expectations.

We now have a robust hospital transfer policy which includes a requirement for a proper conversation with patients and their family members regarding the reason for transfer.

Why weren't all family members properly informed of their loved ones' condition? (JD)
Good communication between doctors, nurses, patients and their relatives is at the heart of good quality care and is a major factor in determining a positive patient experience.

One of the enduring challenges in healthcare is establishing the right point of contact and ensuring that they get timely and accurate information which they can disseminate to other family members.

The evidence heard over the last few weeks suggests that back in the 1990s this did not always happen.

Today communications skills training is central to our training programme and we are regularly assessed on the quality of communications in the national patient survey to ensure that we are meeting patient expectations.

The consultants at QAH were meant to supervise Dr Barton...why didn't they do this properly? (JD/DG)
The CHI review showed that the organisations at the time did not have adequate supervision arrangements in place.

This is a matter of regret to the NHS, but by the time of the CHI review in 2002 all of these issues had been addressed.

We now have a programme of regular appraisals and training for all doctors.

Why did the NHS allow Dr Barton to write prescriptions for patients before assessing them properly/Why was 'anticipatory prescribing' allowed? (JD/DG)
In certain circumstances it can be appropriate to have a prescription available for nurses to administer to ensure that patients don't suffer.

Today there are now much tighter governance arrangements in place in relation to the prescribing and administration of medicines than there were in the early 1990s. We also work to national best practice guidelines for palliative care and nurses working in palliative care receive specialist training in this area.

Why was Dr Barton allowed to prescribe such high doses of diamorphine? Why was diamorphine given for minor medical problems like a broken arm or bed sores? (JD/DG)
We know from the CHI review (and from today's verdicts) that at GWMH in the mid-late 1990s there were failings in prescribing practice.

There are now much tighter governance arrangements in place in relation to the prescribing and administration of medicines than there were in the early 1990s.

For example reviews of prescribing practices and all medicines related incidents are reported on the national risk learning database and analysed by the Trust.

How does the NHS check the care provided by clinical assistants like Dr Barton? (RS)
We now have a comprehensive appraisal system for GPs working as clinical assistants with GPs reviewed annually by their line manager.

Medical experts in court and also other experts (Ford report, Baker report etc) have said that the levels of diamorphine contributed to the deaths of these patients...how did the NHS allow this to happen? (RS)

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It is a matter of regret to the NHS that X verdicts indicate that in the mid/late 1990s the treatment or care of X, X and X has been found to have contributed to their deaths. We appreciate that it has taken those families in particular a number of years to get answers to questions raised over the preceding 10 years which despite a number of investigations by various bodies has not, understandably, allayed the concerns they have continually expressed.

I/NHS Hampshire will be now be contacting these families but would also like to take this opportunity to publicly apologise to the families concerned on behalf of the NHS for any treatment or care which has been found to have contributed to the deaths of their loved ones.

Additional info:

QUESTIONS FOR THE JURY TO CONSIDER:

1. Did the administration of any medication contribute more than minimally or negligibly to the death of the deceased? YES/NO

IF YES:
2. Was that medication given for therapeutic purposes? YES/NO

IF YES:
3. Was the medication appropriate for the condition or symptom from which the deceased was suffering? YES/NO