Gosport scandal: Families of more than 650 patients ask, why has Dr Jane Barton not faced justice?

In 1991, Anita Tubbritt, a staff nurse working nights on an elderly ward at the Gosport War Memorial Hospital in Hampshire, asked to have a quiet word with her local union representative.

Mrs Tubbritt, along with a number of her colleagues, had become concerned over the way medical heroin was being administered to patients, who in their opinion did not require it.

On Wednesday, more than 27 years later, those concerns were finally acknowledged, when an independent inquiry concluded that more than 650 patients’ lives could have been prematurely ended by the “institutionalised regime” of prescribing and administering opioids without medical justification.

In arriving at that conclusion, the Right Rev James Jones, who carried out the inquiry, also uncovered almost 30 years of blunders, failures and alleged cover-ups, which leave the NHS, Hampshire Police, the Crown Prosecution Service (CPS), the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) with serious questions to answer.
Making waves

The nursing staff who first raised concerns about the medical care on the Redclyffe Annexe of the hospital were worried that patients, who were not in pain, were being placed on syringe drivers, which delivered consistently high doses of diamorphine and other strong opioids.

The nurses described it as using a "sledgehammer to crack a nut" and in virtually every case the patient placed on a syringe driver was dead within three days.

The practice was overseen by Dr Jane Barton, a clinical assistant and local GP, who visited the annexe daily. Complaints were quickly brought to the management's attention, including William Hooper, the hospital's General Manager and fellow executives, Tony Horne and Ian Piper.

But the bosses were accused of closing ranks and the nurses were dismissed as being nothing more than a "small group of night staff who are making waves".

Isobel Evans, the patient care manager at the hospital, said the issue had "put a great deal of stress on everyone, particularly the medical staff".

The nurses were told that Dr Barton was a highly respected clinician and it was suggested that because they were working nights they were not seeing the whole picture.

Video: Rt Rev James Jones delivers inquiry verdict

Hospital GP implicated in deaths of hundreds

'Dead loss' ward

While opioids are regularly used on hospital wards, it was the readiness with which they were prescribed on the Redclyffe Annexe - later renamed the Daedalus Ward - that ought to have set alarm bells ringing.

International guidelines to ensure the appropriate use of the drugs depending on the patient's condition, appear to have been entirely ignored, with a powerful trio of opioids often the first port of call for patients, regardless of how ill they were.

In some cases patients who had simply been admitted to hospital for respite care were dead days later after being placed on a syringe driver.
In fact the rate of deaths at the hospital between 1993 and 1998 doubled from around 100 a year to more than 200, before falling off after the departure of Dr Barton.

When the rising pattern was spotted by hospital bosses, it was simply dismissed as either being the result of more patients being admitted, or the patients who were coming in being more ill and therefore more likely to die.

But one nursing auxiliary, Pauline Spilka, later told police the Daedalus ward had become known as the 'Dead Loss' ward, commenting that the regime was "geared towards euthanasia".

In his report, Bishop Jones was critical of some of the nursing staff and also the consultants, whom he accused of failing to challenge the prescribing culture on the ward.

He also highlighted the failure of the chief pharmacist at the hospital for failing to spot the unusually high number of opioids that were being prescribed on the affected wards.

But the report concluded that it was Dr Barton whose role was key in determining how the drugs were prescribed and administered over her 12-years at the hospital.
Criminal investigations

In 1998, the family of Gladys Richards went to Hampshire Police to make a formal complaint after she died during what ought to have been routine rehabilitation following a hip operation.

Over the next three years, three more families went to the police and finally in 2002, detectives launched a major investigation into the deaths of 92 patients.

It took another four years before files on 10 of the deaths were passed to the Crown Prosecution Service (CPS).

Former Chief Constable of Hampshire Police, Paul Kernaghan, was criticised by the families over his force’s handling of the investigation CREDIT: PA

But the report found serious failings in the way Hampshire Constabulary handled the allegations with the families of patients dismissed in some cases as “troublemakers”.

The police were also criticised for failing to identify potential witnesses, not taking statements properly and not securing evidence. After meeting two relatives of one victim, Det Con Richard Maddison wrote: “I have no idea why these two sisters are so out to stir trouble.”

Video: Press conference with inquiry chairman

Gosport inquiry reveals 'institutionalised practice of shortening of lives'

In 2006, the family of one patient lodged a formal complaint against Chief Constable Paul Kernaghan over his lack of direction and control.

He retired from the police in 2008 and, after spending time with the Palestinian Authority in Ramallah, is now an independent member of the Civil Nuclear Police Authority. The report was also critical of delays in the coronial process, which led to further anguish for the families involved.
The coroner David Horsely was also criticised over delays in holding inquests

David Horsley, the local coroner, expressed concern over the strain holding 10 inquests would place on his office and staff. He instead suggested Andrew Bradley, a recently retired solicitor, should undertake the role, but both agreed that the inquests should be limited in scope.

The report said the fact neither of the pair considered the deaths at the hospital as raising matters of national importance was “surprising”.

**Bias in the GMC**

In 2010, the GMC found Dr Barton guilty of serious professional misconduct but did not strike her off the register and she instead quickly retired.

The panel’s report raised questions over why the hearing into her conduct took 10 years to be held from the time she was first reported in 2000 – and why she was allowed to continue to practise during that time. There were also questions raised over the fact her brother, Prof Christopher Bulstrode, was a member of the GMC from July 2003 to December 2008.
Professor Christopher Bulstrode, who is Dr Barton's brother was on the GMC board

While he never sat on any Fitness to Practise panels and was not a council member at the time of her hearing, it later emerged that he had attended a training session with Dr Roger Smith, who sat on the panel at his sister’s hearing five years later. The GMC repeatedly postponed holding a hearing into Dr Barton’s conduct – partly on the request of police.

The report said Dr Barton “benefited from the delay” because she was allowed to continue working. It meant that, by the time her case was considered, she could cite “10 years of good practice to weigh in the balance”. It also pointed out the GMC had evidence about other doctors’ involvement but only chose to pursue Dr Barton.

The local MP

Former Gosport MP Sir Peter Viggers also came in for criticism for his “consistent defence” of the hospital and being “consistent in not supporting his constituents in pressing for further investigations”.

Sir Peter failed to raise any of the concerns brought to him by his constituents in Parliament, instead he asked questions only about when existing investigations would be published and how much they had cost.

The MP, who was knighted in 2008, had campaigned earlier in his political career to keep the hospital open when it was threatened with closure.
Sir Peter Viggers was criticised for his vehement support for the hospital over his constituents' concerns. CREDIT: CARL COURT /PA

He repeatedly defended the hospital in both the Commons and the press and once described campaigning families as “people [who] had begun to wonder whether they might have something to complain about after their 80 or 90-year-old relatives had died in the hospital”.

Sir Peter dismissed concerns raised, not only by families, but by the various inquiries into the hospital over the years and asked instead for the matter to “be allowed to rest”.

Gosport MP Caroline Dinenage has campaigned on behalf of the families CREDIT: DOMINIC LIPINSKI /PA

Ann Reeves, whose mother Elsie Devine died at the hospital in 1999, accused the MP of “a lack of action” and ignoring her letters. Over the years, other family members complained they were similarly ignored.
The former lawyer, who famously claimed for a floating duck island on his MPs expenses, was MP for Gosport from 1974 to 2010 when he was replaced by Caroline Dinenage, who has campaigned for justice for the families.

**The Gosport inquiry A timeline of events**

- **August 1998**
  Gladys Richards dies in Gosport War Memorial Hospital after going in for rehabilitation following a hip operation. Her family report concerns about her treatment to the police and the coroner.

- **2001**
  In the three years after Mrs Richards' family came forward, three more went to police and two more case were reported to the NHS ombudsman.

- **July 2002**
  The Commission for Health Improvement (CHI) criticised Portsmouth Healthcare NHS Trust, which ran the hospital, for excessive use of pain relief and sedative drugs.

- **February 2005**
  Hampshire Police detectives pass files of evidence to the Crown Prosecution Service (CPS) about the deaths of elderly patients.

- **December 2006**
  Hampshire Police announces that no-one would face prosecution over the deaths of patients at the hospital after a four-year inquiry. The CPS says that negligence could not
be proven to a criminal standard and that there was no realistic prospect of conviction of healthcare staff.

- **April 2009**
  An inquest jury rules drugs given to five elderly people at the hospital contributed to their deaths.

- **January 2010**
  The General Medical Council finds Dr Jane Barton guilty of serious professional misconduct. The panel found she made failings in her treatment of the patients, who later died, including issuing drugs which were "excessive, inappropriate and potentially hazardous". Instead of being struck off she was given a list of 11 conditions relating to her practice.

- **March 2010**
  Dr Barton retires from medical practice

- **August 2010**
  The CPS announces no criminal charges after finding there is insufficient evidence to mount a prosecution for gross negligence manslaughter in 10 key cases.

- **September 2010**
  Ann Reeves, the daughter of 88-year-old Elsie Devine, leads a protest march to Downing Street.

- **April 2013**
  A coroner rules that medication given to Mrs Richards contributed "more than insignificantly" to her death.

- **July 2014**
  An independent investigation into more than 90 deaths at the hospital is launched by health minister Norman Lamb and was due to conclude in 2017.

- **2016**
  The inquiry is extended and its publication date is put back to 2018.

- **June 20 2018**
  The inquiry is published.