

The Gosport War Memorial Hospital Panel report and its implications for nursing

Philip Darbyshire
Robin Ion

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“What has to be recognised by those who head up our public institutions is how difficult it is for ordinary people to challenge the closing of ranks of those who hold power”. (vii)

“Shortening lives in hospital” – the long shadow of the Gosport War Memorial Hospital (GWMH) report

Where do we even begin? How do mere words encapsulate the full horror of the Gosport War Memorial Hospital (GWMH) report (Gosport Independent Panel, 2018) and its profound implications for nursing? Many of us thought that in our careers we would never again read anything as damning of health care and health services as the Francis Report; Darbyshire & McKenna, 2013; Hayter, 2013; Nolan, 2013). We were wrong. Politicians, hospitals, health services, educators and regulators at that time were falling over each other to reassure us that ‘lessons had been learned’, ‘things had changed’, ‘new systems were in place’ and that such disasters and failures ‘must never happen again’. Thanks to the forensically detailed work of The Right Reverend James Jones KBE and his team in this review, we now know better and are unlikely to swallow such cant ever again.

The substance of this report into the killing fields of GWMH is as chilling as it is damning. The report describes, in its opening paragraph, that: “The shocking outcome of the Panel’s work is that we have now been able to conclude that *the lives of over 450 patients were shortened while in the hospital*, (p.vii) (our italics). This may only have been the tip of a more lethal iceberg however. The report later finds that: “Taking into account the missing records, there were probably at least another 200 patients similarly affected but whose clinical notes were not found” (2.101:27 [We have followed the notation system of the report when citing it. Report section:page number]). Six hundred plus older people had their ‘lives shortened’ while in GWMH. We invite readers to reflect on the blunt reality behind what this phrase means and to

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consider how they might feel if the life of their loved one was 'shortened' in the circumstances we outline below.

What the Panel report is NOT – syringe drivers and diamorphine are not 'the problem'

Before we continue, there is a vital point to be restated and understood. This report is NOT a criticism of diamorphine or other opioids used in end of life care, or to alleviate excruciating pain, or of using syringe drivers to deliver steady rates of drugs without repeated injections. The Panel are absolutely clear on this issue:

“Opioids are used to help manage the acute pain of trauma and myocardial infarction, in maintaining pain control in anaesthesia, and in the management of post-operative pain. Their appropriate and expert use in palliative care can transform patients' comfort and well-being at the end of life” (2.17:13), and, “The panel concluded that there was value in their (syringe drivers) use” (15:191)

One of the numerous tragedies of GWMH and its practices are that the work of palliative care teams and many other health professionals may become so much more difficult in the future. There are already significant barriers to the optimal use of opioids in end of life care (BMA, 2017; Gardiner et al., 2012) and considerable evidence that: “the use of opioids in palliative care is suboptimal, and many patients do not receive adequate pain control at the end of life” (Gardiner et al., 2012), 206. We could hardly blame patients and relatives for recoiling now at the very mention of the words 'diamorphine' or 'syringe driver', thinking immediately that this is a coded professional euphemism for: 'we are now going to euthanise your loved one'. Patients and families will continue to plead with doctors and nurses to 'please do something' or 'can't you give them something' when their loved one is clearly in extreme pain, distress and suffering. For many years now, health teams have worked tirelessly to judge, assess and titrate the optimum doses of diamorphine and other pain relievers that would allow patients to be as pain-free as possible while also being as responsive as possible. They have also developed systems of Anticipatory Prescribing (Wilson et al., 2014, 2015; Wilson, Seymour, & Seale, 2016) designed to ensure that nurses, other health professionals and even family members/carers can act to administer agreed medications so that patients do not endure long and painful delays before 'someone can be found' to initiate or change their prescriptions. We must hope that they will continue to do so.

Who were the patients whose lives were 'shortened'?

The GWMH patients described in the Panel's report were older people but they were not generally receiving end of life care following discussion with a ward team and with the agreement and involvement of their families. They were not patients in well-assessed and

documented intractable pain from, for example advanced cancer, that required the most powerful analgesia. Instead, they were often prescribed and given a triple cocktail of diamorphine, midazolam and hyoscine via syringe driver for indications, “including deterioration, distress, restlessness and agitation” (2.105:28), dementia (2.9:12) or confusion (3.87:76). We are not making this up or exaggerating here. Worse, “In 29%, (of the initial group of 163 patients investigated (2.3:11) no reason was found or no clear rationale was stated in the clinical records”. (2.105:28), and “In total, the Panel found evidence of opioid usage without appropriate clinical indication in 456 patients – that is, in 40% of the records that contained sufficient information (2.101:27). Other patients whose lives were “shortened” in this way had been admitted for respite care or rehabilitation (2.96:26).

One “repeated finding” in this report that strikes very close to home was that:

“diamorphine usage in patients with a stroke was also of concern. (...) some patients admitted to the hospital after a stroke received diamorphine, with minimal evidence in the clinical notes that these patients had severe pain. Others were given opioids and, when their consciousness was unsurprisingly reduced, diagnosed as having suffered a probable stroke. However, there was no record of any examination for neurological signs of a stroke. (2.114:30)”.

One of us (PD) suffered a stroke in 2016 (with no debilitating sequelae fortunately) and following a five day stay in the hospital stroke unit, a spell of ‘stroke rehabilitation’ was suggested, but thankfully not taken up. Stanley Carby too suffered a “mini-stroke” and was also aged 65 when admitted to GWMH “in good spirits” according to his family. He did not leave GWMH alive (Horton, 2018). Nor did any of the 13 patients from the ‘Initial Group’ who were also in their 60s. What would have happened had I been admitted to GWMH rather than Mr Carby? Would I be here today to write this piece?

What these patients were, was ‘old’. Thirteen were in their 60s, 41 were in their 70s, 57 were in their 80s and 23 were in their 90s. We are now skirting around a ‘heart of darkness’ in health professional practice. There seems no way to avoid asking the question: Were these patients lives “shortened” and were they commenced on syringe drivers loaded with strong opiates, not for any carefully assessed and agreed clinical reasons, but rather perhaps because they were old and mattered less? The Panel’s conclusion here is stark:

“The documents that the Panel has found reveal that, as demonstrated in Table 1 at the end of the Report, during a certain period at Gosport War Memorial Hospital, there was a disregard for human life and a culture of shortening the lives of a large number of patients by prescribing and administering “dangerous doses” of a hazardous combination of medication not clinically indicated or justified” (p.vii).

The deny, deflect, demonise, disregard and delay playbook

Following the depressingly familiar playbook of countless previous health inquiries:

- Families and relatives who asked questions or raised concerns were marginalised, ridiculed, ignored and demonised.
- Nurses who waved red flags and tried to escalate concerns were branded as troublemakers and 'boat-rockers'. Their initially 'legitimate' concerns were quickly mutated into 'allegations' where their manager re-defined their professional questioning and attempts at advocacy as "disruptive criticism which achieves nothing positive and leaves staff feeling frustrated" (1.13:5). By daring to raise these issues, the nurses had, according to their manager, "put a great deal of stress on everyone particularly the medical staff, it has the potential of being detrimental to patient care and relative's (sic) peace of mind and could undermine the good work being done in the unit if allowed to get out of hand" (1.19:6)
- In a telling reminder that the 40-year-old 'doctor-nurse game' (Holyoake, 2011; Liping, 2008) is still very much alive in some minds and places, they were also characterised as being staff who dared to question the integrity and clinical judgement of doctors concerned and thus risked 'upsetting' them (1.7:4).
- Police inquiries and investigations were shambolic. Starting with a mindset that saw relatives as described by one detective: "I have no idea why these two sisters are so out to stir up trouble" (5.23:107), it is small wonder that it was "no surprise to the Panel that the police approach failed to satisfy the families from the start (...) as the quality of the police investigations was consistently poor" (12.57:322).
- Police involvement however, served one useful function for all other organisations concerned. It allowed them to do even less investigation and even more prevarication. This was the gift that allowed them to announce that inquiries were suspended as nothing would be 'appropriate' while police investigations or any other legal machinations were happening. The report mentions Sir Liam Donaldson's 'prescient remarks' that:

"Previous experience has shown that once a NHS investigation is halted by a Police investigation, then it can take years to start again. We cannot afford for this to happen" (DOH000156, p3). The records show that these remarks were prescient. The management investigation would never be restarted. The second CHI investigation was never undertaken" (4.76:96).

- The empires of professional regulation, from GMC through to NMC "failed to act" (viii). They were of no value whatsoever to relatives and families but were simply more professional self-interest obstacles in their path towards honesty and answers, despite these organisations' professed 'missions' of existing to protect and safeguard the public and to 'ensure standards'. Patients, relatives and families: "were failed by the professional bodies and by others in authority charged with responsibility for regulating the practice of professionals in the interests of patient safety" (viii). In short, patient safety and welfare was: "subordinated to the reputation of the hospital and the professions" (viii).
- Vital notes, clinical records, minutes and other documents mysteriously 'went missing' (2.91:25, 2.98:27, 4.73:95, 8.151:247, 11.41, 42:307).

- No opportunity to stonewall, delay, obfuscate, buck-pass and deny was missed by professionals, organisations and regulators alike. Such resistance to the much-vaunted 'transparency' here even extended to the Inquiry Panel itself (11.46:308, 11.37:306-7). In what may pass into quotation history, The Right Reverend James Jones observes in his Foreword that: "It is a lonely place, seeking answers to questions that others wish you were not asking." (vii)

If the overall report is damning, what it says about nursing at GWMH is almost unbearable to read. The Panel:

"found a picture of care which fell well below the expected standards of nursing practice at that time. It is a picture which demonstrates a lack of concern and regard for individuals' assessed needs, as well as a lack of challenge to the prevailing prescribing practice at the hospital. It also illustrates the bravery of the nurses who raised concerns in 1991". (3.25:48) and found "sub-optimal care and lack of diligence by nursing staff in executing their professional accountability for the care delivered. Patients and relatives were marginalised and their interests became subordinate to those of the professional staff (12.21:317).

What this meant in detail was that: nursing documentation was appallingly inadequate. There were often no nursing assessments or notes regarding pain, distress, medication changes, PRN medication commencement, reactions to medications given and much more. This was NOT 'bureaucratic paperwork' detailing how a patient wanted tea rather than coffee, that we could all delight in railing against. These were ANY notes or records describing what would lead a patient to be started on a syringe driver loaded with diamorphine and other drugs. These were notes about ANY discussions, conversations or planning between nurses, patients and family about providing end-of-life care. These were ANY notes about how a patient was reacting or responding to major opiate mixtures. These were ANY notes about why a patient's diamorphine dose should be raised or even doubled, by nursing staff, to anywhere between the allowed "anticipatory prescribing" range of between 20-200mg (3.12:45). These were ANY notes about how ANY nurse had stepped in at ANY time to 'challenge the prevailing practices on the wards' (3.13:45).

Nurses failed at almost every possible juncture to provide individualised care, to protect patients, to keep the most rudimentary of 'good records', to work as a trusted partner with families and relatives, to challenge or question clinical or pharmacological decisions based on sound clinical judgement, to escalate safety and care quality concerns to the point of action, to manage services with the patient as the priority and central focus and to think reflectively and critically about what was happening to their patients and at their hospital.

The NMC, perhaps predictably, given the findings of other inquiries such as Morecambe Bay (Kirkup, 2015), took 10 years, hallmarked by: “the almost complete lack of communication between the NMC and the families” (7.66:229) to “decline to proceed in respect of all the allegations against the nurses concerned” (12.25:318).

Setting aside what the NMC chose not to pursue, what excuses are our profession still prepared to accept for such derelictions of professional responsibility from qualified nurses?

- I was really busy?
- I didn't know it was wrong?
- I'm not paid enough?
- What's the point, nobody would do anything?
- I didn't want to upset colleagues, the management or doctors?
- It wasn't my place to say or do anything?
- My role is strategic, not operational?
- It wasn't my fault, it was 'the system' and I'm a victim here too?
- I'm just not the courageous type?

or,

- I was only following orders'?

“I cannot explain why I didn't speak out against the regime within the ward”. (3.8:42)

There cannot be any reasons or justifications left for the individual and systemic failures at GWMH, certainly none that will satisfy any of the families whose loved ones had their lives “shortened” there. Writing about torture and mistreatment at Abu Ghraib as part of the ‘war on terror’, Miles notes that: “Silence about abuse has two general forms: failing to see abuse for what it is and failing to act when abuse is seen” (Miles, 2009) (p.120). The nurses at GWMH, with the notable exceptions of those who alerted management initially in 1991: “conformed to the norm of not confronting or criticising senior medical colleagues” (Ehrich, 2006)(p.921) and assuredly did not act to question or stop what was happening on their wards but rather continued to administer ‘PRN’ medications such as diamorphine via syringe driver with questionable clinical justification. The report's finding here could not be more damning:

“However, the records also show that nurses in the hospital administered the drugs and continued to do so for many years, although the link with the pattern of deaths would have been apparent to them. Within the professional standards which applied at the time, the nursing staff also had a responsibility to intervene and challenge the prevailing practice on the wards” (3.13:45).

Likewise, almost every official body it seems, from management, health services, police and legal services, regulators and more exhibited an 'organisational deafness' (Jones & Kelly, 2014) towards any concerns or complaints raised by either staff or relatives. Exactly how loudly any 'whistle' would have to be blown to penetrate this wall of inertia and self-interest is unknown.

The responsibilities for GWMH

There is no ambiguity here or ideological battle between individual and systemic or organisational responsibility (Darbyshire, 2014, 2015). This is not a case of 'choosing' who or what is to blame and apportioning all responsibility to *either* individual nurses, doctors, managers *or* whoever or to some nebulous thing called 'the system'. Both are culpable, and neither can be exclusively singled out for blame to the exclusion of the other. As Jones and Kelly note, (Jones & Kelly, 2014) it is not enough to complain that in our health services some do not 'speak out' when there are formidable cultural and organisational forces determined neither to listen nor to hear.

The Liverpool Care Pathway Report (Neuberger, 2013) stripped away all of the ifs and buts from what it means to be a Registered Nurse and accountable for your practice when they stated that:

"Being accountable also means being liable: the registration bodies for doctors and nurses should make it clear to their members that, if there is finding of serious professional misconduct in the treatment of patients at the end of life, the normal sanctions for professional misconduct apply". (2.13:37) (Neuberger, 2013)

The report rightly praises the small group of nurses at GWMH who, in 1991, waved the red flag and directly alerted management via the RCN of their concerns regarding the use of diamorphine cocktails for patients whose clinical condition did not seem to warrant such a powerful pharmacological intervention, such a "sledgehammer to crack a walnut" (1.3:3). After only a few months, the hospital nurse manager had made it clear, in a textbook example of organisational deafness and disregard, (Jones & Kelly, 2014) that such 'professional concerns' were now unwelcome 'allegations'. The repercussions against those nurses who questioned or challenged aspects of the status quo had begun. The report's finding here is worth quoting at length and indeed should be hung in every hospital executive suite in the world:

"A number of nurses raised concerns about the prescribing of drugs, in particular diamorphine. In so doing, the nurses involved, supported by their Royal College of Nursing branch convenor, gave the hospital the opportunity to rectify the practice. In choosing not to do so, the opportunity was lost, deaths

resulted and, 22 years later, it became necessary to establish this Panel in order to discover the truth of what happened. The documents therefore tell a story of missed opportunity and unheeded warnings.” (Conclusion: 9)

The failure of ‘braving the storm’

There is however, a problem with the ‘nurses’ bravery’ narrative. It is certainly true that in many, many contexts and organisational cultures it *does* take courage to confront managers, doctors or other more powerful groups, to challenge existing practices or to question the clinical judgements of other professionals, especially if they are more senior. This, however cannot be seen as a matter of individual nurses being brave or courageous. Bravery may be seen as a characteristic of some, but not all nurses, as an option to be exercised only by the fearless. What do we say to the nurse who argues that he/she is ‘not brave’, who feels that they ‘cannot take the risk of confronting or questioning poor practice’, who ‘doesn’t like to upset colleagues’, who cannot afford to challenge more powerful figures because they ‘need their job to pay the mortgage’? Are they to be allowed to slip off the hook of professional obligation because they are not ‘brave enough’?

Professional responsibility cannot be sloughed off so easily. This is crystal clear from guidance provided by the regulator which requires nurses to prioritise people, practice effectively, preserve safety and promote professionalism and trust. To use the words of the NMC, these things are: “(...) not negotiable or discretionary (...) They are the standards that patients and members of the public (...) expect from healthcare professionals” (NMC, 2015).

There is nowhere to hide. As a Registered Nurse you are responsible for your nursing, your practices, for your actions and omissions and for their impact on patients and colleagues. To be a registrant – and we emphatically include nurse managers and leaders in this – you must accept the possibility that difficult and demanding situations will arise which will stretch your capacity and challenge your preferred ways of practicing or managing. The regulator, the public and hopefully, your conscience, expect that you will approach these situations with a commitment to human dignity, professionalism, critical awareness and a moral compass that, with some very notable exceptions, appeared absent at GWMH. If you do not want such an onerous responsibility for people's lives and wellbeing, you need to reconsider nursing and/or health service management as your career or occupation.

If justice delayed is really justice denied, then the GWMH families and relatives have suffered denial on an epochal scale as: “it is over 27 years since nurses at the hospital first voiced their concerns. It is at least 20 years since the families sought answers through proper investigation” (12.2:315). This report has shown the bankruptcy of organisations’ ‘proper channels’ that can only be seen now as a self-serving panoply of official processes designed primarily to silence, deflect, delay and deter. Health managers and leaders who insist on staff pursuing concerns via such ‘proper channels’ can no longer be under any illusions as to what they are mandating.

Educators must surely also question 'ethics teaching' in nursing, management and professional development programmes. Years of having well-meaning ethicists listing 'ethical principles' have ill-prepared nurses and managers for the realities of today's corporatised health services where 'damage limitation' and 'reputation management' can be so readily seen as more pressing concerns than patient safety and wellbeing.

The question facing all nurses is; Will this report of the deaths at GWMH, the actions and inactions of nurses and other professionals involved and the systemic failures at every management and regulatory level be any kind of 'tipping point'? (Chan Kim & Mauborgne, 2003). Many of us believed that The Francis Report (Francis, 2013) would be the catalyst for significant change in individual and organisation practices, but we were wrong. We surely cannot afford to be wrong again. Having a 'no-blame' (Catchpole, 2009; Wachter, 2013; Walton, 2004) culture is laudable but must not become synonymous with a 'nobody is responsible' culture. Creating such a culture where health professionals have patients, families and those we serve as our centre of gravity and not the organisations we work for or the professions that we belong to will be a seismic shift. For the sake of the others who will place their lives and wellbeing in our hands, we had better be up to the challenge.

Philip DARBYSHIRE, Philip Darbyshire Consulting, Adelaide, Australia

Robin ION, Abertay University, UK

Email: philip@philipdarbyshire.com.au

Twitter: @PDarbyshire

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