Q&AS GOSPORT

What happened at Gosport?

- concerns were raised with CHI about the death of an older person at Gosport War Memorial Hospital and whether the death was related to over prescription of ~~diamorphine~~ pain relief.

What are CHI's main findings?

- ~~CHI worked closely with the police throughout the investigation, including its expert witness panel. Findings of the panel were treated as CHI findings in the writing of this report~~
- the use of ~~diamorphine~~ some medicines in 1997-1998 was excessive and outside normal practice
- ~~patients were being discharged from the acute hospital to the rehabilitation wards too soon and were sicker than the ward staff expected. The acute trust had not explained the extent of the patients illnesses sufficiently to relatives~~
- there were insufficient local prescribing guidelines, local information was not used to identify and address prescribing patterns.
- The trust failed to use the triggers provided by a police investigation, a pattern of complaints and a review by the Health Service Ombudsman to initiate a thorough review of prescribing.
- CHI have no concerns regarding the use of pain relieving medicines at the trust today.

Did any / How many patients died as a result of the excessive prescription?

- CHI is not in a position to say if anybody died as a direct result of this.
- ~~the quantity and combination of drugs could have hastened death in frail older people as it can causes pneumonia and lung collapse~~

Was this a case of one clinician over prescribing?

- CHI investigates systems failures and does not look to unfairly apportion balme to individuals
- in 1997-1998 there were no systems in place to monitor prescribing, no checking of prescriptions

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and no effective monitoring of the amounts of drugs going out of pharmacy. All contributed to the failure

What has happened to the clinical assistant? Is action being taken?

- the individual is no longer the clinical assistant (resigned the post in July 2000)
- the individual is still admitting patients to the GP ward at Gosport and is still acting as a GP
- ~~there is no current action being taken against them (*this answer is subject to change if circumstances with the GMC change)~~
- the GMC are currently considering action regarding one clinician who no longer works at the trust.

Was the over prescription of drugs deliberate euthanasia or an attempt to sedate patients?

- CHI does not have any evidence to confirm either way.
- prescribing was within guidelines set by the acute trust and Portsmouth Healthcare NHS Trust for palliative care. Some of the patients who died had been admitted for rehabilitative care.
- these guidelines were probably too wide and were not tailored to those particular patients

What is the situation now – are patients safe?

- yes – the CHI review of recent anonymised case notes show no problems. This has been confirmed by a trust audit in June 2002
- policies are in place and being implemented
- the analgesic ladder is being used and there is no evidence of anticipatory prescribing

Are the police or Crown Prosecution Service taking any further action?

- the CPS are not taking further action at present
- the police are looking at the conduct of their own investigation following ~~three~~ complaints

Why has the investigation taken so long – this happened in 1998?

- CHI was first contacted about the situation in August 2001

- CHI's investigation took longer than anticipated because of the decision to undertake a review of recent casenotes so that we could confirm if practices had changes and reassure current patients about their local health service

Why did CHI do the investigation when others have abandoned theirs or decided to take no further action?

- serious concerns were and continue to be raised, three years on
- CHI decided there were potential wide ranging lessons for the whole of the NHS
- if services were safe, CHI wanted to be able to restore confidence in the local health services

If things are OK now, why did CHI invest so much time and money in the investigation?

- concerns had been raised with us and until we had completed the investigation, we were not able to confirm whether or not things were safe

Should GPs be working in hospitals? Doesn't this show it is unsafe?

- there should be no problem if trusts have robust systems to ensure their performance is ~~checked and that they are~~ supervised
- GPs need to have appropriate training before undertaking work in hospitals
- GPs working as clinical assistant provide community hospitals with valuable medical support

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Is the level of out of hours care sufficient?

- ~~the trust has clear guidelines covering out of hours cover~~
- CHI has recommended that the trust review these guidelines to ensure that the needs of current patients are met 24hour a day

Why didn't the consultant in charge do anything?

- there was no formal trust system for appraising the clinical assistant ~~and their practice wasn't checked~~. The consultant in charge may not, therefore, have been aware of the levels of prescription

The former chief executive has been given a generous redundancy package – was he culpable and is this a pay off?

- CHI cannot comment on his redundancy package
- there was a wealth of information available to the trust but that wasn't acted upon
- police checks of trust files did not instigate a trust review of prescribing

Why were rehab patients being given diamorphine?

- there was a problem in defining the level of care – some of the patients admitted for rehab were really palliative care patients
- there is a place for sedation and pain relief where the prescription of diamorphine at these levels would be appropriate
- the confusion over levels of care meant some patients were being prescribed levels of pain relief and sedating medication that were inappropriate

Should diamorphine guidelines be reviewed?

- national guidelines need to be implemented by trusts so that they are appropriate to the patients concerned

Are patients now in pain?

- the review of recent case notes did suggest that two patients may have been left in pain longer than necessary

Why didn't the trust investigate?

- the trust believed that they had been exonerated by the outcomes of the three complaints that were investigated by independent reviews / health service ombudsman
- there was an over reliance on external review processes that looked at individual care rather than systems

Isn't this report a whitewash that still doesn't give the families of the patients any answers?

- CHI looks at systems not individual cases

- CHI has done a fundamental review of policies and procedures to ensure good quality patient care
- practice has improved and we have a duty to acknowledge this, especially so local people can have confidence restored in the treatment and care offered by Gosport War Memorial Hospital
- when CHI finds practices that are unsafe, we say so. We are not hiding anything in publishing this report

Could this happen to someone else?

Who was responsible for this?

What has happened to the nurses?