How have we got to this point?

The investigation comes as a result of concerns expressed by the police and others around the care and treatment of frail older people provided by Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital. This follows police investigations between 1998 and 2001 into the potential unlawful killing of a patient in 1998. The patient had undergone an operation on a broken hip at another hospital and had been transferred in October 1998 to Gosport War Memorial Hospital. The patient had died of bronchopneumonia in December 1998, and the complaint was that the patient had received excessive doses of morphine, had not received reasonable medical and nursing care, and had been allowed to become dehydrated. As part of their investigations, the police commissioned expert medical opinion, relating to a total of five patient deaths in 1998. In February 2002, the police decided not to proceed with further investigations.

The standard of NHS care for older people has long caused concern. A number of national reports found aspects of care to be deficient. National concerns raised include: an inadequate and demoralised workforce, poor care environments, and lack of seamless care within the NHS and ageism.

A total of 129 complaints were made regarding the provision of elderly medicine since 1 April 1997. CHI was told that the three wards at Gosport War Memorial Hospital had received over 400 letters of thanks during the same period.

Key events to date:

Date	Event
1995	A trust risk management group was established to oversee the implementation of the trust's risk management strategy, and to provide a forum in which risks could be evaluated and prioritised.
Sept 1998	The trust reacted swiftly to the principles of clinical governance outlined by the Department of Health in *A First Class Service* by devising an appropriate management framework. A paper outlining how the trust planned to develop a system for clinical governance was shared widely across the trust and aimed to include as many staff as possible.
March 1999	Following a complaint made by the relative of a 91 year old patient who died in August 1998 on Daedalus ward, The CPS responded formally indicating that, in their view, there was insufficient evidence to prosecute any staff for manslaughter or any other offence.
July 1999	The Public Interest Disclosure Act became law.
Aug 2001	The CPS advised that there was insufficient evidence to provide a realistic prospect of a conviction against any member of staff.

March 2001	Local media coverage in March 2001 resulted in 11 other families raising concerns about the circumstances of their relatives' deaths in 1997 and 1998. The police decided to refer four of these deaths for expert opinion to determine whether or not a further, more extensive investigation was appropriate.
Dec 2001	Two expert reports were received and made available to CHI. These reports raised very serious clinical concerns regarding prescribing practices in the trust in 1998.
Feb 2002	The police decided that a more intensive police investigation was not an appropriate course of action.

Key findings:

Date	CHI Report	Date	Baker Report
1998	CHI has serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on Dryad and Daedalus wards: • There was lack of clarity amongst all groups of staff and stakeholders about the focus of care for older people and therefore the aim of the care provided. • Serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people. • There were systems in place to monitor and appraise the performance of clinical assistants.	**N/a**	Patients admitted to Gosport hospital were elderly, had severe clinical problems, and had commonly been transferred from acute hospitals after prolonged in-patient stays. Although some were admitted for rehabilitation, most were believed to be unlikely to improve sufficiently to permit discharge to a nursing home. - Opiates had been administered to virtually all patients who died under the care of the Department of Medicine for Elderly People at Gosport, and most had received diamorphine by syringe driver. o Of the 81 patients in the sample, 76 (94%) had received an opiate before death, of whom 72 (89%) had received diamorphine. - Opiates were administered to patients with all types of conditions, including cancer, bronchopneumonia, dementia, and strokes. - Opiates were often prescribed before they were needed – in many cases on the day of admission, although they were not administered until several days or weeks later. - In many records, the stepped approach to management of pain in palliative care had not been followed. - The mean starting dose of diamorphine was greater than would
1998	The police investigation did not provide the trigger for the trust to undertake a review of prescribing practices. The trust should have responded earlier to concerns expressed around levels of sedation which it was aware of in late 1998.		

2000/ 2001	CHI found some evidence to suggest a recent reluctance amongst clinicians to prescribe sufficient pain relieving medication. Despite this, diamorphine usage on Sultan ward 2000/2001 showed a marked increase.		have been expected if the rule of thumb of giving one third of the total daily dose of morphine had been followed.
2001	Though Portsmouth Healthcare NHS Trust did begin to develop a protocol for the prescription and administration of diamorphine by syringe driver in 1999, the delay in finalising this protocol in April 2001, as part of the policy for the assessment and management of pain, was unacceptable.	**N/a**	The amount of information recorded in the clinical notes was often poor, and recent fractures that had contributed to deaths had not been reported on MCCDs. - Some records failed to indicate that an acute deterioration in a patient's condition had been followed by a careful assessment to determine the cause. Opiates may have been administered prematurely in such cases. - The records commonly did not report detailed assessments of the cause of the patient's pain. - The records did not contain full details of care. Only 48 (59.3%) contained sufficient information to enable a judgement to be made about the appropriateness of care. In 16 of these, I had some concerns about the indications for starting opiates, the investigation of pain, or in the choice of analgesic. - Dr Barton did not report recent fractures, including fractured hips, on MCCDs. These cases were commonly reported as having died from bronchopneumonia.
N/a	The trust has a strong staff focus, with some notable examples of good practice. Despite this, CHI found evidence to suggest that not all staff felt adequately supported during the police and other recent investigations.		
N/a	Out of hours medical cover for the three wards out of hours is problematic and does not reflect current levels of patient dependency.		

Dr Barton

The findings of the review of prescribing of controlled drugs indicate that patients in Gosport Hospital whose deaths were certified by Dr Barton were more likely to have been prescribed an opiate (most commonly diamorphine or oramorph). The excess was most evident among patients who were certified as dying from bronchopneumonia with or without other conditions, or from some other condition that was not cancer or cerebro- or cardio-vascular disease. This finding is a cause for concern, since the use of opiates for pain relief in terminal care is more common in conditions in which pain would be expected, in particular cancer. Furthermore, a high proportion of the initial cases referred to the police by concerned relatives had been certified as dying due to bronchopneumonia.

Recommendations

CHI Report	Baker Report
Prescriptions 1. All patient complaints and comments, both informal and formal, should be used at ward level to improve patient care. The Fareham and Gosport PCT and East Hampshire PCT must ensure a mechanism is in place to ensure that shared learning is disseminated amongst all staff caring for older people. 2. Fareham and Gosport PCT should lead an initiative to ensure that relevant staff are appropriately trained to undertake swallowing assessments to ensure that there are no delays out of hours. 3. Daytime activities for patients should be increased. The role of the activities coordinator should be revised and clarified, with input from patients, relatives and all therapists in order that activities complement therapy goals. 4. The Fareham and Gosport PCT must ensure that all local continence management, nutrition and hydration practices are in line with the national standards set out in the Essence of Care guidelines. 5. Within the framework of the new PALS, the Fareham and Gosport PCT should, as a priority, consult with user groups and consider reviewing specialist advice from national support and patient groups, to determine the best way to improve communication with older patients and their relatives and carers.	Investigations should continue into the deaths of individual patients. The findings of this review reinforce concerns about what may have occurred in these cases. In the continuing investigation into deaths in Gosport hospital, information about the rota followed by Dr Barton and her partners should be obtained and used to explore patterns of deaths. Hospital teams who care for patients at the end of life should have explicit policies on the use of opiate medication. These policies should include guidance on the assessment of patients who deteriorate, and the indications for commencing opiates. The development of national guidelines would assist the development of local policies.
Staffing 1. The Fareham and Gosport PCT should develop local guidance for GPs working as clinical assistants. This should address supervision and appraisal arrangements, clinical governance responsibilities and training needs. 2. The provision of out of hours medical cover to Daedalus, Dryad and Sultan wards should be reviewed. The deputising service and PCTs must work towards an out of hours contract which sets out a shared philosophy of care, waiting time standards, adequate payment and a disciplinary framework. 3. Fareham and Gosport PCT and East Hampshire PCT should ensure that appropriate patients are being admitted to the Gosport War Memorial Hospital with appropriate levels of support. 4. The Fareham and Gosport PCT should ensure that arrangements are in place to	The findings reported in this review should not be used to restrict the use of opiate medication to those patients who need it. Indeed, there are reasons to suspect that some patients at the end of life do not receive adequate analgesia.

ensure strong, long term nursing leadership on all wards.

5. Both PCTs must find ways to continue the staff communication developments made by the Portsmouth Healthcare NHS Trust.

Clinical Audit

1. The Fareham and Gosport PCT and East Hampshire PCT must fully embrace the clinical governance developments made and direction set by the trust.
2. All staff must be made aware that the completion of risk and incident reports is a requirement for all staff. Training must be put in place to reinforce the need for rigorous risk management.
3. Clinical governance systems must be put in place to regularly identify and monitor trends revealed by risk reports and to ensure that appropriate action is taken.
4. The Fareham and Gosport PCT and East Hampshire PCT should consider a revision of their whistle blowing policies to make it clear that concerns may be raised outside of normal management channels.