Hampshire NHS
Primary Care Trust

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Gosport War Memorial Hospital Investigations – Summary

Background

Between 1988 and 2001, Hampshire Constabulary undertook investigations into the potential unlawful killing of a patient at Gosport War Memorial Hospital. These investigations did not result in any criminal prosecutions, but the police did have sufficient concerns about the care of older people at Gosport War Memorial Hospital (GWMH) that the decided to share them with the then Commission for Health Improvement (CHI) (a fore-runner of the Healthcare Commission) in august 2001. These concerns centred on the use of some medicines, particularly analgesia and levels of sedation, and the culture in which care was provided for older people at the hospital.

In October 2001, CHI commenced an investigation into the management, provision and quality of healthcare for which Portsmouth Healthcare NHS Trust (the predecessor of Fareham and Gosport PCT and hence Hampshire PCT) was the body responsible for GWMH at the time.

On 1st October 2006, responsibility for the provision of inpatient care at GWMH transferred to Portsmouth Hospitals NHS Trust.

CHI concluded that there had been a failure of Trust systems to ensure good quality patient care, including insufficient local prescrib8ing guidelines, lack of a rigorous, routine review of pharmacy data, and the absence of adequate trust-wide supervision and appraisal systems.

CHI also concluded, however that the Trust had addressed these issues and had adequate policies and guidelines in place which were being adhered to governing the prescription and administration of pain relieving medicines to older patients.

The publicity accompanying the announcement of the findings of the CHI investigation prompted a number of relatives of patients who had died at GWMH to contact the Hampshire and Isle of Wight Strategic Health Authority regarding the care and treatment of their relatives between 1998 and 2001. These contact, allied to the findings of the CHI investigations, resulted in the police, in September 2002, initiating another investigation into the deaths of 92 patients at GWMH.

The focus of the police investigation centred on both organisational failings, (relating to inadequate systems and procedures) and the actions of a number of clinicians. Specifically, the investigation considered the practice of a local GP and Clinical Assistant within GWMH, and a number of the nursing and other staff at the Hospital. In the light of the police investigation, the doctor agreed to voluntary restrictions to practice, which are ongoing.

Outcome of the Police investigation

A total of 92 cases were examined by the police investigation team from 2002. Investigations into a significant proportion of the cases (82) ceased at a relatively early stage on the basis that there was insufficient evidence to justify further criminal investigation.

The remainder were passed to the Crown Prosecution Service (CPS) for review once the police investigation was complete. The CPS concluded that negligence could not be proven to the high criminal standard and that there was no realistic prospect of conviction of healthcare staff.
It is understood that following the CPS' decision, the police met with the General Medical Council (GMC), the Nursing and Midwifery Council (NMC) and H.M. Coroner to determine whether general 'standard of care' issues in respect of the deaths required further examination. The police, however, reiterated that their investigation was now closed.

Coroner

Following the meeting with the Police and representation from families of the deceased, the Coroner met with the Minister for Justice, the Department of Health and the Assistant Chief Constable to discuss the potential of opening inquests on 10 cases. Following this meeting the Coroner (SE Area) opened and adjourned Inquests on 10 named cases. The Coroner held a pre-inquest review meeting with the families in August 2008, to which the NHS was invited but as the invitation did not reach the appropriate people there was no NHS presence at the meeting. Although the inquest cannot be on an Article 2 basis (Right to Life) as this legislation post-dates the events the inquest investigates, the remit is likely to be wide and examine who, what, where, when and in what circumstances, the deaths took place, but is likely also look at issues such as policies, systems, protocols, quality assurance, staffing, training and supervision.

Coroners are required to inquire into deaths reported to them which appear to be violent, unnatural of sudden and unknown cause. The Coroner will seek to establish the medical cause of a death. (If the cause of death remains in doubt after a post-mortem, an inquest is held.) An inquest is an inquiry into who has died and how, when and where and in what circumstances the death occurred, the latter being an addition introduced more recently. An inquest is not a trial and does not apportion blame for a death. Possible verdicts include: natural causes, accident, suicide, unlawful or lawful killing, industrial disease and open verdicts (where there is insufficient evidence for any other verdict) or if death is as a result of neglect. The coroner may bring a narrative verdict, in which case additional text will be included in the verdict. The coroner also has the power to make recommendations if he sees fit.

In this case the coroner has said that he wishes to conduct separate inquests into each death, and has set aside six weeks for the inquests to take place.

General Medical Council (GMC) and Nursing and Midwifery Council (NMC)

The Police forwarded papers in respect of 14 cases to the GMC and NMC. Until the completion of the Police investigation, neither organisation felt able to consider any of the referrals they had received in order not to prejudice the police investigation.

In December 2007 solicitors acting for the GMC contacted the PCT requesting details for a number of clinical and other staff members involved in caring for some patients involved in the police investigations. These details were verified by current employers prior to release to the solicitors early in January 2008.

The GMC are holding a hearing about the doctor, which has been scheduled to take place from June 2009, and for which about 8 weeks have been set aside. The professional body continues to support the doctor, who nevertheless has had restrictions placed upon her.

The solicitors acting the GMC have reviewed witness statements and may wish to take further statements from some clinical and other staff prior the hearing. Staff are being supported through this process and where applicable current employers have been informed.

The NMC have been silent on this matter to date.

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Abbreviations:

CHI	Commission for Health Improvement
CPS	Crown Prosecution Service
DMOP	Division of Medicine for Older People, part of Portsmouth Hospitals NHS Trust
DH	Department of Health
F&GPCT	Fareham and Gosport Primary Care Trust
GMC	General Medical Council
GWMH	Gosport War Memorial Hospital
NMC	Nursing and Midwifery Council
PCPCT	Portsmouth City Primary Care Trust
PHCT	Portsmouth Healthcare NHS Trust
SEPCT	South East Hampshire Primary Care Trust
SHA	Strategic Health Authority