Hampshire NHS
Primary Care Trust

Q&A

Q. What is the purpose of an Inquest?

A. The purpose of an inquest is for the coroner to determine how an individual met his/her death, the cause/ nature of the death and the circumstances around that person's death. An inquest is not a trial.

Q. What is this inquest concerned with?

A. This inquest is concerned with the deaths of people who were in-patients on Dryad and Daedalus wards, at Gosport Ward Memorial Hospital (GWMH) between 1996 and 1999. These deaths came to police and public attention following one complaint made by a relative in 1998.

Q. Isn't it rare to have an inquest 10 years after the death of a person and in the absence of a body or post mortem reports?

A. Yes it is. The decision to conduct these inquests was taken by the Coroner following representation from families of the deceased and a meeting with the Minister for Justice, the Department of Health and the Assistant Chief Constable. There have been three thorough police investigations and a further independent investigation (Commission for Health Improvement) into these matters since 1998.

Q. Why has an inquest into these deaths been called when the police investigations found no evidence of wrong doing?

A. The police investigations focused on whether there was any evidence that any crime had been committed with respect to patient deaths at Gosport War Memorial Hospital. The police were satisfied beyond all reasonable doubt that there was no evidence of any criminal wrong-doing.

The purpose of an inquest is to determine how a person met their death and potentially the circumstances surrounding that death.

Q. Were any staff disciplined as a result of the police investigations?

A. No. At the time two senior members of management were redeployed for six months, while internal investigations took place – this is standard practice. However both internal investigations and the CHI review concluded that there was no evidence to suggest that any individual should be disciplined and the staff members returned to their posts.

Q. What measures have been put in place since these incidents?

The CHI investigation in October 2001 concluded that the PCTs had put in place adequate policies and guidelines governing the prescription and administration of pain relieving medicines to older patients and that these policies and guidelines were and are being adhered to. Full details can be obtained from: http://www.popan.org.uk/policy/Policy_content/abuse_inquires/gosport_war_memorial_chi_July_2002.pdf

Four NHS organisations providing services in the south east Hampshire area have also undertaken their own more recent reviews of compliance with the recommendations CHI made. The Board of each organisation has received assurances that all policies are correct and current and that the quality of care being provided is of the highest standard and in line with modern Clinical Governance standards. Assurances have also been provided to South Central Strategic Health Authority (SHA) as the organisation responsible for monitoring quality within organisations in its area. The SHA will in turn provide assurance to the Department of Health.

Since the deaths at GWMH all NHS organisations now work to modern clinical governance standards which require risk management systems and clinical audit departments. These are integral to the delivery of health services in a modern NHS and have been part of NHS evolution over the last decade.

Q. What is CHI?

A. CHI – is the Commission for Health Improvement. This organisation was replaced by the Healthcare Commission (in April 2004). The Healthcare Commission is the independent watchdog for healthcare in England. It assesses and reports on the quality and safety of services for patients and the public. From April 2009 a new "super-regulator", the Care Quality Commission will combine the functions of the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission.

Q. What is Clinical Governance?

A. Clinical Governance is essentially a term used to describe the way the NHS manages the delivery of health services within a structure of accountability and responsibility. It is intended to ensure that clinical care is delivered on the basis of agreed standards and that outcomes are measured against these standards of care.

Q. Is the mortality rate at GWMH higher than at other community hospitals?

A. There is no statistical assessment that would enable us to compare mortality rates. The range of treatments, patient circumstances, local demographics and the numbers involved all contribute to make a statistical analysis impossible at this current time although we are increasingly putting measures in place that will enable us to work towards this type of data.

However, the care provided by PHT and Hampshire PCT was rated 'excellent' and 'good' by CHI's successor last year and the Hospital received good results from the Patient Environment Action Team (PEAT).

Q. Please comment on the findings of the Baker audit

A: We haven't seen the Baker audit but would be happy to review it if you have a copy for us.

Q. Is this another 'Shipman' case?

A: Absolutely not. There have been three separate police investigations since 1998 plus an independent investigation by the Commission for Health Improvement. None of these four investigations found there to be any evidence of criminal wrong-doing. The current inquest aims to establish how the cause of death arose for the ten patients concerned.

Q. Why is Dr Barton still practising?

A: The GMC has concluded that Dr Barton remains safe and fit to practice. Due to the pressures surrounding these investigations, Dr Barton has resigned from GWMH but still practices as a GP.

Q. Why was nothing done when concerns were initially raised by nurses?

A: It is regrettable that no action was taken although these concerns were brought to the attention of the management team which was in place at the time. It is also regrettable that staff who raised these issues were not supported as they would be now.

The way the NHS monitors patient safety and the quality of care has changed considerably since the early 1990s. Staff are now required to report all incidents and 'near misses' and these are immediately logged and reviewed at the local integrated governance group, if appropriate a detailed action plan is developed and monitored.

This is supported by an active and open policy encouraging staff to report anything they are unhappy about, without fear of blame. We have policies and procedures in place to encourage staff to report any matters of concern and we take immediate action to address these.

Q: Why has it taken so long to reach an inquest?

A: Each of the four independent and police investigations has taken a period of time to complete. Each investigation was extremely thorough and the NHS has co-operated fully and quickly in each instance. Each of the four investigations concluded that there was no evidence of criminal wrong-doing.

Q: How do you account for the procedural failures that have been identified?

A: It has already been established in the four previous investigations that no criminal act has been committed. The CHI investigation details the procedural shortcomings at that time and we acknowledge that it is regrettable that our predecessor organisation did not have sufficient policies and procedures in place to optimise care in 1998. We are confident that these issues were addressed prior to and after the CHI review and in more general terms by changes in NHS governance and procedures.

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Core messages – <u>please review all</u>

<u>Corporate NHS</u>
Spokesperson - Richard Samuel (NHS Hampshire)

- The NHS in Hampshire supports the coroner's inquest as a valuable opportunity to look again at events of the late 1990s and for the families of the deceased to establish closure.

- We sympathise with relatives for the uncertainty that has surrounded these issues over the last ten years, and also with our staff who have been through four investigations over that period.

- Quality and safety is at the heart of all we do. I would like to reassure people being cared for at GWMH today that the quality of care at Gosport War Memorial Hospital is of the highest standard.

- Friends and relatives of patients should not be alarmed by these inquests which are concerned with incidents which took place more than ten years ago and practices which are now outdated.

- The CHI report found that our predecessor organisation didn't have adequate policies and procedures in place and that there were some elements of care that required improvement. It is a matter of regret to the NHS that in 1996 it was found not to have adequate policies in place to optimise care, however action was subsequently taken and this is no longer the case.

- I would like to reassure people that the right policies and procedures are in place at GWMH now to ensure that the care provided is of the highest standard. The Commission for Health Improvement (CHI) investigation in October 2001 concluded that our predecessor organisation had addressed the issues raised and had put in place adequate policies and guidelines, and that these policies and guidelines were being adhered to. Quality and safety are at the very heart of all we do.

- The care provided by PHT and Hampshire PCT was rated 'excellent' and 'good' by CHI's successor last year and the Hospital received good results from the Patient Environment Action Team (PEAT), which were 'Good' cleanliness, 'Excellent' for food, and 'Good' for privacy and dignity.

Clinical practice Graeme Zaki (PHT); Sue Harriman (HCHC), Dr John Hughes

- Safety and quality is at the heart of everything we do. The way the NHS monitors patient safety and the quality of care has changed considerably since the early 1990s. Staff are now required to report all incidents and 'near misses' and these are immediately logged and reviewed at the local integrated governance group, if appropriate a detailed action plan is developed and monitored.

- This is supported by an active and open policy encouraging staff to report anything they are unhappy about, without fear of blame. We have policies and procedures in place to encourage staff to report any matters of concern and we take immediate action to address these.

- We actively seek to quickly reduce and eliminate risk as an ongoing learning process. Untoward incidents or a pattern of care which suggested that clinical practice is not up to standard would be picked up there and then through these procedures and investigated internally. If necessary the Trust concerned may also commission an external investigation.

- Both PHT and Hampshire PCT have a modern matron working at GWMH. These highly experienced senior nurses are responsible for driving-up standards, ensuring privacy and dignity is protected, and that their wards areas are clean and suitable for their patients, whilst leading by example.

- There are much tighter governance arrangements in place in relation to the prescribing and administration of medicines. Reviews of prescribing practices and all medicines related incidents are reported on the national risk learning database and analysed by the Trust and action plans developed, where

appropriate. HCHC also has a pharmacist who reviews practices and prescribing and also trains and educates staff.

- Portsmouth Hospitals NHS Trust and HPCT are members of the South Central Patient Safety Federation and have a multi-disciplinary approach to integrated working. There are number of work streams in place to improve the safety of patient care, including one on the management and administration of medicines.

- All NHS organisations have well developed clinical audit departments. The quality of services at GWMH is monitored via these audits and feedback from patients on their experiences at the Hospital. HCHC has an audit strategy which includes a stringent timetable for completion of audits and implementation of improvements, where required.

- There are no similarities whatsoever between this matter and the investigation which took place at Fordingbridge Community Hospital. It is not appropriate for me to comment on the Fordingbridge investigation at this current time.

Pharmacy: Neil Hardy (NHS Hampshire)

- As current service providers Hampshire PCT and Portsmouth Hospitals NHS Trust have a range of up-to-date policies and procedures governing the administration of medicines.

- HCHC also has a dedicated pharmacist who reviews practices and prescribing and also trains and educates staff.

- There are now much tighter governance arrangements in place in relation to the prescribing and administration of medicines than there were in the early 1990s. Reviews of prescribing practices and all medicines related incidents are reported on the national risk learning database and analysed by the Trust. Action plans developed, where appropriate.

- Current policies and procedures are regularly reviewed and monitored to ensure that they are adhered to.

Primary Care / GP: Stuart Morgan or LMC representative - TBC

- We are confident that the care provided at Gosport War Memorial Hospital is of the highest standards and have complete confidence in referring our patients to the hospital.

Disciplinary

Following the police investigations and CHI report we have undertaken investigations internally into practice and whether staff are fit to practice.

In September 2002 The Chief Executives of Fareham and Gosport and East Hants PCTs temporarily redeployed whilst independent investigation commissioned by SHA/PCT initiated. This was because they were party to management decisions taken in 1991. In March 2003 they were reinstated.

Ian Piper is currently Chief Executive of Portsmouth Council for Voluntary Services and Chair of the SE LIFT co. and Tony Horne is currently working for Portsmouth University on dental education.

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Dr Barton – HPCT Communications line

Dr Jane Barton is a GP working at the Forton Medical Centre in Gosport.

Dr Barton was clinical assistant (part of the general practitioner medical staff) at Gosport War Memorial Hospital from 1st April 1980 until June 2000.

As a result of complaints between 1998 and 2001, from 1st October 2002 onwards (following the publication of the CHI report) Dr Barton voluntarily undertook to not prescribe benzodiazepines or opiate analgesics. Patients requiring ongoing therapy with such drugs were transferred to other partners within the practice, with patients' agreement, so that their care was not compromised. Dr Barton elected not to accept any house visits if there was a possible need for such drugs to be prescribed. Medicines Review Management has reviewed this on a regular basis since 2002 providing the PCT with ongoing auditable assurance. No breaches or problems have been evident throughout this time and the review process continues.

In 2000 Dr Barton resigned from her role as clinical assistant at GWMH to concentrate on her role as a GP. Her position at GWMH was filled by a full time staff grade doctor, later increased to two full time staff grade doctors.
Hampshire PCT is not aware of any complaints that have been made regarding Dr Barton's work as a GP, however under the NHS Complaints Regulations, General Practitioners have the right to handle complaints directly.

In 2008 Hampshire PCT's performance and regulation panel undertook an investigation into Dr Barton's practice and found that she was fit to practice with these voluntary restrictions. The General Medical Council (GMC) also conducted an investigation into Dr Barton's practice in 2008 and found her fit to practice with these restrictions formalised.

The GMC wrote to Hampshire PCT in July 2008 and the PCT submitted information about Dr Barton's voluntary prescribing restrictions relating to benzodiazepines and opiate analgesics. These were formalised by the GMC on 17th July 2008. Dr Barton is the subject of a GMC hearing in July / August 2009.