Gosport War Memorial Hospital - The Baker Report - A Review of the Deaths of Patient at Gosport War Memorial Hospital

Due to be published 2 August 2013

Background:

Inquiry report due to be published by the Department of Health into deaths at Gosport War Memorial Hospital at the end of July. The report was commissioned by the CMO, Sir Liam Donaldson, in 2002 and finished in 2003 and completed by Dr Richard Baker, Clinical Governance Research and Development Unit, University of Leicester.

Below outlines our actions in circulating the reporting and responding to any press and media enquiries.

Action plan:

Action	Status update	Lead
Engage with CCG on approach and agree how to take forward	• **NB to speak with Sara Tiller and Sarette Martin** • Sara Tiller (CCG) is speaking to Gail Rossiter (NHS England) as it is not thought that the CCG should be fronting any response as it was a different organisation who commissioned the hospital in 2002 and the report was written so long ago. Feelings are that they will not agree to front it. • Sarette Martin to update NB on outcomes of conversations. **OUTCOME: NHS England will front any media for the publication of the report but we still may be contacted for comment.**	**NB**
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Circulate report to interested parties when published	**NB to monitor DoH website and speak to CCG colleagues to find out when due to be published** **OUTCOME: Report due to be published 2 August. Embargoed copy circulated to colleagues 31 July.**	**NB**

NB to lialise with Jude Diggins, CCG, Gethin Hughes around lines and actions and report back	**NB to prepare briefing and circulate for feedback OUTOME: NB circulated briefing 31 July 2013.**	**NB**

Risks and concerns:

Although the paper makes a number of recommendations to the level of care and processes, it must be noted that these have been either implemented over the last ten years or that clinical practice has changed making the recommendations obsolete. Jude Diggins to advise further should we be asked about specific recommendations. Although we will not be responding to media interest it is likely that we will be associated with the report which is a potential reputational risk. All coverage will be logged and monitored throughout.

Potential Media Interest:

- The Portsmouth News has spoken to Gillian Mackenzie (daughter of Gladys Richards - last inquest) so it is likely that they will be running with this story and will look for comment. We were not approached by Portsmouth News directly following the last inquest, but they did attend and cover it.
- In the past the cases and inquests have attracted a lot of regional and national media attention and this report has been pushed for by families so we should expect quite a lot of interest.
- CCG are looking for NHS England to front the response to the report and are claiming no involvement. Portsmouth Hospitals NHS Trust did not attend the last inquest and have remained quiet throughout. Therefore it is likely that if media cannot get a response from those more directly involved they may come to us for comment.

Potential media angles to be aware of:

- "Trust did not listen to staff concerns around the pre-prescribing of diamorphone." Could link with recent news around whistleblowing in the NHS.
- "Inappropriate use of diamorphine in pain control and end of life care". Could raise questions around the current use of diamorphine and processes in place to assess pain and deterioration.
- "End of life care not delivered well in NHS" could raise questions around Liverpool Care Pathway and how we deliver end of life care.
- Incomplete record keeping
- Some patients considered in the review it is believed could have made a full recovery and returned home.

Additional information to send to CQC

- Going Viral/Viral Quality etc (Leadership Development)
- Weekly Bulletin/Journal
- Research and Development
- National awards received (E&D already submitted)
- Star awards (this year's shortlisted applications)
- Patient Experience reports/ team performance reporting (Simon B)
- Quality Programme
- Outcome measures work – including PROMs/PREMs (Chris Woodfine)
- The Recovery College (Kate Sault)
- Operation Serenity (mental health crisis care partnership with police – Colin Edwards)
- Values-based recruitment (Lorna Mills)
- Joint Safeguarding newsletter
- Equality and Diversity

Baker Report – statement

Richard Samuel, chief officer at NHS Fareham & Gosport Clinical Commissioning Group (CCG) said: "We welcome the publication of Professor Richard Baker's report, and hope that this helps to bring closure to the families of those patients whose deaths in the 1990s have been the subject of numerous enquiries and investigations.

"We will need time to study the detail of Prof Baker's 2002 report to fully assess whether any further action is required by the CCG.

"Previous investigations have included three by the police, all of which found that there was insufficient evidence to support any prosecution. In addition, the Commission for Health Improvement (CHI) – the health regulator at the time – published a report with recommendations in 2002, all of which have been met. Eleven inquests have also taken place into deaths at the hospital, and a GMC hearing. We understand that the Baker report was used by all these bodies in undertaking their investigations.

"Much has changed at Gosport War Memorial Hospital in the last decade, in line with clinical developments across the country. Investment totalling £16.5 million has also been spent modernising the hospital.

"The CCG, which has been in operation since 1 April 2013, works closely with providers of healthcare services at the hospital, and monitors the quality of care that patients receive. Regular quality review meetings also take place with the trusts whose staff provide that care, and staff receive mandatory training every year.

"I would like to reassure local people that NHS Fareham & Gosport CCG is constantly working to ensure that patients at Gosport War Memorial Hospital receive care of the highest order."

ENDS

Notes to reporters:

1. It is recognised that national methods of capturing mortality data do not give a helpful picture of mortality in community or mental health hospitals, in part because relatively low bed numbers in individual sites can prevent meaningful statistical analysis. Southern Health NHS Foundation Trust, which provides physical and mental health services at the hospital, is looking at working with the Health and Social Care Data Centre to consider ways to make quantitative analysis of mortality rates more meaningful.

2. The CHI was satisfied at the time of its report that Gosport War Memorial Hospital had adequate policies and guidelines in place governing the prescription and administration of pain-relieving medication to older patients, and that these policies and procedures were being adhered to. This remains the case.
3. NHS Fareham & Gosport CCG took over responsibility for commissioning healthcare for residents of the two towns on 1 April 2013, following the abolition of primary care trusts.

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Gosport War Memorial Hospital Patient Inquest

Media Briefing Pack

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Contents

1. Gosport War Memorial Hospital Inquest

On 9th April a coroner's inquest into the death of Gladys Richards at Gosport War Memorial Hospital (GWMH) in 1998 will begin. The inquest is scheduled for two weeks. There have been ten previous inquests into the deaths of patients at the hospital that date from the late 1990s and a number of investigations following up concerns over the care provided at the hospital around that time. Given the length of time that has passed since these incidents took place, it is perhaps not surprising that organisations and services have changed over that time, sometimes more than once, so the purpose of this briefing paper is to provide some information which seeks to set out the background to this case.

2 Timeline of key events

- In 1998 the police undertook an investigation into the death of a patient whose family were not happy about the circumstances of their death at Gosport War Memorial Hospital (GWMH). In March 1999 the Crown Prosecution Service (CPS) decided that there was insufficient evidence to bring a successful prosecution.
- In 1998 there was a complaint to the NHS Commissioner (Ombudsman) about the care of a different patient. This death is not the subject of an inquest.
- In 2001 there was an independent NHS review panel into the care of a third patient which was subsequently referred to the NHS Commissioner. The Commissioner concluded that the prescribing was appropriate in the circumstances. This death was the subject of a previous inquest.
- In 1999 following publicity surrounding the initial investigation, the Police looked at the notes of four more patients who had died at GWMH. In February 2002 the police decided there was no evidence for a prosecution and they were not going to investigate further.
- In the course of their investigation the Police alerted the Commission for Health Improvement (CHI) in August 2001 and CHI commenced an investigation in October 2001.
- In July 2002 CHI published a report with recommendations.
- In November 2002 Fareham and Gosport and East Hampshire PCTs produced a joint action plan to address the recommendations made in the CHI report.
- In September 2002 the Police began a third investigation into the deaths of patients at GWMH.

- In January 2004 the Fareham and Gosport Clinical Governance group took over responsibility for overseeing the CHI action plan and ensuring objectives were met.
- In October 2006 Portsmouth Hospitals NHS Trust took over the management of services for Medicine for Older People throughout South East Hampshire including those provided at Gosport War Memorial Hospital.
- Following detailed investigation which included expert reports the Police handed the outcome of their investigation into ten deaths to the Crown Prosecution Service (CPS) in July 2006.
- In October 2007 the CPS concluded that there was insufficient evidence to prosecute any health care staff.
- This Police report was passed to HM Coroner in early 2008.
- Following discussion 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 in August 2007 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 in May 2008. The names did not include one of the early original cases – Gladys Richards, although an inquest was (to be held in April 2013) was later agreed.
- 10 Inquests took place in March 2009. The jury ruled that medication **did not** contribute to the deaths of five patients: Leslie Pittock, Helena Service, Ruby Lake, Enid Spurgin and Sheila Gregory. The verdict indicated that the medication administered to.Robert Wilson, Elsie Devine and Geoffrey Packman had contributed to their deaths but it was given for therapeutic reasons and was appropriate for their condition. Medication also contributed to the death of Elsie Lavender and Arthur Cunningham (known as Brian), but it was given for therapeutic reasons and was appropriate for their condition.
- Dr Barton was the subject of a GMC Fitness to Practice hearing in 2010. The hearing concluded that Dr Barton could continue to practice with restrictions, particularly on her prescribing practice.
- Dr Barton voluntarily removed herself from the GMC register in 2011.

3. What happens at the Hospital now?

Since the time of these deaths over ten years ago and the subsequent CHI review in 2002 much has changed at Gosport War Memorial Hospital, in line with developments in clinical practice across the country.

1991 saw the commencement of a £10.5 million, two-phase development which was complete in 1995. This was followed by a £6m redevelopment in the last year.

The Hospital now houses:

- 20 bedded community ward for GP admissions and acute 'step down' beds
- 33 beds for older peoples' mental health (17 beds on Deadalus Ward and 16 beds on Dryad Ward)
- 20 rehabilitation beds on Ark Royal Ward
- Blake birth centre
- Occupational Therapy and Physiotherapy to support the community wards (with some outreach into the community)
- Two Day Hospitals for older people
- X-ray and ultrasound
- Out Patient Clinics provided on behalf of external organisations
- Red Cross
- Minor injuries unit
- Endoscopy unit
- Community health clinics
- GP Out of Hours Service

By the time of the CHI investigation in 2002 the regulator was satisfied that GWMH_had adequate policies and guidelines in place governing the prescription and administration of pain relieving medicines to older patients and that these policies and procedures were being adhered to. This remains the case and there have been no incidents subsequently which have required external investigation by CHI or its successor the Care Quality Commission or the Police.

Policies and procedures at the Hospital are reviewed regularly and staff receive mandatory training every year.

The Patient Environment Action Team inspection last year (2012) rated the Hospital as excellent on cleanliness, excellent for food and good for privacy and dignity. Patient

experience surveys are conducted regularly and feedback is very positive, with comments including 'privacy and dignity is well respected' and 'cleanliness impeccable'.

There were six complaints for the PHT Department of Medicine for Older people, Stroke and Rehabilitation last year (this includes PHT wards and activity based at both GWMH and QAH) with a further five complaints relating to other wards at GWMH. All complaints are taken very seriously and investigated internally in line with the relevant organisations complaints policy. However, where appropriate organisations work together to ensure an integrated, in-depth investigation is completed to inform the response and appropriate future action. In addition to this, to note, during 2007/2008 all complaints received were investigated and resolved locally.

In addition to the complaints received, Gosport War Memorial Hospital as a whole also receives many thanks and compliments from patients and their families, with over 200 cards and letters received last year.

Staff at the Hospital received a Chairman's award from Portsmouth Hospitals NHS Trust Chairman in 2007 for their professionalism and dedication.

In 2008 Portsmouth Hospitals NHS Trust's modern matron at GWMH received a Clinical Governance Award from the Trust's Patient Experience Council.

In 2012 Sultan Ward was runner up in The Portsmouth News Best of Health Awards for Hospital team of the Year.

4. NHS organisation structure summary in SE Hampshire 1994 – present

- Portsmouth Healthcare NHS Trust managed the Department of Medicine for Elderly People from April 1994 until March 2002 when it was dissolved. Portsmouth Healthcare NHS Trust was a predecessor of PCTs and a separate organisation from Portsmouth Hospitals NHS Trust.
- In April 2002 responsibility for the services transferred to Fareham and Gosport PCT and East Hampshire PCT.
- In April 2006 responsibility for commissioning and providing the services transferred to Hampshire PCT.
- In October 2006 responsibility for Dryad and Daedalus wards and the employment of the nursing and medical staff transferred to Division of Medicine for Older People (DMOP) at Portsmouth Hospitals NHS Trust.

- Sultan Ward remained the responsibility of Hampshire Community Healthcare and Hampshire Partnership NHS Trust remained responsible for Older People's Mental Health Services in Ark Royal and Collingwood wards. At a later date, PHT then took over responsibility for Ark Royal Ward and Collingwood ward closed as a rehab unit to reopen at a later date as a Rapid Assessment Unit, provided by Southern Health.
- In 2011 Hampshire Community Healthcare merged with Hampshire Partnership bringing together mental and physical health services in preparation for foundation trust status.
- Southern Health NHS Foundation Trust (previously organisations as detailed above) was awarded foundation trust status in Spring 2011.
- In 2013 Fareham and Gosport CCG took over responsibility for commissioning the services at GWMH from Hampshire PCT.

5. Questions and answers

The questions below are intended to provide some general background about this particular case.

a) General interest

Q. What is an inquest?

A. An inquest is a limited fact-finding inquiry to establish the answers to

- **who** has died,
- **when** and **where** the death occurred, and
- **how** the cause of death arose

An inquest is not a trial. It is an inquiry into the facts surrounding a death. It is not the job of the coroner to blame anyone for the death, as a trial would do, and there are no speeches. However, the Coroner does have the power to investigate the main cause of death and also "any acts or omissions which directly led to the cause of death".

Q. What is this inquest concerned with?

A. This inquest is concerned with the death of Gladys Mable RICHARDS in August 1998. She was an in-patient at Gosport Ward Memorial Hospital at the time of her death.

Q. Isn't it rare to have an inquest 15 years after the death of a person and in the absence of a body or post mortem reports?

A. Yes it is, however an inquest is an opportunity for families to get some answers about how their loved ones died.

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

A. The police investigations focused on whether there was any evidence of criminality with respect to this patient's death at Gosport War Memorial hospital. The role of an inquest is to determine how a person met their death and potentially the circumstances surrounding their death.

Q. Is this inquest related to ten others held four years ago?

A. Yes it is. In 2009, the Portsmouth Coroner, David Horsley, heard ten inquests into the deaths of patients at the Gosport War Memorial Hospital. These cases came to light after the death of Gladys Richards was investigated by the police and highlighted in the media. At the time this patient wasn't included in the list, hence the separate inquest now.

Q. How were patients cared for at GWMH at the time?

A. At the time, a local Gosport GP was employed to work as clinical assistant to provide junior medical cover at GWMH. The GP worked under the guidance of a consultant and visited Dryad and Daedalus wards at GWMH each morning, Monday to Friday. The GP surgery provided an out of hours service with one of the partners attending the wards for specific needs when required. Each ward had a consultant round approximately once a week, a different consultant covering each ward. The consultants, all geriatricians, were based at Queen Alexandra Hospital in Portsmouth. Their clinical caseload could include a day hospital session and/or outpatient session at GWMH, and thus they were present on the GWMH site for advice at specific periods in addition to their ward rounds.

Q. How was diamorphine prescribed and administered at GWMH?

A. Each ward had a controlled drug book in which would be entered details of the ward stock levels of the drug in question; the amount administered to any patient at a specific time and date, and a running total of the stock.

Before nursing staff could administer a controlled drug, the stock levels and the amount to be given would have to be checked by two members of staff. They would then draw it up and prepare the syringe. The syringe driver mechanism would then be set to release the amount of medication prescribed for the 24-hour period.

Q. What is meant by palliative care?

A. The term palliative care means treating symptoms (e.g. pain, nausea, vomiting etc) rather than trying to cure an illness. This approach is taken when it is recognised that a cure is not possible or may in itself pose unacceptable risks, and this could be for a number of reasons.

Q. What was the approach to end of life care at GWMH.?

A. Health services must always be subjected to public scrutiny; however issues around pain relief and end of life care are seldom clear cut.

Some of the complaints at the time related to the ability of staff to talk to families and it has become clear that often friends and relatives were not properly informed or aware that a palliative care approach was being taken.

Since then a range of new approaches to end of life care have been introduced designed to drive up sustained quality of care in the last hours and days of life.

b) Family Concerns Over Patient Care Q&A

Q. What opportunities were there for family members to raise concerns about the care of a loved one?

A. The hospital had a complaints procedure in place, which could be accessed by the family as well as patients. Complaints and concerns could also have been raised with the Trusts running services at the site. At that time patients and their relatives were also able to refer concerns to the NHS Commissioner (Ombudsman).

Q. What has been done to ensure care at the hospital is better now?

A.The Commission for Health Improvement 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.

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 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.

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 the Fareham and Gosport Clinical Commissioning Group doing to ensure patients receive good care?

A. The Fareham and Gosport Clinical Commissioning Group (CCG) is responsible for commissioning or buying/arranging healthcare for residents living in Fareham and in Gosport.

The CCG has detailed quality clauses in its contracts with the NHS Trusts that provide services at Gosport War Memorial Hospital. We monitor the quality of care that patients receive at the hospital regularly which includes reviewing the rates of infections, serious incidents, patient surveys and complaints, and also cross reference this with what local people and patients are saying about care at the hospital. We hold regular quality review meetings with the Trusts where any issues are discussed and our clinicians conduct visits to wards and departments to check the quality of care and services on site.

Q. How will the Clinical Commissioning Group ensure concerns or complaints are heard and acted upon?

A. The CCG believes that it is crucially important to hear about the concerns of patients and/or their families and as a result, it has established a number of mechanisms to ensure this. The community hospital also has a concerns and complaints service in place.

In addition, the CCG receives concerns or complaints from patients or family members and we have a network of patient participation groups, locality patient groups and a Stakeholder Advisory Board where we take feedback from local people about the care they have received. This feedback, along with the quality data is reported regularly to the CCG's Quality and Safety Committee and to our Governing Body.

Both the CCG and the service provider will investigate every concern or complaint raised and will ensure feedback is given to the complainant. In addition, where appropriate, improvements to the services will be enacted as quickly as possible.

The CCG will follow recommendation 109 of the Francis Report to ensure that methods of registering a complaint are readily accessible and easily understood and that opportunities for feedback and complaints are offered to patients and families, both during treatment and after its conclusion.

c) Dr Barton

Q. What happened to Dr Barton after the last inquests?

A. Dr Barton was the subject of a General Medical Council Fitness to Practice hearing in 2010. The hearing concluded that Dr Barton could continue to practice with restrictions, particularly on her prescribing practice.

However Dr Barton took voluntary erasure from the medical register with effect from 9 March 2011 and is no longer able to practise medicine in the UK.

The GMC produces monthly decision circulars. These circulars, which include information about doctors who have been the subject of fitness to practise action or have taken voluntary erasure, are provided to a range of UK bodies and international regulators via email. Dr Barton's name has been included within these circulars on three separate occasions during 2010 and 2011.

NHS Hampshire

Gosport War Memorial Hospital Patient Inquests

Media Briefing Pack

Office hours Communications Team numbers

Hampshire PCT Communications Team: 023 8062 7434

Other contacts:

Royal College of Nursing

Helen Wigginton (SE Press officer): Code A

National press office: 0207 647 3633

Contents

NHS Hampshire

1. Gosport War Memorial Hospital Inquests

HM Coroner has ordered inquests into the deaths of ten patients at Gosport War Memorial Hospital (GWMH) from 1996 – 1999.

The inquest is concerned with the deaths of people who were in-patients on Dryad and Daedalus wards at GWMH.

The inquests are scheduled for six weeks from 18th March 2009 and ten separate verdicts will be delivered at the close of proceedings. The coroner is A.M. Bradley, HM Assistant Deputy Coroner Portsmouth and South East. The inquests will take place at Portsmouth Combined Court, Winston Churchill Avenue, Portsmouth.

Listed Inquests:

- Leslie Pittock (died 24/01/96) Dryad Ward - aged 83
- Elsie Lavender (06/03/96) Daedalus Ward - aged 84
- Robert Wilson (died 18/10/96) Dryad Ward - aged 73
- Helena Service (died 05/06/97) Dryad Ward - aged 99
- Ruby Lake (died 21/08/98) Dryad Ward - aged 85
- Arthur Cunningham (died 26/09/98) Dryad Ward - aged 79
- Enid Spurgeon (died 13/04/99) Dryad Ward - aged 92
- Geoffrey Packman (died 03/09/99) Dryad Ward - aged 68
- Elsie Devine (died 21/11/99) Dryad Ward - aged 88
- Sheila Gregory (died 22/11/1999) Dryad Ward - aged 91

NHS
Hampshire

2. Timeline of key events

- In 1998 the police undertook an investigation into the death of a patient whose family were not happy about the circumstances of their death at Gosport War Memorial Hospital (GWMH). This death will be the subject of a separate inquest.
- In March 1999 the Crown Prosecution Service (CPS) decided that there was insufficient evidence to bring a successful prosecution.
- In 1998 there was a complaint to the NHS Commissioner (Ombudsman) about the care of a different patient. This death is not the subject of an inquest.
- In 2001 there was an independent NHS review panel into the care of a third patient which was subsequently referred to the NHS Commissioner. The Commissioner concluded that the prescribing was appropriate in the circumstances. This death is the subject of an inquest.
- In 1999 following publicity surrounding the initial investigation, the Police looked at the notes of four more patients who had died at GWMH. Two of these deaths are the subject of inquests, Arthur Cunningham, and Robert Wilson. In February 2002 the police decided there was no evidence for a prosecution and they were not going to investigate further.
- In the course of their investigation the Police alerted the Commission for Health Improvement (CHI) in August 2001 and CHI commenced an investigation in October 2001.

CHI

  - In July 2002 CHI published a report with recommendations.
  - In November 2002 Fareham and Gosport and East Hampshire PCTs produced a joint action plan to address the recommendations made in the CHI report.
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- In September 2002 the Police began a third investigation into the deaths of patients at GWMH.
- In October 2006 Portsmouth Hospitals NHS Trust took over the management of services for Medicine for Older People throughout South East Hampshire including those provided at Gosport War Memorial Hospital.
- Following detailed investigation which included expert reports the Police handed the outcome of their investigation into ten deaths to the CPS in July 2006.
- In October 2007 the CPS concluded that there was insufficient evidence to prosecute any health care staff.
- This Police report was passed to HM Coroner in early 2008.
- Following discussion 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 in August 2007 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 in May 2008.

3. Details of investigations

Background

In 1996 GWMH was run by Portsmouth Healthcare NHS Trust (a predecessor of PCTs and a separate organisation from Portsmouth Hospitals NHS Trust).

In April 2002 responsibility for the services transferred to Fareham and Gosport PCT and East Hampshire PCT.

In April 2006 responsibility for Dryad and Daedalus wards and the employment of the nursing and medical staff transferred to Division of Medicine for Older People (DMOP) at Portsmouth Hospitals NHS Trust.
Nursing staff on Sultan Ward transferred to Hampshire PCT and Hampshire Partnership NHS Trust took over responsibility for Older People's Mental Health Services in Ark Royal and Collingwood wards.

In line with national guidance the mental health service was transferred to Dryad and Daedalus wards on the ground floor in Feb 2008.

Early Police investigations

Between 1998 and 2002, Hampshire Constabulary undertook two investigations into the potential unlawful killin of patients at Gosport War Memorial Hospital.

These investigations did not result in any criminal prosecutions, but the police shared their concerns about the care of older people at Gosport War Memorial Hospital (GWMH) 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.

Commission for Health Improvement investigation

In 2001, CHI commenced an investigation into the management, provision and quality of healthcare at Gosport War Memorial Hospital managed by Portsmouth Healthcare NHS Trust (the predecessor of the then Fareham and Gosport PCT and East Hampshire PCT and a different organisation to Portsmouth Hospitals NHS Trust).

NHS Hampshire

On 1st October 2006, responsibility for the provision of inpatient care at GWMH transferred to Portsmouth Hospitals NHS Trust as part of a service reorganisation involving both elderly medicine and elderly mental health services in the area.

CHI concluded that in the late 1990s there had been a failure of Portsmouth Healthcare NHS Trust's systems t ensure good quality patient care, including insufficient local prescribing guidelines, lack of a rigorous, routine review of pharmacy data, and the absence of adequate Trust-wide supervision and appraisal systems.

CHI also concluded that by the time of their investigation, in 2002, the successor PCTs had addressed these. CHI reported that the reconfigured PCTs (Fareham and Gosport PCT and East Hampshire PCT) had adequate policies and guidelines in place governing the prescription and administration of pain relieving medicines to old patients and that these policies and procedures were being adhered to.

Outcome of the final Police investigation

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. Following these contacts the police initiated another investigation into the deaths of patients at GWMH in September 2002.

Following detailed investigation and expert reports ten cases were passed to the Crown Prosecution Service (CPS) for review once the police investigation was complete. The CPS concluded that there was insufficient evidence to prosecute and that there was no realistic prospect of any conviction.

Following the CPS' decision, the police met with the General Medical Council (GMC), the Nursing and Midwifer 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. No NHS representation occurred at the pre-inquest review as the invitation did not reach the appropriate people within the NHS.

The Coroner has announced that he intends to conduct separate inquests into each death, and has set aside six weeks for the inquests to take place. Verdicts into each death will be reached when all inquests have been concluded.

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

The Police forwarded papers to the General Medical Council and Nursing and Midwifery Council and each organisation is undertaking its own inquiries.

4. What happens at the Hospital now?

Since the time of these deaths over ten years ago and the subsequent CHI review in 2002 much has changed at Gosport War Memorial Hospital, in line with developments in clinical practice across the country.

1991 saw the commencement of a £10.5 million, two-phase development which was complete in 1995. This was followed by a £6m redevelopment in the last year.

The Hospital now houses:

- 20 bed GP ward
- 32 beds for older peoples' mental health
- 35 beds for stroke and general rehabilitation
- Blake birth centre
- Physiotherapy department
- Two day hospitals for older people
- X-ray and ultrasound
- Red Cross
- Minor injuries unit
- Endoscopy unit
- Community health clinics
- GP Out of Hours Service

By the time of the CHI investigation in 2002 the regulator was satisfied that GWMH had adequate policies and guidelines in place governing the prescription and administration of pain relieving medicines to older patients and that these policies and procedures were being adhered to. This remains the case and there have been no incidents subsequently which have required external investigation by CHI or its successor the Healthcare Commission or the Police.

Policies and procedures at the Hospital are reviewed regularly and staff receive mandatory training every year. Details of the policies in place on Sultan ward can be found at:

NHS Hampshire

http://www.hampshirepct.nhs.uk/index/documents/policies-home/policies-clinical.htm
Details of policies in place on Ark Royal and Collingwood wards are available from Portsmouth Hospitals NHS Trust on request.

The Patient Environment Action Team inspection last year rated the Hospital as good on cleanliness, excellent for food and good for privacy and dignity. Patient experience surveys are conducted regularly and feedback is very positive, with comments including 'privacy and dignity is well respected' and 'cleanliness impeccable'.

There were six complaints for the whole of the Department of Medicine for Older people, Stroke and Rehabilitation last year (this includes GWMH and QAH) and five for the other wards at GWMH. All complaints are taken very seriously and investigated internally in line with the PCT and Trust's complaints policy. All complaints in 2007/2008 were resolved locally.

The Hospital also receives many thanks and compliments from patients and their families, with over 200 cards and letter last year.

Staff at the Hospital received a Chairman's award from Portsmouth Hospitals NHS Trust Chairman in 2007 for their professionalism and dedication.

In 2008 Portsmouth Hospitals NHS Trust's modern matron at GWMH received a Clinical Governance Award from the Trust's Patient Experience Council. This award of £9773 contributed to the installation of cushioned floor in both wards, to minimize injury if a patient should experience a fall during rehabilitation.

In February 2009 Ark Royal, Collingwood and Sultan wards have benefitted from anti microbial curtains and new bedside lockers and tables which are much easier to clean. Overhead hoists are available over every bed and in bathrooms and the Trust have increased call bells in day room areas enhancing patient safety.

In 2008/09 Portsmouth Hospitals NHS Trust was independently assessed as providing an 'excellent' quality of services by the Healthcare Commission (formerly CHI).

NHS Hampshire

5. Questions and Answers

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.

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.

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 of criminality with respect to patient deaths at Gosport War Memorial Hospital. 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. 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 substantive posts.

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

Following the CHI investigation in October 2001, CHI concluded that the PCTs had addressed the issues raised and 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.

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

organisations 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 will 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.

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NHS Hampshire

6. Organisation structure in South East Hampshire 1994 – present

Organisational Structure

- Portsmouth Healthcare NHS Trust managed the Department of Medicine for Elderly People from April 1994 until March 2002 when it was dissolved. Portsmouth Healthcare NHS Trust was a predecessor of PCTs and a separate organisation from Portsmouth Hospitals NHS Trust.
- In April 2002 responsibility for the services transferred to Fareham and Gosport PCT and East Hampshire PCT.
- In October 2006 responsibility for Dryad and Daedalus wards and the employment of the nursing and medical staff transferred to Division of Medicine for Older People (DMOP) at Portsmouth Hospitals NHS Trust.
- At the same time nursing staff on Sultan Ward transferred to Hampshire PCT and Hampshire Partnership NHS Trust took over responsibility for Older People's Mental Health Services in Ark Royal and Collingwood wards.

* Portsmouth Healthcare NHS Trust is not the same organisation as Portsmouth Hospitals NHS Trust

DRAFT

Gosport War Memorial Hospital Patient Inquest

Media Briefing Pack

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Contents

1. Gosport War Memorial Hospital Inquest

On 9th April a coroner's inquest into the death of Gladys Richards at Gosport War Memorial Hospital (GWMH) in 1998 will begin. The inquest is scheduled for two weeks. There have been ten previous inquests into the deaths of patients at the hospital that date from the late 1990s and a number of investigations following up concerns over the care provided at the hospital around that time. Given the length of time that has passed since these incidents took place, it is perhaps not surprising that organisations and services have changed over that time, sometimes more than once, so the purpose of this briefing paper is to provide some information which seeks to set out the background to this case.

2 Timeline of key events

- In 1998 the police undertook an investigation into the death of a patient whose family were not happy about the circumstances of their death at Gosport War Memorial Hospital (GWMH). In March 1999 the Crown Prosecution Service (CPS) decided that there was insufficient evidence to bring a successful prosecution.
- In 1998 there was a complaint to the NHS Commissioner (Ombudsman) about the care of a different patient. This death is not the subject of an inquest.
- In 2001 there was an independent NHS review panel into the care of a third patient which was subsequently referred to the NHS Commissioner. The Commissioner concluded that the prescribing was appropriate in the circumstances. This death was the subject of a previous inquest.
- In 1999 following publicity surrounding the initial investigation, the Police looked at the notes of four more patients who had died at GWMH. In February 2002 the police decided there was no evidence for a prosecution and they were not going to investigate further.
- In the course of their investigation the Police alerted the Commission for Health Improvement (CHI) in August 2001 and CHI commenced an investigation in October 2001.
- In July 2002 CHI published a report with recommendations.
- In November 2002 Fareham and Gosport and East Hampshire PCTs produced a joint action plan to address the recommendations made in the CHI report.
- In September 2002 the Police began a third investigation into the deaths of patients at GWMH.

- In January 2004 the Fareham and Gosport Clinical Governance group took over responsibility for overseeing the CHI action plan and ensuring objectives were met.
- In October 2006 Portsmouth Hospitals NHS Trust took over the management of services for Medicine for Older People throughout South East Hampshire including those provided at Gosport War Memorial Hospital.
- Following detailed investigation which included expert reports the Police handed the outcome of their investigation into ten deaths to the Crown Prosecution Service (CPS) in July 2006.
- In October 2007 the CPS concluded that there was insufficient evidence to prosecute any health care staff.
- This Police report was passed to HM Coroner in early 2008.
- Following discussion 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 in August 2007 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 in May 2008. The names did not include one of the early original cases – Gladys Richards, although an inquest was (to be held in April 2013) was later agreed.
- 10 Inquests took place in March 2009. The jury ruled that medication **did not** contribute to the deaths of five patients: Leslie Pittock, Helena Service, Ruby Lake, Enid Spurgin and Sheila Gregory. The verdict indicated that the medication administered to.Robert Wilson, Elsie Devine and Geoffrey Packman had contributed to their deaths but it was given for therapeutic reasons and was appropriate for their condition. Medication also contributed to the death of Elsie Lavender and Arthur Cunningham (known as Brian), but it was given for therapeutic reasons and was appropriate for their condition.
- Dr Barton was the subject of a GMC Fitness to Practice hearing in 2010. The hearing concluded that Dr Barton could continue to practice with restrictions, particularly on her prescribing practice.
- Dr Barton voluntarily removed herself from the GMC register in 2011.

3. What happens at the Hospital now?

Since the time of these deaths over ten years ago and the subsequent CHI review in 2002 much has changed at Gosport War Memorial Hospital, in line with developments in clinical practice across the country.

1991 saw the commencement of a £10.5 million, two-phase development which was complete in 1995. This was followed by a £6m redevelopment in the last year.

The Hospital now houses:

- 20 bed GP ward
- 32 beds for older peoples' mental health
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- Community health clinics
- GP Out of Hours Service

By the time of the CHI investigation in 2002 the regulator was satisfied that GWMH had adequate policies and guidelines in place governing the prescription and administration of pain relieving medicines to older patients and that these policies and procedures were being adhered to. This remains the case and there have been no incidents subsequently which have required external investigation by CHI or its successor the Care Quality Commission or the Police.

Policies and procedures at the Hospital are reviewed regularly and staff receive mandatory training every year.

The Patient Environment Action Team inspection last year (2012) rated the Hospital as excellent on cleanliness, excellent for food and good for privacy and dignity. Patient experience surveys are conducted regularly and feedback is very positive, with comments including 'privacy and dignity is well respected' and 'cleanliness impeccable'.

There were six complaints for the whole of the Department of Medicine for Older people, Stroke and Rehabilitation last year (this includes GWMH and QAH) and five for the other wards at GWMH. All complaints are taken very seriously and investigated internally in line with the PCT and Trust's complaints policy. All complaints in 2007/2008 were resolved locally.

The Hospital also receives many thanks and compliments from patients and their families, with over 200 cards and letter last year.

Staff at the Hospital received a Chairman's award from Portsmouth Hospitals NHS Trust Chairman in 2007 for their professionalism and dedication.

In 2008 Portsmouth Hospitals NHS Trust's modern matron at GWMH received a Clinical Governance Award from the Trust's Patient Experience Council.

In 2012 Sultan Ward was runner up in The Portsmouth News Best of Health Awards for Hospital team of the Year.

4. NHS organisation structure summary in SE Hampshire 1994 – present

- Portsmouth Healthcare NHS Trust managed the Department of Medicine for Elderly People from April 1994 until March 2002 when it was dissolved. Portsmouth Healthcare NHS Trust was a predecessor of PCTs and a separate organisation from Portsmouth Hospitals NHS Trust.
- In April 2002 responsibility for the services transferred to Fareham and Gosport PCT and East Hampshire PCT.
- In April 2006 responsibility for commissioning and providing the services transferred to Hampshire PCT.
- In October 2006 responsibility for Dryad and Daedalus wards and the employment of the nursing and medical staff transferred to Division of Medicine for Older People (DMOP) at Portsmouth Hospitals NHS Trust.
- Sultan Ward remained the responsibility of Hampshire PCT and Hampshire Partnership NHS Trust took over responsibility for Older People's Mental Health Services in Ark Royal and Collingwood wards.
- In 2010 nursing staff transferred into Hampshire Partnership NHS Trust
- In 2011 Hampshire Partnership Trust gained foundation trust status and became Southern Health NHS Foundation Trust
- In 2013 Fareham and Gosport CCG took over responsibility for commissioning the services at GWMH from Hampshire PCT.

5. Questions and answers

The questions below are intended to provide some general background about this particular case.

a) General interest

Q. What is an inquest?

A. An inquest is a limited fact-finding inquiry to establish the answers to

- **who** has died,
- **when** and **where** the death occurred, and
- **how** the cause of death arose

An inquest is not a trial. It is an inquiry into the facts surrounding a death. It is not the job of the coroner to blame anyone for the death, as a trial would do, and there are no speeches. However, the Coroner does have the power to investigate the main cause of death and also "any acts or omissions which directly led to the cause of death".

Q. What is this inquest concerned with?

A. This inquest is concerned with the death of Gladys Mable RICHARDS in August 1998. She was an in-patient at Gosport Ward Memorial Hospital at the time of her death.

Q. Isn't it rare to have an inquest 15 years after the death of a person and in the absence of a body or post mortem reports?

A. Yes it is, however an inquest is an opportunity for families to get some answers about how their loved ones died.

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

A. The police investigations focused on whether there was any evidence of criminality with respect to this patient's death at Gosport War Memorial hospital. The role of an inquest is to determine how a person met their death and potentially the circumstances surrounding their death.

Q. Is this inquest related to ten others held four years ago?

A. Yes it is. In 2009, the Portsmouth Coroner, David Horsley, heard ten inquests into the deaths of patients at the Gosport War Memorial Hospital. These cases came to light after the death of Gladys Richards was investigated by the police and highlighted in the media. At the time this patient wasn't included in the list, hence the separate inquest now.

Q. How were patients cared for at GWMH at the time?

A. At the time, a local Gosport GP was employed to work as clinical assistant to provide junior medical cover at GWMH. The GP worked under the guidance of a consultant and visited Dryad and Daedalus wards at GWMH each morning, Monday to Friday. The GP surgery provided an out of hours service with one of the partners attending the wards for specific needs when required. Each ward had a consultant round approximately once a week, a different consultant covering each ward. The consultants, all geriatricians, were based at Queen Alexandra Hospital in Portsmouth. Their clinical caseload could include a day hospital session and/or outpatient session at GWMH, and thus they were present on the GWMH site for advice at specific periods in addition to their ward rounds.

Q. How was diamorphine prescribed and administered at GWMH?

A. Each ward had a controlled drug book in which would be entered details of the ward stock levels of the drug in question; the amount administered to any patient at a specific time and date, and a running total of the stock.

Before nursing staff could administer a controlled drug, the stock levels and the amount to be given would have to be checked by two members of staff. They would then draw it up and prepare the syringe. The syringe driver mechanism would then be set to release the amount of medication prescribed for the 24-hour period.

Q. What is meant by palliative care?

A. The term palliative care means treating symptoms (e.g. pain, nausea, vomiting etc) rather than trying to cure an illness. This approach is taken when it is recognised that a cure is not possible or may in itself pose unacceptable risks, and this could be for a number of reasons.

Q. What was the approach to end of life care at GWMH.?

A. Health services must always be subjected to public scrutiny; however issues around pain relief and end of life care are seldom clear cut.

Some of the complaints at the time related to the ability of staff to talk to families and it has become clear that often friends and relatives were not properly informed or aware that a palliative care approach was being taken.

Since then a range of new approaches to end of life care have been introduced designed to drive up sustained quality of care in the last hours and days of life.

b) Family Concerns Over Patient Care Q&A

Q. What opportunities were there for family members to raise concerns about the care of a loved one?

A. The hospital had a complaints procedure in place, which could be accessed by the family as well as patients. Complaints and concerns could also have been raised with the Trusts running services at the site. At that time patients and their relatives were also able to refer concerns to the NHS Commissioner (Ombudsman).

Q. What has been done to ensure care at the hospital is better now?

A.The Commission for Health Improvement 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.

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 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.

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 the Fareham and Gosport Clinical Commissioning Group doing to ensure patients receive good care?

A. The Fareham and Gosport Clinical Commissioning Group (CCG) is responsible for commissioning or buying/arranging healthcare for residents living in Fareham and in Gosport.

The CCG has detailed quality clauses in its contracts with the NHS Trusts that provide services at Gosport War Memorial Hospital. We monitor the quality of care that patients receive at the hospital regularly which includes reviewing the rates of infections, serious incidents, patient surveys and complaints, and also cross reference this with what local people and patients are saying about care at the hospital. We hold regular quality review meetings with the Trusts where any issues are discussed and our clinicians conduct visits to wards and departments to check the quality of care and services on site.

Q. How will the Clinical Commissioning Group ensure concerns or complaints are heard and acted upon?

A. The CCG believes that it is crucially important to hear about the concerns of patients and/or their families and as a result, it has established a number of mechanisms to ensure this. The community hospital also has a concerns and complaints service in place.

In addition, the CCG receives concerns or complaints from patients or family members and we have a network of patient participation groups, locality patient groups and a Stakeholder Advisory Board where we take feedback from local people about the care they have received. This feedback, along with the quality data is reported regularly to the CCG's Quality and Safety Committee and to our Governing Body.

Both the CCG and the service provider will investigate every concern or complaint raised and will ensure feedback is given to the complainant. In addition, where appropriate, improvements to the services will be enacted as quickly as possible.

The CCG will follow recommendation 109 of the Francis Report to ensure that methods of registering a complaint are readily accessible and easily understood and that opportunities for feedback and complaints are offered to patients and families, both during treatment and after its conclusion.

c) Dr Barton

Q. What happened to Dr Barton after the last inquests?

A. Dr Barton was the subject of a General Medical Council Fitness to Practice hearing in 2010. The hearing concluded that Dr Barton could continue to practice with restrictions, particularly on her prescribing practice.

However Dr Barton took voluntary erasure from the medical register with effect from 9 March 2011 and is no longer able to practise medicine in the UK.

The GMC produces monthly decision circulars. These circulars, which include information about doctors who have been the subject of fitness to practise action or have taken voluntary erasure, are provided to a range of UK bodies and international regulators via email. Dr Barton's name has been included within these circulars on three separate occasions during 2010 and 2011.

NHS
Hampshire

Statement in relation to Gosport War Memorial Hospital Inquest Verdicts

Director of Performance and Standards for NHS Hampshire, Richard Samuel, said;

"The local NHS sympathises with the families for the uncertainty they have felt around the circumstances of their relatives' death. We sincerely hope that these inquests have provided an opportunity for the families to hear more about the care their relative received and that these verdicts have provided answers for all the families regarding the circumstances of their loved ones' deaths.

"We welcome these verdicts because they give us is the final piece of the jigsaw - whether the prescribing and practices at the time contributed to the deaths of any individual.

"It is important for everyone involved in the care of these patients that all ten verdicts indicate that the patients were cared for appropriately/and that the medication used to treat and relieve their symptoms was correct.

"We are confident that staff were acting in the best interests of their patients at all times. We have fully supported the Coroner's inquests as an opportunity to review the events of the late 1990s. However, our staff and their families have now been subject to a total of five thorough investigations - none of which found any evidence of intent or criminal wrong-doing. We hope for their sake that these matters can now finally be closed.

"The care at Gosport War Memorial Hospital in the mid/late 1990s has been the subject of many investigations in the last ten years. This included a thorough independent investigation in2002 by the then healthcare watchdog - the Commission for Health Improvement. The inquests have confirmed the findings of this review – and that means we can be confident that challenges highlighted by the Inquests have already been addressed.

"Patient safety and quality of care is at the very heart of everything we do at NHS Hampshire and we are confident that the quality of care provided at Gosport War Memorial Hospital is of the highest standard."

Ends…. For further information contact: 023 8062 7434

NHS
Hampshire

Statement in relation to Gosport War Memorial Hospital Inquest Verdicts

Director of Performance and Standards for NHS Hampshire, Richard Samuel, said; "We have fully supported the Coroner's inquests as a valuable opportunity to review the events of the late 1990s and we sympathise with the families for the uncertainty they have felt around the circumstances of their relatives' death.

"It is a matter of regret to the NHS that these ten verdicts indicate that in the mid/late 1990s the treatment or care given to these ten patients has been found to have contributed to their deaths.

"NHS Hampshire will be now be contacting the families of the ten patients, but I would also like to take this opportunity to apologise to the families concerned on behalf of the NHS for any treatment or care which has been found to have contributed to the deaths of their loved ones.

"Since the late 1990s the systems and policies in place at Gosport War Memorial Hospital have undergone a complete overhaul. I can assure the families and local people that all the issues highlighted by these inquests have been addressed and the care at Gosport War Memorial Hospital today is of the highest standard."

- Ends –

For further information contact: 023 8062 7434

NHS Hampshire

Gosport War Memorial Hospital Patient Inquests

Media Briefing Pack

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NHS
Hampshire

1. Gosport War Memorial Hospital Inquests

HM Coroner has ordered inquests into the deaths of ten patients at Gosport War Memorial Hospital (GWMH) from 1996 – 1999.

The inquest is concerned with the deaths of people who were in-patients on Dryad and Daedalus wards at GWMH.

The inquests are scheduled for six weeks from 18th March 2009 and ten separate verdicts will be delivered at the close of proceedings. The coroner is A.M. Bradley, HM Assistant Deputy Coroner Portsmouth and South East. The inquests will take place at Portsmouth Combined Court, Winston Churchill Avenue, Portsmouth.

Listed Inquests:

- Leslie Pittock (died 24/01/96) Dryad Ward - aged 83
- Elsie Lavender (06/03/96) Daedalus Ward - aged 84
- Robert Wilson (died 18/10/96) Dryad Ward - aged 73
- Helena Service (died 05/06/97) Dryad Ward - aged 99
- Ruby Lake (died 21/08/98) Dryad Ward - aged 85
- Arthur Cunningham (died 26/09/98) Dryad Ward - aged 79
- Enid Spurgeon (died 13/04/99) Dryad Ward - aged 92
- Geoffrey Packman (died 03/09/99) Dryad Ward - aged 68
- Elsie Devine (died 21/11/99) Dryad Ward - aged 88
- Sheila Gregory (died 22/11/1999) Dryad Ward - aged 91

NHS Hampshire

2. Timeline of key events

- In 1998 the police undertook an investigation into the death of a patient whose family were not happy about the circumstances of their death at Gosport War Memorial Hospital (GWMH). This death will be the subject of a separate inquest.
- In March 1999 the Crown Prosecution Service (CPS) decided that there was insufficient evidence to bring a successful prosecution.
- In 1998 there was a complaint to the NHS Commissioner (Ombudsman) about the care of a different patient. This death is not the subject of an inquest.
- In 2001 there was an independent NHS review panel into the care of a third patient which was subsequently referred to the NHS Commissioner. The Commissioner concluded that the prescribing was appropriate in the circumstances. This death is the subject of an inquest.
- In 1999 following publicity surrounding the initial investigation, the Police looked at the notes of four more patients who had died at GWMH. Two of these deaths are the subject of inquests, Arthur Cunningham, and Robert Wilson. In February 2002 the police decided there was no evidence for a prosecution and they were not going to investigate further.
- In the course of their investigation the Police alerted the Commission for Health Improvement (CHI) in August 2001 and CHI commenced an investigation in October 2001.

CHI

  - In July 2002 CHI published a report with recommendations.
  - In November 2002 Fareham and Gosport and East Hampshire PCTs produced a joint action plan to address the recommendations made in the CHI report.
  - In January 2004 the Fareham and Gosport Clinical Governance group took over responsibility for overseeing the CHI action plan and ensuring objectives were met.

- In September 2002 the Police began a third investigation into the deaths of patients at GWMH.
- In October 2006 Portsmouth Hospitals NHS Trust took over the management of services for Medicine for Older People throughout South East Hampshire including those provided at Gosport War Memorial Hospital.
- Following detailed investigation which included expert reports the Police handed the outcome of their investigation into ten deaths to the CPS in July 2006.
- In October 2007 the CPS concluded that there was insufficient evidence to prosecute any health care staff.
- This Police report was passed to HM Coroner in early 2008.
- Following discussion 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 in August 2007 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 in May 2008.

3. Details of investigations

Background

In 1996 GWMH was run by Portsmouth Healthcare NHS Trust (a predecessor of PCTs and a separate organisation from Portsmouth Hospitals NHS Trust).

In April 2002 responsibility for the services transferred to Fareham and Gosport PCT and East Hampshire PCT.

In April 2006 responsibility for Dryad and Daedalus wards and the employment of the nursing and medical staff transferred to Division of Medicine for Older People (DMOP) at Portsmouth Hospitals NHS Trust.
Nursing staff on Sultan Ward transferred to Hampshire PCT and Hampshire Partnership NHS Trust took over responsibility for Older People's Mental Health Services in Ark Royal and Collingwood wards.

In line with national guidance the mental health service was transferred to Dryad and Daedalus wards on the ground floor in Feb 2008.

Early Police investigations

Between 1998 and 2002, Hampshire Constabulary undertook two investigations into the potential unlawful killir of patients at Gosport War Memorial Hospital.

These investigations did not result in any criminal prosecutions, but the police shared their concerns about the care of older people at Gosport War Memorial Hospital (GWMH) 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.

Commission for Health Improvement investigation

In 2001, CHI commenced an investigation into the management, provision and quality of healthcare at Gosport War Memorial Hospital managed by Portsmouth Healthcare NHS Trust (the predecessor of the then Fareham and Gosport PCT and East Hampshire PCT and a different organisation to Portsmouth Hospitals NHS Trust).

NHS Hampshire

On 1st October 2006, responsibility for the provision of inpatient care at GWMH transferred to Portsmouth Hospitals NHS Trust as part of a service reorganisation involving both elderly medicine and elderly mental health services in the area.

CHI concluded that in the late 1990s there had been a failure of Portsmouth Healthcare NHS Trust's systems t ensure good quality patient care, including insufficient local prescribing guidelines, lack of a rigorous, routine review of pharmacy data, and the absence of adequate Trust-wide supervision and appraisal systems.

CHI also concluded that by the time of their investigation, in 2002, the successor PCTs had addressed these. CHI reported that the reconfigured PCTs (Fareham and Gosport PCT and East Hampshire PCT) had adequate policies and guidelines in place governing the prescription and administration of pain relieving medicines to old patients and that these policies and procedures were being adhered to.

Outcome of the final Police investigation

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. Following these contacts the police initiated another investigation into the deaths of patients at GWMH in September 2002.

Following detailed investigation and expert reports ten cases were passed to the Crown Prosecution Service (CPS) for review once the police investigation was complete. The CPS concluded that there was insufficient evidence to prosecute and that there was no realistic prospect of any conviction.

Following the CPS' decision, the police met with the General Medical Council (GMC), the Nursing and Midwifer 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. No NHS representation occurred at the pre-inquest review as the invitation did not reach the appropriate people within the NHS.

NHS Hampshire

The Coroner has announced that he intends to conduct separate inquests into each death, and has set aside six weeks for the inquests to take place. Verdicts into each death will be reached when all inquests have been concluded.

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

The Police forwarded papers to the General Medical Council and Nursing and Midwifery Council and each organisation is undertaking its own inquiries.

4. What happens at the Hospital now?

Since the time of these deaths over ten years ago and the subsequent CHI review in 2002 much has changed at Gosport War Memorial Hospital, in line with developments in clinical practice across the country.

1991 saw the commencement of a £10.5 million, two-phase development which was complete in 1995. This was followed by a £6m redevelopment in the last year.

The Hospital now houses:

- 20 bed GP ward
- 32 beds for older peoples' mental health
- 35 beds for stroke and general rehabilitation
- Blake birth centre
- Physiotherapy department
- Two day hospitals for older people
- X-ray and ultrasound
- Red Cross
- Minor injuries unit
- Endoscopy unit
- Community health clinics
- GP Out of Hours Service

By the time of the CHI investigation in 2002 the regulator was satisfied that GWMH had adequate policies and guidelines in place governing the prescription and administration of pain relieving medicines to older patients and that these policies and procedures were being adhered to. This remains the case and there have been no incidents subsequently which have required external investigation by CHI or its successor the Healthcare Commission or the Police.

Policies and procedures at the Hospital are reviewed regularly and staff receive mandatory training every year. Details of the policies in place on Sultan ward can be found at:

NHS Hampshire

http://www.hampshirepct.nhs.uk/index/documents/policies-home/policies-clinical.htm
Details of policies in place on Ark Royal and Collingwood wards are available from Portsmouth Hospitals NHS Trust on request.

The Patient Environment Action Team inspection last year rated the Hospital as good on cleanliness, excellent for food and good for privacy and dignity. Patient experience surveys are conducted regularly and feedback is very positive, with comments including 'privacy and dignity is well respected' and 'cleanliness impeccable'.

There were six complaints for the whole of the Department of Medicine for Older people, Stroke and Rehabilitation last year (this includes GWMH and QAH) and five for the other wards at GWMH. All complaints are taken very seriously and investigated internally in line with the PCT and Trust's complaints policy. All complaints in 2007/2008 were resolved locally.

The Hospital also receives many thanks and compliments from patients and their families, with over 200 cards and letter last year.

Staff at the Hospital received a Chairman's award from Portsmouth Hospitals NHS Trust Chairman in 2007 for their professionalism and dedication.

In 2008 Portsmouth Hospitals NHS Trust's modern matron at GWMH received a Clinical Governance Award from the Trust's Patient Experience Council. This award of £9773 contributed to the installation of cushioned floor in both wards, to minimize injury if a patient should experience a fall during rehabilitation.

In February 2009 Ark Royal, Collingwood and Sultan wards have benefitted from anti microbial curtains and new bedside lockers and tables which are much easier to clean. Overhead hoists are available over every bed and in bathrooms and the Trust have increased call bells in day room areas enhancing patient safety.

In 2008/09 Portsmouth Hospitals NHS Trust was independently assessed as providing an 'excellent' quality of services by the Healthcare Commission (formerly CHI).

NHS Hampshire

5. Questions and Answers

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.

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.

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 of criminality with respect to patient deaths at Gosport War Memorial Hospital. 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. 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 substantive posts.

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

Following the CHI investigation in October 2001, CHI concluded that the PCTs had addressed the issues raised and 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.

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

NHS Hampshire

organisations 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 will 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.

NHS Hampshire

6. Organisation structure in South East Hampshire 1994 – present

Organisational Structure

- Portsmouth Healthcare NHS Trust managed the Department of Medicine for Elderly People from April 1994 until March 2002 when it was dissolved. Portsmouth Healthcare NHS Trust was a predecessor of PCTs and a separate organisation from Portsmouth Hospitals NHS Trust.
- In April 2002 responsibility for the services transferred to Fareham and Gosport PCT and East Hampshire PCT.
- In October 2006 responsibility for Dryad and Daedalus wards and the employment of the nursing and medical staff transferred to Division of Medicine for Older People (DMOP) at Portsmouth Hospitals NHS Trust.
- At the same time nursing staff on Sultan Ward transferred to Hampshire PCT and Hampshire Partnership NHS Trust took over responsibility for Older People's Mental Health Services in Ark Royal and Collingwood wards.

* Portsmouth Healthcare NHS Trust is not the same organisation as Portsmouth Hospitals NHS Trust

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CONFIDENTIAL

Gosport War Memorial Hospital
GR Inquest
Spokesperson's Briefing Pack

INTERNAL REFERENCE DOCUMENT ONLY - NOT FOR EXTERNAL DISTRIBUTION

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Spokespersons and distribution

- Richard Samuel, Chief Officer, Fareham and Gosport CCG
- Sue Harriman, Acting CEO, Southern Health NHS Foundation Trust
- Dr Martyn Diaper, Medical Director, Southern Health NHS Foundation Trust
- Julia Barton, Chief Quality Officer, Fareham and Gosport CCG
- ?, Portsmouth Hospitals NHS Trust

Consultation on legal issues

- Kiran Bhogal, Weightmans

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Communications policy for inquests

Following a consultation process with the communications teams from Fareham and Gosport CCG, Southern Health NHS Foundation Trust and senior management and legal representation from these organisations the following approach to dealing with media enquiries during the inquest has been agreed.

- Media pack to be prepared prior to inquests to provide detailed background information and a selection of Q&As. This will be issued to journalists on request.
- Kiran Bhogal to attend the first day of the inquest accompanied by Carole Kelly and Sarette Martin. Thereafter Carole Kelly will attend to keep a watching brief.
- No interviews or comments to be provided during the course of the inquests on evidence or comments as they arise. Statements to be provided to correct misconceptions or provide policy information where appropriate (in response to requests which might otherwise become FOI requests or to correct misrepresentation). Advice to be sought from Kiran Bhogal in each instance.
- 1-2-1 interviews to be organised at the court post verdict with spokespersons, if required.

It is acknowledged that this approach may result in media seeking information from staff, families, residents etc. Staff will be briefed as to how to handle media requests and on the nature of coverage expected. Patient information will be drafted for current GWMH patients and their families.

Enquiries relating to nurses will be referred to RCN press office.
Enquiries relating to PHT staff will be referred to PHT communications team.
Enquiries relating to Dr Barton will be passed to Dr Barton's legal representation.
Enquiries relating to SHFT will be handled by SHFT communications team.
Enquiries of a 'corporate' nature will be handled by NHS South CSU communications team.

Negative coverage is expected throughout the course of the inquests and it will not be possible to comment on or engage in this coverage while the legal process is in place.

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Media will be informed that it is inappropriate for us to provide comment until all evidence has been heard. There will be opportunities for individual interviews after the verdict has been delivered by the coroner.

Key areas of media interest are anticipated to be:

- Dr Barton;
- The issue of nurses' concerns not being acted upon by management (whistleblowing), with particular reference to Francis report;
- The issue of the family's concerns not being acted upon by management (whistleblowing), with particular reference to Francis report;
- Prescribing practice;
- Policies and procedures with particular reference to the Francis Report eg. patient communication, record keeping.

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Handling media enquiries

Press should identify themselves to you and will have a press badge. They are not permitted to film on NHS premises without prior consent.

Refer enquiries in the first instance to the NHS South CSU communications team.

The communications team is proactively managing media enquiries around the GWMH inquests and will co-ordinate all statements and interviews.

Office hours Communications Team numbers
Main contact number where all calls will be logged and referred to the appropriate team member / spokesperson: **023 8092 684821**

Out of office hours:
NHS South CSU: 07017 362430

Team mobiles :
Sara Tiller, Fareham and Gosport CCG - mobile Code A
Sarette Martin, NHS South CSU - mobile Code A
Emma McKinney, Southern Health NHS Foundation Trust – Code A
Allison Stratford, PHT, – mobile

Other contacts:
Royal College of Nursing
National press office: 0207 647 3633

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Overview

On 9th April a coroner's inquest into the deaths of Gladys Richards at Gosport War Memorial Hospital (GWMH) will commence. The inquest is scheduled for two weeks. The coroner is XXXX, HM Assistant Deputy Coroner Portsmouth and South East. The inquests will take place at Portsmouth Combined Court, Winston Churchill Avenue, Portsmouth.

What is an Inquest?

An inquest is a limited fact-finding inquiry to establish the answers to

- **who** has died,
- **when** and **where** the death occurred, and
- **how** the cause of death arose

An inquest is not a trial. It is an inquiry into the facts surrounding a death. It is not the job of the coroner to blame anyone for the death, as a trial would do, and there are no speeches. However, the Coroner does have the power to investigate the main cause of death and also "any acts or omissions which directly led to the cause of death".

In 2009 there were ten inquests concerning the death of 10 patients at GWMH (average age at time of death: 84)

- Leslie Pittock (died 24/01/96) Dryad Ward - aged 83
- Elsie Lavender (06/03/96) Daedalus Ward - aged 84
- Robert Wilson (died 18/10/96) Dryad Ward - aged 73
- Helena Service (died 05/06/97) Dryad Ward - aged 99
- Ruby Lake (died 21/08/98) Dryad Ward - aged 85
- Gladys Richards (died 22/08/98), aged
- Arthur Cunningham (died 26/09/98) Dryad Ward - aged 79
- Enid Spurgeon (died 13/04/99) Dryad Ward - aged 92
- Geoffrey Packman (died 03/09/99) Dryad Ward - aged 68
- Elsie Devine (died 21/11/99) Dryad Ward - aged 88
- Sheila Gregory (died 22/11/1999) Dryad Ward - aged 91

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Media statement approved for response to initial enquiries

Inquest into deaths at Gosport War Memorial Hospital

A coroner's inquest is being held into the death of Gladys Richards at Gosport War Memorial Hospital in the late 1990s.

The local NHS has been working closely with HM Coroner over the last few months to ensure that all the relevant information is available to support the Coroner's investigation.

We co-operated fully with previous police investigations [1998, 1999 and 2002] and with an earlier independent review by the Commission for Health Improvement (CHI) [2002].

Procedures at Gosport War Memorial Hospital were revised as a result of the earlier enquiries. We are very confident that the hospital provides safe, high quality care to all its patients and will continue to play an important role in local healthcare services for many years to come.

Ends

For further information please contact **023 8092 684821**

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Timeline of events

- In 1998 the police undertook an investigation into the death of Gladys Richards whose family were not happy about the circumstances of their death at Gosport War Memorial Hospital (GWMH). This death is now the subject of this inquest.
- In March 1999 the Crown Prosecution Service (CPS) decided that there was insufficient evidence to bring a successful prosecution.
- In 1998 there was a complaint to the NHS Commissioner (Ombudsman) about the care of a different patient. This death is not the subject of an inquest.
- In 2001 there was an independent NHS review panel into the care of a third patient which was subsequently referred to the NHS Commissioner. The Commissioner concluded that the prescribing was appropriate in the circumstances. This death is the subject of an inquest.
- In 1999 following publicity surrounding the initial investigation, the Police looked at the notes of four more patients who had died at GWMH. Two of these deaths are the subject of inquests, Arthur Cunningham, and Robert Wilson.
- In February 2002 the police decided there was no evidence for a prosecution and they were not going to investigate further.
- In the course of their investigation the Police alerted the Commission for Health Improvement (CHI) in August 2001 and CHI commenced an investigation in October 2001.
- In July 2002 CHI published a report with recommendations.
- In November 2002 Fareham and Gosport and East Hampshire PCTs produced a joint action plan to address the recommendations made in the CHI report.
- In January 2004 the Fareham and Gosport Clinical Governance group took over responsibility for overseeing the CHI action plan and ensuring objectives were met.
- In September 2002 the Police began a third investigation into the deaths of patients at GWMH.
- In October 2006 Portsmouth Hospitals NHS Trust took over the management of services for Medicine for Older People throughout South East Hampshire including those provided at Gosport War Memorial Hospital.

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- Following detailed investigation which included expert reports the Police handed the outcome of their investigation into ten deaths to the CPS in July 2006.
- In October 2007 the CPS concluded that there was insufficient evidence to prosecute any health care staff.
- This Police report was passed to HM Coroner in early 2008.
- Following discussion 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 in August 2007 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 in May 2008. The names did not include one of the early original cases – Gladys Richards.
- Her family objected to this decision and lobbied HM Coroner and the media for an inquest to be held.
- The 10 Inquests took place in March 2009 and attracted significant national publicity.
- The verdicts of the Inquests was.....
- Dr Barton was the subject of a GMC Fitness to Practice hearing in 2010.
- The hearing concluded that XXX
- Br Barton voluntarily removed herself from the GMC register in 2011.

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Organisation structure in South East Hampshire 1994 - Present

Date	Organisation	Function
April 1994	Portsmouth Healthcare NHS Trust established. SI 1993/2569	Department of Medicine for Elderly People provided acute care, stroke care, continuing care, rehabilitation, day hospitals, and outpatient department at QAH and St Mary's Hospitals. Provided both medical and nursing staff on wards at GWMH. Service at GWMH was for continuing care, intermediate care, day hospital and outpatients department.
From April 1995	Portsmouth Hospitals NHS Trust	Provided care at QAH but at this stage was not providing any care at GWMH.
March 2002	Portsmouth Healthcare NHS Trust dissolved SI 2002/1323	
April 2002	Fareham & Gosport PCT established SI 2002/1120 East Hants PCT established SI 2001/331	F&G responsible for management of wards at GWMH. Employed ward nurses on Dryad and Daedalus. EHants managed Medicine for Elderly People service. Employed consultants for this service at GWMH.
2005	Fareham & Gosport and East Hampshire PCTs merge to form one 'cluster'.	Cluster retains responsibilities and roles from both PCTs as above.
Sept 2006	'Cluster' dissolved.	
October 2006	Hampshire PCT established SI2006/2072	Hampshire PCT assumes responsibility (commissions) for services at GWMH. Responsibility for Dryad and Daedalus wards and the employment of the nursing and medical staff goes to Division of Medicine for Older People (DMOP) at Portsmouth Hospitals NHS Trust. Sultan ward is staffed by Hampshire PCT, but medical input is from local GP consortium.
2010	Hampshire Partnership NHS Trust	Provider arm of Hampshire PCT transfers into Hampshire Partnership NHS Trust as part of 'Transforming Community Services'. Ownership of GWMH stays with Hampshire PCT but staffing on Sultan ward is provided by HPT. Medical input is provided by X ?What about OPMH ward?
April 2011	Southern Health NHS Foundation Trust	Hampshire Partnership NHS Trust gains foundation Trust status and changes its name to Southern Health NHS Foundation Trust.
April 2013	Hampshire PCT dissolved – Fareham and Gosport CCG established	Ownership of GWMH transfers from Hampshire PCT to Southern Health NHS Foundation Trust. Fareham and Gosport CCG take over responsibility for

		commissioning services at the hospital.

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Detailed chronology of events		
Date		**Note**
1980	Dr J Barton contracts with Health Authority to work at GWMH	
1988	New contract for Dr JB with Health Authority.	
1991	First formal letter sent expressing concerns at prescribing practice and use of syringe drivers at Redclyffe Annexe. More detail in separate dedicated document. This dedicated document refers to concerns having been raised two years earlier, and them not being addressed since then.	
1994	Portsmouth Healthcare Trust (PHCT) established. Provides care at all community hospitals in SE Hants. Service management and medical staff come from Medicine for Elderly People division, and nursing staff managed by F&G division of PHCT	New service provider taking over responsibility from the Health Authority
1995	Portsmouth Hospitals NHS Trust established. Provides acute care in this area.	
1996	Leslie Pittock died – Dryad Ward Elsie Lavender died – Daedalus Ward Robert Wilson died – Dryad Ward	
1997	Helena Service died – Dryad Ward	
1998	Arthur Cunningham died – Dryad Ward Ruby Lake died – Dryad Ward Gladys Richards died	
1999 Dec 98 – March 99 Oct 99	Enid Spurgin died – Dryad Ward Geoffrey Packman died – Dryad Ward Elsie Devine died – Dryad Ward Sheila Gregory died – Dryad Ward. Police conducted investigation into the death of Gladys Richards (RIP 22/08/98), but CPS decided insufficient evidence to prosecute. Second Police investigation announced.	 1st Police inv. 2nd Police inv.
2000	Staff grade took up post at GWMH, replacing clinical assistant (Dr JB)	
2001 March 01 2001 onwards April 01 Aug 01 Oct 01	Independent Review into death of Elsie Devine. Local media coverage leads to other families coming forward with concerns. Dr JB enters into voluntary agreement to restrict her prescribing and for her prescribing to be monitored. PCPCT established 2nd Police investigation concludes insufficient evidence for prosecution, but have concerns about practices at GWMH and refer to CHI. CHI starts investigation.	 New service provider CHI
2002	PHCT dissolved, and F&G PCT and EH PCTs established. Management of wards and employment of nurses at GWMH transferred to F&GPCT, whilst management of Medicine for	New service providers

	Elderly People service, including employment of medical staff working at GWMH, transferred to EHPCT.	
July 2002	CHI reports. 1991 events made public. SHA set up helpline as more families come forward with concerns.	CHI
Sept 02	Police begin collating evidence for third investigation. 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.	3rd Police inv.
Nov 02	Joint Action Plan between F&G and EH PCTs to address recommendations made in CHI report approved by F&G PCT Board.	CHI
March 03	Tony Horne and Ian Piper reinstated in their posts.	
Jan 04	F&G Clinical Governance group takes over responsibility for overseeing CHI Action Plan, which has met its objectives.	
March 05	F&G and EH PCTs linked into one cluster PCT	New organisational arrangement
Sept 06	F&G and EH PCT cluster formally dissolved.	
Oct 06	Portsmouth Hospitals Trust takes over the management of services for Medicine for Older People (DMOP). Now both nurses and medical staff have same employer. Dryad and Daedalus ward teams formally transferred to PHT, and so medical services for older people now provided in Collingwood and Ark Royal wards. CPS concludes the 3rd Police investigation, saying insufficient evidence to prosecute any health care staff.	New service provider
May 07	Home Secretary ordered inquest into the deaths of 10 people at GWMH (listed earlier).	
Aug 07	Coroner met with Ministry of Justice and DH to discuss inquest	
Dec 07	GMC decides to hold hearing into deaths regarding the role of Dr J Barton	
May 08	Coroner opens and adjourns inquests into ten deaths at GWMH.	
Jan 09	Coroner holds pre-inquest review with families and legal teams from NHS and NMC.	
March 09	Inquests in 10 deaths held. Verdict was:	
2010	Dr Barton GMC Fitness to practice hearing	
2011	Dr Barton voluntarily removes herself from GMC register	

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

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Details of previous investigations

Background

In 1996 Mulberry Ward at GWMH comprised 40 beds split into A (13 beds), B (13 beds) and C (14 beds) areas. All areas were run by Portsmouth Healthcare NHS Trust (a predecessor of PCTs and a separate organisation from Portsmouth Hospitals NHS Trust).

In January 2000 Mulberry A, B and C became Ark Royal Ward (13 beds) and Collingwood Ward (27 beds). Later these numbers became 17 beds on Ark Royal and 17 beds on Collingwood.

In April 2002 Fareham and Gosport PCT took over responsibility for management of Dryad, Daedalus and Sultan wards at GWMH. East Hampshire PCT took over responsibility for managing the older people's mental health service in Ark Royal and Collingwood wards and employed consultants for this service at GWMH.

In April 2006 responsibility for Dryad and Daedalus wards and the employment of the nursing and medical staff transferred to Division of Medicine for Older People (DMOP) at Portsmouth Hospitals NHS Trust. Nursing staff on Sultan Ward transferred to Hampshire PCT, but medical input was provided by the local GP consortium. Hampshire Partnership NHS Trust took over responsibility for Older People's Mental Health Services in Ark Royal and Collingwood wards.

In line with national guidance the mental health service was transferred to Dryad and Daedalus wards on the ground floor in Feb 2008.

Early Police investigations

Between 1998 and 2002, Hampshire Constabulary undertook two investigations into the potential unlawful killing of patients at Gosport War Memorial Hospital.

These investigations did not result in any criminal prosecutions, but the police shared their concerns about the care of older people at Gosport War Memorial Hospital (GWMH) 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.

Commission for Health Improvement investigation

In 2001, CHI commenced an investigation into the management, provision and quality of healthcare at Gosport War Memorial Hospital managed by Portsmouth Healthcare NHS Trust (the predecessor of the then Fareham and Gosport PCT and East Hampshire PCT and a different organisation to Portsmouth Hospitals NHS Trust).

CHI concluded that in the late1990s there had been a failure of the then PCT systems to ensure good quality patient care, including insufficient local prescribing guidelines, lack of a rigorous, routine review of pharmacy data, and the absence of adequate Trust-wide supervision and appraisal systems.

CHI also concluded that by the time of their investigation, in 2002, the successor PCTs had addressed these. CHI reported that the PCTs (Fareham and Gosport PCT and East Hampshire PCT) had adequate policies and guidelines in place governing the prescription and administration of pain relieving medicines to older patients and that these policies and procedures were being adhered to.

Outcome of the final Police investigation

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. Following these contacts the police initiated another investigation into the deaths of patients at GWMH in September 2002.

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Following detailed investigation and expert reports ten cases were passed to the Crown Prosecution Service (CPS) for review once the police investigation was complete. The CPS concluded that there was insufficient evidence to prosecute and that there was no realistic prospect of any conviction.

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.
These inquests took place in March 2009 and five verdicts indicated that the medication used to treat and relieve symptoms did not contribute to deaths.
In two verdicts, whilst contributing to death, medication was appropriately given.
Three verdicts indicated that the medication administered to these patients had contributed to their deaths. However, in those cases it was found to have been given for therapeutic purposes.

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. After the Coroner's verdict in 2009 the GMC held a Fitness to Practice hearing for Dr Jane Barton which concluded..... To date the NMC have not taken any action.

GWMH IN 2013

Since the time of these deaths 15 years ago and the subsequent CHI review in 2002 much has changed at Gosport War Memorial Hospital, in line with developments in clinical practice across the country.

1991 saw the commencement of a £10.5 million, two-phase development which was complete in 1995. This was followed by a £6m redevelopment in 2009.
The Hospital now houses:

- 20 bed GP ward
- 32 beds for older peoples' mental health
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- Blake birth centre
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- Community health clinics
- GP Out of Hours Service

By the time of the CHI investigation in 2002 the regulator was satisfied that GWMH had adequate policies and guidelines in place governing the prescription and administration of pain relieving medicines to older patients and that these policies and procedures were being adhered to. This remains the case and there have been no incidents subsequently which have required external investigation by CHI or its successor the Healthcare Commission or the Police.

Policies and procedures at the Hospital are reviewed regularly and staff receive mandatory training every year. Details of policies in place are available from Portsmouth Hospitals NHS Trust and Southern Health NHS Foundation Trust on request.

The Patient Environment Action Team inspection last year rated the Hospital as good on cleanliness, excellent for food and good for privacy and dignity. Patient experience surveys are conducted regularly and feedback is very positive, with

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comments including 'privacy and dignity is well respected' and 'cleanliness impeccable'.

There were X complaints relating to Portsmouth Hospitals NHS Trust re: the Department of Medicine for Older people, Stroke and Rehabilitation last year (this includes GWMH and QAH) and X relating to Southern Health NHS Foundation Trust for the other wards at GWMH. All complaints are taken very seriously and investigated internally in line with the Trust's complaints policy.

The Hospital also receives many thanks and compliments from patients and their families, with over 200 cards and letters last year.

Staff at the Hospital received a Chairman's award from Portsmouth Hospitals NHS Trust Chairman in 2007 for their professionalism and dedication.

In 2008 Portsmouth Hospitals NHS Trust's modern matron at GWMH received a Clinical Governance Award from the Trust's Patient Experience Council. This award of £9773 contributed to the installation of cushioned floor in both wards, to minimize injury if a patient should experience a fall during rehabilitation.

In February 2009 Ark Royal, Collingwood and Sultan wards have benefitted from anti microbial curtains and new bedside lockers and tables which are much easier to clean. Overhead hoists are available over every bed and in bathrooms and the Trust have increased call bells in day room areas enhancing patient safety.

In 2008/09 Portsmouth Hospitals NHS Trust was independently assessed as providing an 'excellent' quality of services by the Healthcare Commission (formerly CHI) and Hampshire PCT was assessed as providing a 'good' quality of services by the Healthcare Commission.

Southern/PHT to add subsequent info

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Q&A

Q. What is the purpose of an Inquest?

A. The purpose of an inquest is for the coroner to determine how the individual met their death, the cause / nature of the death and in some circumstances investigate further the circumstance of that person's death.

Q. What is this inquest concerned with?

A. This inquest is concerned with the death of Gladys Mable RICHARDS in August 1998. She was an in-patient at Gosport Ward Memorial Hospital at the time of her death.

Q. Isn't it rare to have an inquest 15 years after the death of a person and in the absence of a body or post mortem reports?

A. Yes it is, however an inquest is an opportunity for families to get some answers about how their loved ones died.

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

A. The police investigations focused on whether there was any evidence of criminality with respect to this patient's death at Gosport War Memorial hospital. The role of an inquest is to determine how a person met their death and potentially the circumstances surrounding their death.

Q. Is this inquest related to ten others held four years ago?

A. Yes it is. In 2009, the Portsmouth Coroner, David Horsley, heard ten inquests into the deaths of patients at the Gosport War Memorial Hospital. These cases came to light after the death of Gladys Richards was investigated by the police and highlighted in the media.

Q. How were cared for at GWMH at the time?

A. At the time, a local Gosport GP was employed to work as clinical assistant to provide junior medical cover at GWMH. The GP worked under the guidance of a consultant and visited Dryad and Daedalus wards at GWMH each morning, Monday to Friday. The GP surgery provided an out of hours service with one of the partners attending the wards for specific needs when required. Each ward had a consultant

round approximately once a week, a different consultant covering each ward. The consultants, all geriatricians were based at Queen Alexandra Hospital in Portsmouth.. Their clinical caseload could include a day hospital session and/or outpatient session at GWMH, and thus they were present on the GWMH site for advice at specific periods in addition to their ward rounds.

Q. How was diamorphine prescribed and administered at GWMH?

A. Each ward had a controlled drug book in which would be entered details of the ward stock levels of the drug in question; the amount administered to any patient at a specific time and date, and a running total of the stock.

Before nursing staff could administer a controlled drug, the stock levels and the amount to be given would have to be checked by two members of staff. They would then draw it up and prepare the syringe. The syringe driver mechanism would then be set to release the amount of medication prescribed for the 24-hour period.

Q. What is meant by palliative care?

A. The term palliative care means treating symptoms (e.g. pain, nausea, vomiting etc) rather than trying to cure an illness. This approach is taken when it is recognised that a cure is not possible or may in itself pose unacceptable risks, and this could be for a number of reasons.

Q. What was the approach to end of life care at GWMH.?

A. Health services must always be subjected to public scrutiny; however issues around pain relief and end of life care are seldom clear cut. Both the previous inquests and the GMC hearing concluded that XXX

Some of the complaints at the time related to the ability of staff to talk to families and it has become clear that often friends and relatives were not properly informed or aware that a palliative care approach was being taken.

Since then a range of new approaches to end of life care have been introduced designed to drive up sustained quality of care in the last hours and days of life.

Q. What opportunities were there for family members to raise concerns about the care of a loved one?

A. The hospital had a complaints procedure in place, which could be accessed by the family as well as patients. Complaints and concerns could also have been raised with

the Trusts running services at the site. At that time patients and their relatives were also able to refer concerns to the NHS Commissioner (Ombudsman).

Q. What has been done to ensure care at the hospital is better now?

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.

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 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.

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 the Fareham & Gosport Clinical Commissioning Group doing to ensure patients receive good care?

The CCG has detailed quality clauses in its contracts with the NHS Trusts that provide services at Gosport War Memorial Hospital. We monitor the quality of care that patients receive at the hospital regularly which includes reviewing the rates of infections, serious incidents, patient surveys and complaints, and also cross reference this with what local people and patients are saying about care at the hospital. We hold regular quality review meetings with the trusts where any issues are discussed and our clinicians conduct visits to wards and departments to check the quality of care and services on site.

Q. How will the Clinical Commissioning Group ensure concerns or complaints are heard and acted upon?

A. The Fareham and Gosport Clinical Commissioning Group (CCG) is responsible for commissioning or buying/arranging healthcare for residents living in Fareham and in Gosport.

The CCG believes that it is crucially important to hear about the concerns of patients and/or their families and as a result, it has established a number of mechanisms to ensure this. The community hospital has a concerns and complaints service in place. In addition, the CCG receives concerns or complaints from patients or family members and we have a network of patient participation groups, locality patient groups and a Stakeholder Advisory Board where we take feedback from local people about the care they have received. This feedback, along with the quality data is reported regularly to the CCG's Quality and Safety Committee and to our Governing Body.

Both the CCG and the service provider will investigate every concern or complaint raised and will ensure feedback is given to the complainant. In addition, where appropriate, improvements to the services will be enacted as quickly as possible.

The CCG will follow recommendation 109 of the Francis Report to ensure that methods of registering a complaint are readily accessible and easily understood and that opportunities for feedback and complaints are offered to patients and families, both during treatment and after its conclusion.

Q. Following the publication of the Francis Report in early February 2013, what is the CCG doing to ensure high standards at the Gosport War Memorial Hospital?

The CCG readily accepts its responsibilities to ensure that the events at the Mid Staffordshire NHS Foundation Trust are not repeated. It is working with NHS England and with local partners to devise enhanced quality standards that will drive improvement in the health service. The CCG is also developing its own action plan to address the recommendations of the Francis report and will work closely with local providers of care to ensure that they take forward the actions from the report.

Crucially the CCG will work hard to ensure excellent communication with and about patients. It will look to ensure that information about an older patient's condition, progress and care and discharge plans is available and shared with that patient and.where appropriate, with those close to them.

In addition, it will ensure, through effective relationship management with its providers, that it receives accurate information about the performance of its providers. This includes monitoring the quality of care that patients receive at the hospital by looking at the rates of infections, serious incidents, patient surveys and complaints,and cross referencing this data with what local people and patients are

saying about care at the hospital. We hold regular quality review meetings with the trusts where any issues are considered and our clinicians also conduct unannounced visits to check the quality of care and services on site.

The CCG fully understands that it is accountable to the public for the scope and quality of the services it commissions and is committed to ensuring meaningful patient and public involvement in all of its activities. We have a network of patient participation groups, locality patient groups and a Stakeholder Advisory Board where we take feedback from local people about the care they have received. This feedback is combined with data about the quality of services and reported regularly to a Quality and Safety Committee and to our Governing Body.

Q: What happened to Dr Barton after the last inquests?

Dr Barton was the subject of a General Medical Council Fitness to Practice hearing in 2010. The hearing concluded that Dr Barton could continue to practice with restrictions, particularly on her prescribing practice.

However Dr Barton took voluntary erasure from the medical register with effect from 9 March 2011 and is no longer able to practise medicine in the UK

The GMC produces monthly decision circulars. These circulars, which include information about doctors who have been the subject of fitness to practise action or have taken voluntary erasure, are provided to a range of UK bodies and international regulators via email. Dr Barton's name has been included within these circulars on three separate occasions during 2010 and 2011.

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.

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?

DRAFT

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 Gladys Richards.

Q: Is this another Mid Staffs?

We deeply regret that care at GWMH in the 1990s was not of the standard that patients and their families should expect. But there have been enormous changes made to Gosport War Memorial Hospital since the then Commission for Health Improvement identified concerns about in-patient services that were delivered at the hospital as far back as 1997.

The NHS has introduced a range of new clinical policies and practices to ensure that care is safe and of the highest quality. The introduction of these new policies were checked and approved by the independent regulator back in 2002 and have been operating successfully ever since.

The NHS also invested £6.5 million to create a facility that is very different to the hospital that was subject to concerns 15 years ago. The hospital now provides more rehabilitative care which supports patients who need care for short periods of time and means they spend less time in acute hospitals.

Southern Health NHS Foundation Trust, Portsmouth Hospitals NHS Trust and NHS Fareham and Gosport CCG would like to reassure local people and patients that they can be assured of the highest quality care at Gosport War Memorial Hospital.

Patient and their carers regularly compliment and thank the hospital for the care received and the level of complaints at the Hospital is low.

During 2012/13 XXX patients were cared for at the wards at Gosport and only X concerns were raised with Portsmouth Hospitals NHS Trust and Southern Health NHS Trust who provide care at the hospital. Most of there were informal complaints that were made verbally.

DRAFT

Fareham and Gosport CCG are committed to ensuring that the services we commission are of the highest quality and our Chief Quality Officer visited GWMH earlier this month. During the visit we looked at infection control, medicines

control, equipment, environment, staffing and staff attitudes, communication, privacy and dignity, patient information and many more components of a safe, high quality services and were assured that GWMH is delivering a high quality service for local people.

Q. Why was Dr Barton still practising up until 2011?

A: At that time the GMC concluded that Dr Barton remains safe and fit to practice. Due to the pressures surrounding the investigations, Dr Barton resigned from GWMH but still practiced as a GP until 2011. Following the GMC hearing in 2010 she voluntarily withdrew herself from the GMC list.

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.

DRAFT

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.

Hampshire NHS
Primary Care Trust

DRAFT

Core messages – please review all

Corporate NHS

Spokesperson – Julia Barton Fareham and Gosport CCG

- 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 family of the deceased to establish closure.

- We sympathise with relatives for the uncertainty that has surrounded these issues over the last 15 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 15 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.

Hampshire NHS
Primary Care Trust

DRAFT

Clinical practice: Dr Martyn Diaper/Julia Barton

- 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 and 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 Southern Health NHS Foundation Trust 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. Southern Health FT also has a pharmacist who reviews practices and prescribing and also trains and educates staff.

- 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.

DRAFT

Pharmacy: ???

- Current service providers have a range of up-to-date policies and procedures governing the administration of medicines.

- SHFT 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.

Key words:

1998 / more than 15 years ago

Predecessor organisation

Integrated working

Multi-disciplinary approach

Confidence

Reassure

Quality and safety

Patient centred care

Dedicated pharmacist

Audits / CHI report

Ongoing learning

Supportive policies and procedures

Minimise and eliminate risk

Hampshire NHS
Primary Care Trust

DRAFT

Tighter governance

High standard of care

Four thorough investigations since 1998

No evidence of criminal wrong-doing

Hampshire NHS
Primary Care Trust

Draft verdict responses

What do you say to the families?
I would like to extend my sympathies to the families for the uncertainty they have experienced over the last ten years concerning their loved ones' deaths. I sincerely hope that these inquests have provided an opportunity for the families to hear more about the care their relative received and that these verdicts have provided answers for all the families regarding the circumstances of their loved ones' deaths.

What's your response to the verdicts?
The local NHS welcomes these verdicts and the insight they provide into the deaths of these ten patients.
Previous police investigations found no evidence of criminal wrongdoing and it is important for everyone involved in the care of these patients that X verdicts indicate that the patients were cared for appropriately/and that the medication used to treat and relieve their symptoms was correct.

It is a matter of regret to the NHS that X verdicts suggest that in the mid/late 1990s the organisations responsible for care at the time did not provide the highest quality care for these patients. (We would like to apologise unreservedly to the families concerned and assure local people that all these issues have been addressed and this was confirmed by CHI in 2000).
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These verdicts have highlighted some serious problems with the NHS...what's your response to this?
See above.

Who is to blame/has anyone taken responsibility?
An inquest is not a trial and the purpose of an inquest is not to apportion blame – so it is not appropriate to talk about who's resposible. These inquests were to determine how these ten individuals met their deaths.
Internal investigations and the CHI review concluded that there was no evidence to suggest that any individual should be disciplined. Furthermore three police investigations found that there was no evidence of any criminal wrong-doing. We await the outcome of the GMC investigation and reconsider our position when the outcome of this investigation is known.

We've heard a whole catalogue of problems/errors/poor care at GWMH how do you explain/justify this?
We know from the thorough investigation conducted in 2002 by the then health watchdog, the Commission for Health Improvement, that predecessor organisations did not have adequate policies and procedures in place and this has been further demonstrated by the evidence heard in court.

Hampshire NHS
Primary Care Trust

It is a matter of regret that the organisations responsible for care at the time had not done everything possible to ensure high quality care. However we are confident that the quality of care provided at Gosport War Memorial Hospital today is of the highest standard – the Healthcare Commission has rated the care provided by us as excellent and good in the last year.

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.

We've heard about people being discharged too early from QAH because of bed blocking...is this the case/explain why this happened?
(DN: needs clinical input) There are always pressures on large acute hospitals – that was the case in the late 1990s and it remains the case today. Sometimes this does mean that patients are transferred to other hospitals. However patients should always undergo a clinical assessment of their fitness to travel and receiving hospitals must confirm that they can meet the care needs of the patient. Today all transfers are subject to strict assessments to ensure that patients are only transferred if it is in their best interests to do so.....

Dr Barton says that she was overworked and unsupported and this meant she had to cut corners...why did the NHS put her in this position?
(DN: did CHI review make recommendations about clinical cover?)
(?We believe that everyone involved in the care of patients at GWMH has always put patient care foremost, however)...We know from the CHI review and the verdicts today that in the late 1990s the organisations responsible for care at the time did not have adequate resource and policies in place to provide the highest quality care for patients at GWMH. This is a matter of regret and in 2000 the NHS took steps to provide more cover at GWMH. We are confident that there is more than sufficient clinical cover at GWMH today with X doctors providing cover on the five wards at GWMH.

What are you going to do about Dr Barton now?
The GMC will consider Dr Barton's case in June. Until then she continues to practice although the GMC have imposed some restrictions on her prescribing. Once we know the outcome of the GMC hearing we will take appropriate action.

Why were the families told that their relatives would receive rehabilitation at GWMH when this clearly wasn't the case?
Good communication between doctors, nurses, patients and their relatives is at the heart of good quality care and is a major factor in determining a positive patient experience. One of the enduring challenges in healthcare is establishing the right point of contact and ensuring that they get timely and accurate information which they can disseminate to other family members. The evidence heard over the last few weeks suggests that back in the 1990s this process did not always happen. Today this is what we do.....

Hampshire NHS
Primary Care Trust

The consultants at QAH were meant to supervise Dr Barton...why didn't they do this properly?
Supervision was in lines with procedures at the time. Prescriptions were reviewed by the pharmacist weekly and regularly reviewed by consultants.

Why did the NHS allow Dr Barton to write prescriptions for patients before assessing them properly?
?Was this standard practice at the time and does it happen now?

Why was Dr Barton allowed to prescribe such high doses of diamorphine? Why was diamorphine given for minor medical problems like a broken arm or bed sores?
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. For example 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.

How does the NHS check the care provided by clinical assistants like Dr Barton?

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Medical experts in court and also other experts (Ford report, Baker report etc) have said that the levels of diamorphine contributed to the deaths of these patients...how did the NHS allow this to happen?
It is a matter of regret to the NHS that X verdicts suggest that in the late 1990s the organisations responsible for care at the time did not have adequate resource and policies in place to provide the highest quality care for these patients. (We would like to apologise unreservedly to the families concerned and assure local people that all these issues have been addressed and this was confirmed by CHI in 2000).

We would like to apologise to the families concerned that the NHS at the time did not have adequate policies and procedures in place to ensure that their relatives were cared for appropriately. All issues highlighted by CHI were addressed as early as 2002 and we are confident that care at the Hospital today is of the highest standard.

NHS
Hampshire

Statement in relation to Gosport War Memorial Hospital Inquest Verdicts

Director of Performance and Standards for NHS Hampshire, Richard Samuel, said;

"The local NHS sympathises with the families for the uncertainty they have felt around the circumstances of their relatives' death. We sincerely hope that these inquests have provided an opportunity for the families to hear more about the care their relative received and that these verdicts have provided answers for all the families regarding the circumstances of their loved ones' deaths.

"We welcome these verdicts because they give us is the final piece of the jigsaw - whether the prescribing and practices at the time contributed to the deaths of any individual.

"It is important for everyone involved in the care of these patients that all ten verdicts indicate that the patients were cared for appropriately/and that the medication used to treat and relieve their symptoms was correct.

"We are confident that staff were acting in the best interests of their patients at all times. We have fully supported the Coroner's inquests as an opportunity to review the events of the late 1990s. However, our staff and their families have now been subject to a total of five thorough investigations - none of which found any evidence of intent or criminal wrong-doing. We hope for their sake that these matters can now finally be closed.

"The care at Gosport War Memorial Hospital in the mid/late 1990s has been the subject of many investigations in the last ten years. This included a thorough independent investigation in2002 by the then healthcare watchdog - the Commission for Health Improvement. The inquests have confirmed the findings of this review – and that means we can be confident that challenges highlighted by the Inquests have already been addressed.

"Patient safety and quality of care is at the very heart of everything we do at NHS Hampshire and we are confident that the quality of care provided at Gosport War Memorial Hospital is of the highest standard."

Ends…. For further information contact: 023 8062 7434

NHS
Hampshire

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"It is important for everyone involved in the care of these patients that verdicts indicate that the patients were cared for appropriately/and that the medication used to treat and relieve their symptoms was correct.

"However it is a matter of regret to the NHS that verdicts indicate that in the mid/late 1990s the treatment or care of these patients has been found to have contributed to their deaths.

"NHS Hampshire will be now be contacting these families but I would also like to take this opportunity to apologise to the families concerned on behalf of the NHS for any treatment or care which has been found to have contributed to the deaths of their loved ones.

"Since the late 1990s the systems and policies in place at Gosport War Memorial Hospital have undergone a complete overhaul. I can assure the families and local people that all the issues highlighted by these inquests have been addressed and the care at Gosport War Memorial Hospital today is of the highest standard."

- **Ends –**

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"It is a matter of regret to the NHS that these ten verdicts indicate that in the mid/late 1990s the treatment or care given to these ten patients has been found to have contributed to their deaths.

"NHS Hampshire will be now be contacting the families of the ten patients, but I would also like to take this opportunity to apologise to the families concerned on behalf of the NHS for any treatment or care which has been found to have contributed to the deaths of their loved ones.

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- **Ends –**

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