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).

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?

?

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.

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**
Holding statement	**No holding statement will be prepared. All media requests will be directed back to NHS England**	**Comms team**
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.

GOSPORT INDEPENDENT PANEL

Wellington House, 133-155 Waterloo Road, London, SE1 8UG
TEL: 020 7972 4212 Email: enquiries@gosportpanel.independent.gov.uk

Katrina Percy
Chief Executive
Southern Health NHS Foundation Trust
Tatchbury Mount
Calmore
Southampton
Hampshire
SO40 2RZ

25th September 2014

Dear Ms Percy

GOSPORT INDEPENDENT PANEL

You may be aware that on 10th July 2014, Norman Lamb MP, Minister of State for Care and Support at the Department of Health announced in the House of Commons that he was establishing an Independent Panel in response to concerns raised over a number of years about the higher than expected deaths of a number elderly patients at Gosport War Memorial Hospital and the subsequent investigations into their deaths. The Panel will be chaired by Bishop James Jones, the former Bishop of Liverpool. Please see the attached Written Ministerial Statement.

I have been appointed Secretary to the Panel and am working with the Bishop to agree terms of reference which we expect to be announced in the Autumn. We are in discussions with family members about their concerns and questions relating to deaths of their relatives. Once we have the agreed terms of reference, the Bishop will write to you in order to arrange a meeting and initiate discussions about any material you have. In the meantime, it is clearly important that information which may be even remotely relevant to the work of the Panel is preserved. While it is difficult to define this ahead of the terms of reference, the type of material which will be in scope includes:

- Personal medical records
- Documentary records relating to complaints and investigations
- Internal and published reports, correspondence (including inter-organisation), minutes of internal and external meetings, records of telephone conversations relating to concerns about treatment and care at the Gosport War Memorial Hospital.

I would ask you to retain anything which may potentially be of relevance to our investigation. If you or any of your staff are in any doubt about whether documents can be destroyed I would urge you, in the first instance, to seek advice from Peter Burgin, a member of my Secretariat. Peter can be contacted on 07900 678606 (peter.burgin@dh.gsi.gov.uk).

GOSPORT INDEPENDENT PANEL

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Please do contact me if you wish to discuss.

Yours sincerely,

Louise Dominian

LOUISE DOMINIAN

Secretary, Gosport Independent Panel

GOSPORT INDEPENDENT PANEL

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Written Ministerial Statement

DEPARTMENT OF HEALTH

Death rates of elderly patients at Gosport War Memorial Hospital between 1988 and 2000

Thursday 10 July 2014

The Minister of State, Department of Health (Norman Lamb): Following the publication of the Baker Report in August 2013 into higher than expected death rates of elderly patients at Gosport War Memorial Hospital between 1988 and 2000, families have continued to raise concerns about the initial care of their relatives and the subsequent investigations into their deaths. In order to try and address their concerns, and having given consideration to a number of alternative options, I am setting up an independent panel to review the documentary evidence held across a range of organisations.

I have asked Bishop James Jones to chair the panel. Having successfully steered the Hillsborough panel, he brings a wealth of expertise and experience to this work. He has begun to work with affected families, and will continue to do so over the coming weeks and months to ensure that the views of those most affected by these deaths are taken into account. I have also asked Christine Gifford, a recognised expert in the field of access to information, to work alongside him and the various organisations to ensure maximum possible disclosure of the documentary evidence to the panel.

I will announce further details of the other panel members and agreed terms of reference in the autumn.

NHS
Fareham and Gosport
Clinical Commissioning Group

GWMH: additional commissioner assurance questions

(Based on Wessex Area Team feedback and Baker report)

No.	Question for additional assurance	SHFT Response
1.	Are there explicit policies on the use of opiate medication? Please list the titles of these and indicate when they were ratified/are due for review.	The Southern Health NHS Foundation Trust (SHFT) Clinical Policy (CP 99) Guidance on the Safe Prescribing and Administration of Opioid Doses for Pain, Palliative Care or Substance Misuse was ratified October 2010 and is due for review December 2013. In addition to this SHFT policy the Countess Mountbatten House Palliative care handbook 'Green book' (7th Edition) has been endorsed by the medicines management committee and is available on the ward or via the medicines management website http://www.southernhealth.nhs.uk/knowledge/medicines-management/useful-links/ The prescribing of opiates in palliative care also follows National NICE guidance CG140 Opioids in palliative care available at http://guidance.nice.org.uk/CG140/NICEGuidance/pdf/English and a step wise approach is taken which is based on the World Health Organisation (WHO) analgesic ladder http://www.who.int/cancer/palliative/painladder/en/
2.	Do the policies for opiates include guidance on the assessment of patients who deteriorate and the indications for commencing opiates in accordance with national guidance?	Nursing assessment of deteriorating patients is covered by the Trust 'Track and Trigger' tool. Palliative care prescribing advice is accessed by contacting The Rowans Hospice, our local specialist palliative care team. Consultant and nurse specialists will visit the ward or give advice over the phone. The Countess Mountbatten House Palliative care handbook 'Green book' (7th Edition) is also available on the ward and online via the SHFT medicines management website. The prescribing of opiates in palliative care also follows National NICE guidance CG140 Opioids in palliative care available at http://guidance.nice.org.uk/CG140/NICEGuidance/pdf/English and a step wise approach is also based on the WHO analgesic ladder http://www.who.int/cancer/palliative/painladder/en/

		The SHFT Clinical Policy (CP 112) Acute Pain Guidelines and current British National Formulary (BNF) guidance are followed for non-palliative care patients requiring analgesia.
3.	Can the trust provide assurance that the policies are being adhered to especially in relation to prescriptions, administration/review and recording of medicines -- please provide details of audit processes	SHFT Clinical Policy (CP 1) Medicines Control and Prescribing Policy (MCAPP) is an overarching policy defining the policies and procedures to be followed for the prescribing, administering, supplying, dispensing, storing and recording of medicines. Adherence to the MCAPP policy was last audited prior the inclusion of integrated community services (ICS) within the Trust. Therefore Sultan ward has not been audited on this. However, assurance of adherence to all SHFT policies (including MCAPP) is provided by regular prescription monitoring. The SHFT pharmacist provides a twice weekly clinical ward visit where all in-patient prescription charts are reviewed. The SHFT pharmacist will challenge prescriber's on dosing increments in discussion with nursing team, when necessary, to ensure patient safety and recommend dose reductions where side effects are identified or pain intensity reduced. The SHFT pharmacist will also identify and challenge the in-appropriate or un-explained initiation of medication on admission through the medicines reconciliation process and on each prescription chart review. The SHFT medicines management intervention audit is undertaken annually. This was last undertaken in January 2013. The objective of the audit being to evaluate the extent to which prescribing issues would potentially harm patients' health or mitigate the effectiveness of treatment and the extent to which SHFT medicines management team interventions are medically beneficial. Correct documentation of drug administration is continually monitored by the SHFT pharmacist during the twice weekly clinical visits to the ward. Data is also collected during the annual SHFT omissions audit. The last omissions audit was completed in September 2012 and a local action plan was developed, agreed and is regularly reviewed. Data collection for 2013 omissions audit has been completed and the report will be available in due course. Spot checks are also undertaken as part of the Modern Matron walk around and nursing teams check for omissions and 'blanks' on the drug charts at each nursing hand over.
4.	Prescribing practice -- can the trust assure commissioners that there is a robust process for escalation of any notable increase in the prescribing of opiates? I.e. are there checking mechanisms/triggers in place that would highlight high levels of prescribing	A notable increase in the prescribing of opiates would be identified during the twice weekly medicines management visits to the ward, where each in-patient prescription is clinically screened by the pharmacist. An increase in opiate prescribing, ordering and administration would also be identifiable via the 3 monthly controlled drug audits. Trends would also be identified by incident

	opiates	reporting, the clinical pharmacist receives an electronic summary of every medicine related incident reported by the ward. All controlled drug incidents are included in the SHFT controlled drug Accountable Officers report.
5.	Can commissioners be assured that the practice of prescribing opiates (before they are needed/on admission) is now obsolete practice and would not happen on any occasion?	The inappropriate prescribing of opiates before they are needed/on admission does not occur. Assurance can be provided by the twice weekly pharmacist clinical ward visits to review every in-patient prescription. The inappropriate prescribing of opiates would also be picked up by the medicines reconciliation process undertaken for each patient admission. The provision of a clinical pharmacy service to the ward was developed in response to the CHI report to ensure continued prescribing monitoring to include and ensure the appropriate and safe prescribing of opiates.
6.	What supervision, performance monitoring and appraisal policies and processes currently exist for medical, nursing and other staff?	Awaiting feedback from Dr Walker as regards PHT medics. SHFT clinical staff is given annual development appraisals where their clinical and leadership skills are benchmarked against core themes (releasing ambition, value through innovation, forging relationships, training). Where are developmental needs a plan of action will be implemented and regularly reviewed. Staff performance is monitored via regular performance reviews using standards identified within the trust Managing performance (capability) policy
7.	Can the trust provide evidence from recent audit of good record keeping around the assessment of patients before prescribing opiates for example: • The reason for starting opiate medication, e.g. why is morphine selected rather than an non-opiate analgesic • Detailed assessment of the reasons for the patient's pain	The Trust wide audit action plan and the medicines management team action plan does not include a specific audit covering the reason for starting opiate medication or the assessment of patient's pain. Any decision to start opiates is made by senior doctor Dr J Walker or Professor Severs (Portsmouth Hospitals Trust) or the local palliative care consultant and documented in the patient notes.
8.	Can the trust give an update on how it monitors patient clinical outcomes i.e. mortality rates	Mortality rates are recognised within the framework of the community hospitals dashboard. How this is reviewed corporately – SMT will need to consider the response on this. Unexpected deaths are reviewed immediately requiring senior clinicians to complete IMA reporting as a baseline for consideration of further in-depth investigation. Patient harms are monitored monthly using a recognised national thematic tool – known as patient safety thermometer.

9.	Can the trust provide information about the frequency and content of MDT meetings, where the management of individual patients is discussed & documented?	Inpatient settings have regular weekly MDT meeting. This is led by the ward medics with influential background information coming from the clinical nursing staff. In attendance at MDT will be designated AHP and social services. Predicted date of discharge is established to promote timely discharge
10.	What current or recent evidence can the trust provide with regard to the culture of the ward e.g. safety culture; can staff raise concerns, how is that managed?	Staff are encouraged to raise concerns using safeguard system, through supervision and also using HR for advice.
11.	Can the trust confirm there is an up to date whistleblowing policy in place which has been disseminated to all community hospital staff. What evidence is there that staff feel confident to raise concerns? Have there been any whistleblowing incidents in the last year?	There is whistle blowing policies in place and there is recent evidence to support that staff will voice concerns when and should they arise
12.	What is the current process for raising complaints and managing family concerns?	Current process – patient or family are encouraged to make contact with SHFT PALS service. Clinical staff is happy to make the initial contact with PALS so that they can bridge the initial communication with the family. Once the complaint have been identified then there is a period of 30 days for the complaint to be investigated by the service lead with drafted responses going to the divisional director for sign off. Once a response to the complaint has been agreed then there will be an action plan developed by the investigating officer which consider all of the outcomes of learning out of the concerns raised.
13.	What processes are in place to monitor working time directives i.e. making sure doctors are not working beyond their contracted hours especially where they have a second contract?	Awaiting feedback from Dr Walker as regards PHT medics.
14.	Is there an End of life pathway in place? Is it adhered to? What has been decided in terms of the use of the Liverpool care pathway and	Get Jude to respond on this as a SHFT position on the LCP. Sultan ward have been using the LCP for over 6-7 years, the staff are very experienced about the principles of the LCP and it recognisable in the planning and implementation of EOL care provided to patients on the ward. Syringe drivers are used effectively to manage symptoms
15.	Is there a routine process for auditing of death certificates? (To ensure investigation takes place following high numbers of deaths)	How this is reviewed corporately – SMT will need to consider the response on this.
16.	Are CD registers completed correctly? What evidence	A quarterly controlled drug standards audit is undertaken. All lapses in standards

	can the trust provide commissioners on recent audits of controlled drug practice at GWMH?	are recorded in the Trust wide controlled drug report. The local SHFT pharmacist follows up any failed CD standards directly with the team and helps develop and review action plans to improve practice.

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.

NHS Hampshire

- 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

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