**From:** Lawes, Susan </O=BAS EXCHANGE/OU=FIRST ADMINISTRATIVE GROUP/CN=RECIPIENTS/CN= Code A
**Sent:** 20 February 2009 12:03
**To:** Douglas, Keith; Harris, Elizabeth; Harvey, Leanne; Holden, Emma; Ollerhead, Keith (NhsNet); Samuel, Richard; Smart, Fiona; SUInotificationHPCT; Tiller, Sara; Zabiela, Jackie; Deeks, Mary; Williams, Elaine
**Cc:** Blake, Chris; Bradlow, Jean; Harriman, Sue; Percy, Katrina; Tyler, Hilary; Hebden, Inger; Johnson, David; Nash, Jenny CIO; Pike, Jane; Wilson, Diane; May, Zena; Ashton-Key, Martin; Jackson, Christine; Kickham, Noreen; Berry, Alex; Clanchy, Helen
**Subject:** SUI Declaration NHS Hampshire 2009/1704
**Attachments:** helpbubbleblue1.gif?OpenImageResource; ecblank.gif

**Importance:** High
**Sensitivity:** Confidential

**Follow Up Flag:** Follow up
**Flag Status:** Flagged

**Categories:** Urgent

# Untoward Incident Document

Created by LSQC on 19/02/2009 at 17:43:12

[Exit]

| Reporting Organisation: | Hampshire PCT | Log No: | 2009/1704 |
|---|---|---|---|
| Health Authority: | South Central | Status: | Ongoing |
| RDPH : | | BF/wd Date: | 19/03/2009 |

## When, Where & Your Details

| Date of Incident: | 31/12/96 | Reporter Name: | Susan Lawes |
|---|---|---|---|
| Time of Incident: | | Reporter Job Title: | Head of Risk |
| Site of Incident: | GWMH | Reporter Tel. No.: | 02380627453 |
| Location of Incident: | Ward areas | Reporter Email: | Code A |

## Who

| Care Sector: | Primary Care | Type of Patient: | GP Patient |
|---|---|---|---|
| Clinical Area: | Other - Community Medicine | Gender: | |
| Date of Birth (dd/mm/yyyy, N/A or Not Known): | N/A | Ethnic Group: | Not Stated |

| What Happened? | | | |
|---|---|---|---|
| Type of Incident: | Allegation Against HC Professional | Actual / Near miss: | Actual |
| Description of what happened: | This is not a new incident: HM Coroner has ordered inquests into the deaths of ten patients at Gosport War Memorial Hospital (GWMH) from 1996 to1999. The inquests are concerned with the deaths of people who were in-patients on Dryad and Daedalus wards at GWMH.<br><br>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.<br><br>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.<br><br>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.<br><br>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 older patients and that these policies and procedures were being adhered to.<br><br>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.<br><br>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. | | |
| Case summary for weekly bulletin: (READ-ONLY) | To be completed by the SHA | | |
| Immediate action taken: | Preparation for inquests including look back at all available documentation. Detailed media and Comms Strategy in place. | | |
| Further Information: | There is increasing press interest in the case as the start date of the inquests approaches, with staff being approached both at home and in the street. Links are likely to be made to other similar cases, and indeed a recent BBC Radio 4 programme linked these events to the Harold Shipman case.<br>Because of increasing media interest a formal SUI is being declared. | | |
| Media Interest: | Yes | Line being taken by Trust/ PCT: | The PCT will cooperate fully with the Coroner and support staff in dealing with media interest. |
| Externally reportable: | | Externally reportable to: | Coroner |
| Report to Health Protection Agency: | No | | |
| Apparent outcome of incident: | | Likelihood of recurrence: | |
| Most likely consequences: | | Potential risk to future patients: | |

| Trust File Details | | | |
|---|---|---|---|
| Lead Officer at Trust: | Mary Deeks | Lead Officer Tel No.: | 023 8062 7695 |
| Current File Holder: | Mary Deeks | BF/wd Date: | 19/03/2009 |
| Reports: | Please Select | Date Completed: | |
| Correspondence History: | | | |
| Comments: | | | |

| Root Cause and Lessons Learnt | |
|---|---|
| Lesson can be disseminated to other parties?: | Yes |
| Root Cause and Lessons Learnt: | |

[Exit]

| Modified Date and Time | By |
|---|---|
| 19/02/2009 17:19<br>19/02/2009 17:43<br>19/02/2009 17:46 | U5QC<br>U5QC<br>U5QC |