A Review of Deaths of Patients

at

Gosport War Memorial Hospital

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Acknowledgements

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Richard Baker

Clinical Governance Research and Development Unit

Department of Health Sciences

University of Leicester

Summary

This report presents the findings of an audit of care at Gosport War Memorial Hospital that was commissioned by the Chief Medical Officer. Concerns about the care of patients in Gosport hospital were first raised in 1998, and a police investigation is continuing.

The audit has drawn on documentary evidence that has included:

1. A random sample of 81 clinical records of patients who died in Gosport hospital between 1988 and 2000
2. The counterfoils of medical certificates of the cause of death (MCCDs) retained at Gosport hospital relating to deaths in the hospital 1987-2001
3. The admissions books of Dryad ward at Gosport, 1993-2001
4. Surviving controlled drugs registers at Gosport hospital
5. MCCDs completed by a sample of general practitioners in Gosport.

On the basis of these sources of evidence, I have concluded that a practice of almost routine use of opiates before death had been followed in the care of patients of the Department of Medicine for Elderly People at Gosport hospital, and the attitude underlying this approach may be described in the words found in many clinical records – 'please make comfortable'. It has not been possible to identify the origin of this practice, since evidence of it is found from as early as 1988. The practice almost certainly had shortened the lives of some patients, and it cannot be ruled out that a small number of these would otherwise have been eventually discharged from hospital alive.

The practice was disclosed in several key findings.

- Opiates had been administered to virtually all patients who died under the care of the Department of Medicine for Elderly People at Gosport, and most had received diamorphine by syringe driver.
- Opiates were administered to patients with all types of conditions, including cancer, bronchopneumonia, dementia, and strokes.
- Opiates were often prescribed before they were needed – in many cases on the day of admission, although they were not administered until several days or weeks later.
- In many records, evidence of a careful assessment before use of opiates was absent, and the stepped approach to management of pain in palliative care had not been followed.

In addition to these findings, two other matters also gave rise to concern. The amount of information recorded in the clinical notes was often poor, and recent fractures that had contributed to deaths, most commonly fractured hips, had not been reported on MCCDs.

Most patients admitted to Gosport under the care of the Department of Medicine for Elderly People had severe clinical problems, and many had been transferred from acute hospitals after prolonged in-patient stays. Some had been admitted for rehabilitation, but many were believed to be unlikely to improve sufficiently for discharge to a nursing home. Consequently, a relatively high number of deaths among those admitted would have been expected. The types of patients (case mix) admitted to Gosport varied during the period of interest (1988-2000), and it was not possible to identify an adequate source of data about numbers of deaths in similar hospitals that admitted similar types of patients in the same time periods to enable a reliable estimate of excess deaths to be calculated. Nevertheless, the findings tend

to indicate that the finding of a statistical excess of deaths among patients admitted to Gosport would be unlikely.

In undertaking the audit, I have drawn on documentary evidence only. There has been no opportunity for relatives or staff involved in the care of patients in Gosport to give information or comment on the findings. Dr Barton in particular has not been invited to give a first hand account of care at Gosport or comment on the findings of the review. It is possible, therefore, that my conclusions would be altered in the light of information from Dr Barton or other individuals. However, such information would be more appropriately considered in a different type of inquiry, for example that being undertaken by the police, rather than in the context of an audit.

Recommendations

In view of the findings of the audit, I submit the following recommendations:

1. Investigations should continue into the deaths of individual patients. The findings of this review reinforce concerns about what may have occurred in these cases.
2. In the continuing investigation into deaths in Gosport hospital, information about the rota followed by Dr Barton and her partners should be obtained and used to explore patterns of deaths.
3. Hospital teams who care for patients at the end of life should have explicit policies on the use of opiate medication. These policies should include guidance on the assessment of patients who deteriorate, and the indications for commencing opiates. The development of national guidelines would assist the development of local policies.
4. The findings reported in this review should not be used to restrict the use of opiate medication to those patients who need it. Indeed, there are reasons to

suspect that some patients at the end of life do not receive adequate analgesia.

5. In this review, evidence has been retrospectively pieced together from a variety of sources. Continued monitoring of outcomes at a local level might have prompted questions about care at Gosport hospital before they were raised by relatives, but continued monitoring is difficult with current data systems. Hospital episode statistics are an important resource, but continued prospective monitoring of the outcomes achieved by clinical teams requires a more detailed set of codes.