Hampshire NHS
Primary Care Trust

Gosport War Memorial Hospital
Patient Inquests
Media Briefing Pack

Pre Inquest Communications Team Numbers

Hampshire PCT Communications Team: Code A

Portsmouth Hospitals NHS Trust Communications Team: Code A

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1. Gosport War Memorial Hospital Inquests

~~The~~ HM C~~c~~oroner 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
- Elsie Lavender (06/03/96) Daedalus Ward
- Robert Wilson (died 18/10/96) Dryad Ward
- Helena Service (died 05/06/97) Dryad Ward
- Ruby Lake (died 21/08/98) Dryad Ward
- Arthur Cunningham (died 26/09/98) Dryad Ward
- Enid Spurgeon (died 13/04/99) Dryad Ward
- Geoffrey Packman (died 03/09/99) Dryad Ward
- Elsie Devine (died 21/11/99) Dryad Ward
- Sheila Gregory (died 22/11/1999) Dryad Ward

The witness list issued by the Coroner is available from the Coroner's Office on XXX

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2. ~~Brief overview~~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 is not the subject of an 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 one of the patients (is this the same case?), which concluded that the prescribing was appropriate in the circumstances.
- In 1991 (?2001) 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 referred the case to 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 published 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.
- (Following further publicity around the second investigation) In March 2000, (a further?)11 families raised concerns with the Police about deaths during 1998
- In September 2002 the Police began a third investigation into the deaths of 92 patients at GWMH. 82 of these investigations ceased at an early stage on the basis that there was insufficient evidence to justify criminal investigation..

- 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 and expert reports into the remaining ten deaths the Police handed the outcome of their investigation to the CPS in 2005.
- 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 late 2007.
- 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 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. ~~Summary of Police and CHI~~Details of investigations

Background

In 1995 GWMH was providing care from the following wards:

- Dryad ward was a continuing care ward providing 20 beds for the care of elderly, frail patients (replacing Redclyffe annexe);
- Sultan Ward provided accommodation for 24 patients under the care of their own GP;
- Daedalus ward provided accommodation for 24 elderly patients, made up of nine places allocated for stroke rehabilitation, the remainder for continuing care.

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Early Police investigations

Between 1998 and 2001, 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) .

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 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 reconfigured 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 92 patients at GWMH in September 2002.

A total of 92 cases were examined by the Police investigation team from 2002. Investigations into a significant proportion of the cases (82) ceased at a relatively early stage on the basis that there was insufficient evidence to justify criminal investigation.

The remainder were passed to the Crown Prosecution Service (CPS) for review once the police investigation was complete. The CPS concluded that negligence could not be proven 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. 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 in respect of 14 cases to the GMC and NMC and each organisation is undertaking its own inquiries the status of which is unknown.

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.

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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.

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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.

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Policies and procedures at the Hospital are reviewed (annually) and staff receive mandatory training every year. Details of the policies in place can be found at: Add links

Patient Experience and Treatment inspections 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.

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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.

Recently X and X 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.

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

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 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.

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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 have developed risk management systems, supported and clinical audit departments which are integral to the delivery of health services in a the modern NHS as part of the NHS's 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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6. Organisation structure in South East Hampshire 1991 - 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.
March 2002	Portsmouth Healthcare NHS Trust dissolved SI 2002/1323	
April 2002	Fareham & Gosport PCT established SI 2002/1120 East Hampshire PCT established SI 2001/331	F&G responsible for management of wards at GWMH. Employed ward nurses on Dryad and Daedalus. E Hampshire 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 along with five others in Hampshire	
October 2006	Hampshire PCT established SI2006/2072	HPCT 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. Nursing staff on Sultan ward is provided by HPCT, but medical input is from local GP consortium.

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