DRAFT

Gosport War Memorial Hospital Patient Inquest

Media Briefing Pack

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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. 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.

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?

A.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.

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.

3 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. It found Robert Wilson, Elsie Devine and Geoffrey Packman were given heavy-duty painkillers that were not appropriate to their condition and symptoms. 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.

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 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.

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

Organisational Structure

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	Cluster retains responsibilities and roles from both

	PCTs merge to form one 'cluster'.	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.