Questions and Answers

General Inquest Q&As

Q. What is the purpose of an Inquest?

A. The purpose of an inquest is for the coroner to determine how the individual met their death, the cause / nature of the death and in some circumstances investigate further the circumstance of that person's 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 (GWMH) 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.

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 (such as pain, nausea and vomiting) 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. The two inquests concluded that It is important for everyone involved in the care of these patients that five verdicts indicate that the medication used to treat and relieve their symptoms did not contribute to their deaths. In three verdicts, whilst contributing to death, medication was appropriately given.
It is a matter of regret to the NHS that three verdicts indicate that in the mid/late 1990s the medication administered to these patients has been found to have contributed to their deaths. However, in those cases it was found to have been given for therapeutic purposes.

The GMC hearing 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.

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.

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 (CHI) investigation in October 2001 concluded that the Primary Care Trusts (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 & Gosport Clinical Commissioning Group (CCG) doing to ensure patients receive good care?

A. 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 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 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 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 Community Engagement Committee 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 Community Engagement Committee 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.

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 March 9, 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 practice 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.

Dr Baker Report

Q. What is the Baker Report?

A. In 2002 the Chief Medical Officer, Sir Liam Donaldson, commissioned a clinical audit to examine the death rates at the hospital in September 2002. This audit was carried out by Richard Baker, a professor of clinical governance at Leicester University.

Q. Why has the report been published?

A. The report was commissioned by the Chief Medical Officer and as such does not belong to the PCT or, subsequently, the Clinical Commissioning Group.

Q. Do you not audit death rates at the hospital anyway?

A. It is recognised that national methods of capturing mortality data do not give a helpful picture of mortality in community or mental health hospitals, in part because relatively low bed numbers in individual sites can prevent meaningful statistical analysis. Southern Health NHS Foundation Trust,

which provides physical and mental health services at GWMH, is looking at working with the Health and Social Care Data Centre to consider ways to make quantitative analysis of mortality rates more meaningful.

However we do review all deaths at our hospitals to identify any trends and improvements that could be made to our services. In addition, an unexpected death at any hospital is always treated as a Serious Incident Requiring Investigation (SIRI) in the first instance. In the case of Gosport Police have for many years attended when there is an unexpected death and continue to do so.