CHAPTER 2 BACKGROUND TO THE INVESTIGATION

EVENTS SURROUNDING THE CHI INVESTIGATION

Police investigations

2.1 A relative of a 91 year old female patient who died in August 1998 on Daedalus ward made a complaint to the trust about her care and treatment. A daughter of the patient contacted the police in September 1998 alleging that her mother had been unlawfully killed. A range of issues were identified by the police in support of the allegation. Following an investigation, documents were referred to the Crown Prosecution Service in November 1998 and again in February 1999. The Crown Prosecution Service responded formally in March 1999 indicating that, in their view, there was insufficient evidence to prosecute any staff for manslaughter or any other offence.

2.2 This police investigation was the subject of a complaint to the police regarding its thoroughness. A further police investigation was started in August 1999. Subsequently, in December 2000, further information was submitted to the Crown Prosecution Service concerning the circumstances of the patient's death. In August 2001 the Crown Prosecution Service advised that there was insufficient evidence to provide a realistic prospect of a conviction against any member of staff.

2.3 Local media coverage in March 2001 resulted in eleven other families raising concerns about the circumstances of their relatives' deaths in 1997 and 1998. The police decided to refer four of these deaths for expert opinion to determine whether or not a further, more extensive investigation was appropriate. Two expert reports were received in November and December 2001 and these were made available to CHI. These reports raised very serious clinical concerns regarding prescribing practices in the trust in 1998.

2.4 In February 2002, the police decided that a more intensive police investigation was not an appropriate course of action. In addition to CHI, the police have referred the expert reports to the General Medical Council, the United Kingdom Central Council (after 1 April 2002, the Nursing and Midwifery Council), the trust, the Isle of Wight, Portsmouth and East Hampshire Health Authority and the NHS south east regional office.

2.5 The trust were made aware of potential issues around diamorphine usage by the police in December 1998.

ACTION TAKEN BY PROFESSIONAL REGULATORY BODIES

2.6 The General Medical Council is currently reviewing whether any action against any individual doctor is warranted under its fitness to practice procedures.

2.7 The Nursing and Midwifery Council are considering whether there are any issues of professional misconduct in relation to any of the nurses referred to in police documentation.

COMPLAINTS TO THE TRUST

2.6 There have been ten complaints to the trust concerning patients treated on Daedalus, Dryad and Sultan wards since 1998. Three complaints between August and November 1998 raised concerns which included pain management, the use of diamorphine and levels of sedation on Daedalus and Dryad wards, including the complaint which triggered the initial police investigation. This initial complaint was not pursued through the NHS complaints procedure.

ACTION TAKEN BY HEALTH AUTHORITY

2.6 In the context of this investigation, the Isle of Wight, Portsmouth and East Hampshire Health Authority had two responsibilities. Firstly, as the statutory body responsible for commissioning NHS services for local people in 1998 and, secondly, as the body through which GPs were permitted to practice. Some of the care provided to patients at the Gosport War Memorial Hospital, as in community hospitals throughout the NHS, is delivered by GPs on hospital premises.

2.7 In June 2001, the health authority voluntary local procedure for the identification and support of primary care medical practitioners whose practice is giving cause for concern reviewed the prescribing practice of one local GP. No concerns were found. This was communicated to the trust.

2.8 In July 2001, the chief executive of the health authority asked CHI for advice in obtaining a source of expertise in order to reestablish public confidence in the services for older people in Gosport. This was at the same time as the police contacted CHI. CHI then began a screening process to determine whether to initiate an investigation.

2.9 Following receipt of the police expert witness reports in February 2002, the health authority sought local changes in relation to the prescription of certain painkillers and sedatives (opiates and benzodiazepines) in general practice.

ACTION TAKEN BY NHS SOUTH EAST REGIONAL OFFICE

2.10 For the period of the investigation, the NHS regional offices were responsible for the strategic and performance management of the NHS, including trusts and health authorities. The NHS south east regional office had information available regarding concerns around prescribing levels at the Gosport War Memorial Hospital. Information included a report by the Health Service Ombudsman and serious untoward incident reports completed by the NHS south east region in April and July 2001 in response to media articles about the death of a patient at the Gosport War Memorial Hospital. The health

authority and NHS south east regional office met to discuss these issues on 6 April 2001.