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Agenda item 4

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COMMISSION FOR HEALTH IMPROVEMENT
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COMMISSION FOR HEALTH IMPROVEMENT

Report for the Investigations and Fast Track Clinical Governance Review Programme board meeting on 18 September 2001

Gosport War Memorial Hospital

File No. 0201 July 2001

Concern raised by:

(i) Regional Director of Public Health at NHS Executive South East
(ii) Detective Superintendent John James, Major Incident complex, Portsmouth
(iii) Chief Executive of the Isle of Wight, Portsmouth and South East Hampshire Health Authority

Synopsis

A patient died following a fall when she was rehabilitating at Gosport War Memorial Hospital (GWMH) after hip surgery at the Hasler Hospital. The police were requested to investigate the circumstances of the lady's death by her family.

Two police investigations have ensued, the first of which was referred to as superficial, but on each occasion the crown prosecution service had decided there was insufficient evidence to proceed.

Following local press coverage about the case, the police were contacted by nine other families. Thus the Detective Superintendent in charge of the case is pursuing further enquiries. He has also contacted CHI to outline his concerns.

Press interest in the issues still continues

Source of Information

(i) Record of a telephone conversation between CHI's Medical Director and Professor Ford, Professor of

Pharmacology and Geriatric Medicine at Newcastle University who has been called in as an expert witness by the police to review cases

(ii) Sequence of events provided by the trust's Chief Executive and statement prepared by consultant Gerontologist on the care of the patient

(iii) Interview with Detective Superintendent James

Background

Gosport War Memorial Hospital (GWMH) provides day care by a team of nurse and therapists. Medical care, except on GP wards, is overseen by a medical consultant, depending on the ward speciality, who conducts weekly ward rounds. At the time in question, the day to day medical care on Daedalin's ward (where the patient was cared for) was provided by a local GP acting as a clinical assistant and making daily and on request visits to the ward.

The nursing care provided is non-acute. The ward has 24 beds, 8 for people needing slow stream rehabilitation and 16 for those who meet criteria for NHS continuing care.

The broad prescribing practice of the GP locum, as there was no resident medical cover at GWMH, was to allow sufficient flexibility within the prescription to allow nurses(s) to administer pain relief through a syringe driver. The practice was to prescribe 20/40 mg - 200 mgs over a twenty four hour period.

The case which triggered the police investigation, was that of a 91 year old lady who was admitted to Hasler Hospital for hip surgery on 30 July 1998. She was subsequently transferred to GWMH for rehabilitation.

During the period until her death on 21 August, dislocation of the right hip occurred necessitating transfer to Hasler Hospital for treatment. On return to GWMH the patient was prescribed pain control (diamorphine) via a syringe driver.

Prior to the patient's death the family had complained about the events surrounding the patient's unwitnessed fall, delay in transferring the patient to Hasler following her fall at GWMH, pain and discomfort following transfer back to GWMH, transfer arrangements between the two hospitals. They subsequently complained to the police.

Although the CPS has indicated there is insufficient evidence to proceed, Detective Superintendent James has

arranged for four other cases (out of the nine families who came forward) to be reviewed by 2 experts (one of whom is a clinician in geriatric medicine). The cases selected are broadly similar to that of the first case, i.e.

- Condition on admission apparently not terminal
- All pre-prescribed diamorphine
- All had diamorphine administered continuously
- Quantities administered sufficient to keep patient sedated

The experts have been asked specifically to consider:

- How patients were managed / clinical practice
- Roles / responsibilities – issues of duty of care
- Diagnosis / prognosis for each patient
- Evaluation of drug regime
- Adequacy of records
- Justification for decisions

Management action

- Since the death of the patient the trust has reviewed their policies on prescription writing and the assessment and management of pain (copies of which have been provided).

- A formal policy on transferring patients to Hasler Hospital on the basis of clinical need out of hours has now been developed.

- Daytime medical support formally covered by the GP clinical assistant is now covered by a staff grade post. Out of hours cover is provided by a local GP practice.

The trust has expressed a willingness to participate in a review of any of the issues arising in the case. They have also expressed an interest in exploring palliative versus active treatment decisions although this is outwith the statutory function of CHI.

As this is a community and mental health trust they are not scheduled for clinical governance review.

Issues

- When the trust gerontologist prepared a report for the police investigation she wrote separately to the Quality Manager expressing concern that

  - She had not been consulted on the reply to the patient's family in response to their compliant

  - That a 'policy' of the medical team not to transfer patients to Hasler A & E out of hours was inaccurate since no such policy existed. Note: The consultant has subsequently issued guidance indicating that patients should be transferred on basis of clinical need

  - That at no point was the consultant gerontologist or the duty consultant geriatrician involved in making the decision not to transfer the patient to Hasler hospital.

- Poor relationships between public and local hospital and press reporting of complaints and patients being 'killed' by the hospital

- First expert report (for police investigation) raised a number of concerns

  - Locum GP pre prescribed diamorphine
  - Nursing staff at liberty to administer
  - Delivered continuously with no record to suggest review
  - Although apparently no record to indicate patient dying, staff interviewed felt that treatment appropriate because they thought she was dying. (Note: the trust response to complaint implies that there was discussion with the family and treatment given palliative)

- While the new experts called in to review the four cases for the police have yet to report, their immediate concerns relate to

  - Quantity of drugs administered
  - Continuous administration
  - No record of review of quantity and administration

- Whatever the outcome of the review – Detective Superintendent James thinks it is unlikely to lead to prosecution. He believes their remains a residual anxiety about quality of care and a culture which may have evolved:

- Colloquially known as 'dead loss ward'
- 'Patient in danger of talking himself into a syringe drawer'
- GP talked of a culture of euthanasia'

- Police have no means of assessing whether the cause of 600 deaths, two thirds of which were recorded as bronchial pneumonia was within the norm for this type of hospital and felt this merited review.

Recommendation

That there should be an investigation into the issues raised in this report based on the following guiding principles:

- Evidence of high risk activity (A.ii)
- CHI action is likely to result in lessons for the whole of the NHS (C.vi)

Margaret Tozer
Investigations Manager

September 2001