Williams, Elaine

From: Williams, Elaine

Sent: 04 January 2008 11:33

To: Samuel, Richard

Subject: Board Update on GWMH investigations 040108

Richard
You asked for an update on the 06/32 Board Report, which is attached. Please feel free to amend, I'm not sure if you want all the background stuff in again. I assume it will be on Part 2 as the GMC solicitors were clear that the subject is embargoed and the case that Dr Barton has to answer will not be published until the day the case opens.
Let me know if you need any more info.
At the moment, I am waiting for confirmation of staff details from PHT before providing it to the Solicitors via Code A page. I have chased PHT again today.
Elaine

Code A

Hampshire NHS
Primary Care Trust

Board Paper PCT [PART TWO]

Hampshire Primary Care Trust
Update on Gosport War Memorial Hospital Investigations

Executive Summary:

BACKGROUND

Between 1998 and 2001, Hampshire Constabulary undertook investigations into the potential unlawful killing of a patient at Gosport War Memorial Hospital. These investigations did not result in any criminal prosecutions, but the Police did have sufficient concerns about the care of older people at Gosport War Memorial Hospital [GWMH] that they decided to share them 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.

In October 2001 CHI commenced an investigation into the management, provision and quality of healthcare for which Portsmouth Healthcare NHS Trust (the predecessor of Fareham and Gosport PCT and hence Hampshire PCT) which was the body responsible for Gosport War Memorial Hospital at the time. The Board is asked to note, however, that on 1 October 2006, responsibility for the provision of inpatient care at GWMH transferred to Portsmouth Hospitals NHS Trust.

CHI concluded that there had been a failure of trust systems to ensure good quality patient care, including insufficient local prescribing guidelines, a lack of a rigorous, routine review of pharmacy data, and the absence of adequate trust wide supervision and appraisal systems.

CHI also concluded, however, that the trust had addressed these issues and had adequate policies and guidelines in place which are being adhered to governing the prescription and administration of pain relieving medicines to older patients.

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. These contacts, allied to the findings of the CHI investigation, resulted in the Police, in September 2002, initiating another investigation into the deaths of 92 patients at GWMH. The focus of the Police investigation centred on both organisational failings (relating to inadequate systems and procedures) and the actions of a number of clinicians. Specifically, the investigation has considered the practice of Dr Jane Barton, a local GP and Clinical Assistant within GWMH, and a number of the nursing staff at the Hospital. In the light of the Police investigation, Dr Barton agreed to voluntary restrictions to practice, which are ongoing.

Following both the CHI report and the commencement of the police investigation, the Chief Medical Officer commissioned a clinical audit of the service concerned. This audit was undertaken by Professor Richard Baker from the Clinical Governance Research and Development Unit at the University of Leicester. The outcome of this Audit was reported to the Board previously.

OUTCOME OF THE POLICE INVESTIGATION

A total of 92 cases were examined by the Police Investigation Team since September 2002. A significant proportion of those cases (82) were ceased following detailed review upon the basis that there was insufficient evidence to justify further criminal investigation.

The Police stated that they were satisfied that all relevant material had been passed to the Crown Prosecution Service between December 2004 and December 2006 in order for them to consider whether there was a sufficiency of evidence to instigate criminal proceedings.

The Crown Prosecution Service has since announced that, following careful consideration, negligence could not be proven to the high criminal standard and that there was no realistic prospect of conviction of healthcare staff. This has been reported to the Board previously.

It is understood that the Police met with the General Medical Council, the Nursing and Midwifery Council and H.M. Coroner to determine whether general 'standard of care' issues in respect of the deaths require further examination. The Police, however, reiterated that their investigation was now closed.

All family members were afforded the opportunity to meet with CPS to discuss its decision. To date, just two family group members had taken up this opportunity. The remainder seem to have accepted the decision of the CPS. One of these two families is represented by Alexander Harris (a legal firm specialising in clinical negligence) and it remains possible that civil action will ensue.

NMC and GMC

The Police forwarded papers in respect of 14 cases to the General Medical Council [GMC] and Nursing and Midwifery Council [NMC]. Until the completion of the Police investigation, the GMC and NMC were not able to consider any of the referrals they had received for fear of prejudicing the police investigation. This was reported to the Board previously.

CURRENT SITUATION

Coroner

Following the completion of the Police investigation, It is understood that the Coroner met with the Minister of Justice, the DoH and the Assistant Chief Constable to open inquests on 10 cases which he feels, having received the Police investigation report, may be worthy of having Inquests. The outcome of this meeting held during the Autumn of 2007, originally due to have been held on 21st August 2007 is not yet known.

If Inquests do take place they are likely to run concurrently, and witnesses would probably be called once. There is no indication of timescales but if held the Inquests could be over a 2 to 3 week period. A task group has been formed in preparation for action the PCT will need to take should Inquests be held.

Coroners are required to inquire into deaths reported to them, which appear to be violent, unnatural, or of sudden and unknown cause. The Coroner will seek to establish the medical cause of death; if the cause remains in doubt after a post mortem, an inquest will be held. Not all deaths are reported to the coroner. In many cases a GP or hospital doctor can certify the medical cause of death and the death can be registered by the Registrar of Births and Deaths in the usual way. However, these Registrars must report deaths to the Coroner in certain circumstances. For example if a doctor cannot give a satisfactory cause of death; if the death occurred during or shortly after an operation; was due to industrial disease; occurred whilst the person was in custody, or if the death was unnatural or due to

violence or occurred in other suspicious circumstances.

An Inquest is an inquiry into who has died and how, when and where the death occurred and in what circumstances the death occurred, an addition introduced more recently. An inquest is not a trial and does not apportion blame for a death. Possible verdicts include: natural causes, accident, suicide, unlawful or lawful killing, industrial disease and open verdicts (where there is insufficient evidence for any other verdict) or if death is as a result of neglect. The Coroner may bring a narrative verdict, in which case additional text will be included in the verdict.

GMC – Strictly confidential

In December 2007 Solicitors acting for the GMC contacted the PCT requesting contact details for a number of clinical and other staff members involved in caring for some of patients involved in the Police investigations. These details are being verified by current employers prior to release to the Solicitors early in January 2008.

It is understood that the GMC intend to hold a case against Dr Jane Barton which has been provisionally scheduled for September/October 2008. All aspects of the GMC case are currently embargoed and details of any "charges" to be answered by Dr Barton are not available and are not expected to be released until the day the case is opened. Dr Barton continues to be supported by her professional body.

The Solicitors acting for the GMC will be reviewing witness statements and may wish to take further statements from some clinical and other staff. Staff will be supported though this process and where applicable current employers have been informed. Staff involved will be contacted by the PCT, via the HR Department. Support mechanisms previously in place will continue. The task group outlined above will also take the GMC issues forward.

NMC

No contact has made by the NMC to the PCT to date.

Actions Requested:

The Board is asked to:

- Note the updated position.

Aims Supported by this Paper:

To ensure the development of good governance for the Hampshire Primary Care Trust

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Lead Director:

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Date: 4 January 2008