BOARD OF DIRECTORS

SEPTEMBER 2018

FINDING OF THE GOSPORT INDEPENDENT PANEL REPORT

1 Introduction

A report was published in June 2018 into the premature deaths of hundreds of elderly patients at Gosport War Memorial Hospital in Hampshire. The Gosport Independent Panel Report is an in depth review of the practise at the hospital of prescribing dangerous amounts of opiate painkillers for elderly patients, many of whom died, between 1989 and 2000.

Gosport War Memorial Hospital is a community based hospital where patients remain under the care of hospital based GPs, with input from Consultant and nursing staff as required. From as early as 1991, a staff nurse at Gosport expressed concerns about the use of syringe drivers administering diamorphine to patients on one particular ward. Diamorphine, a controlled drug, is a potent opiate painkiller and syringe drivers are automated devices designed to administer an ongoing dose of medication. While Diamorphine is a valuable effective painkiller it can have a narrow therapeutic window in as much as the difference between a therapeutic dose and a harmful dose is small. The elderly patients involved were in a ward isolated from the main unit of the hospital. A number of nurses subsequently had concerns that diamorphine was being administered to elderly patients who in many cases did not need such powerful painkillers. At times they felt the drugs were being used unnecessarily, at high doses to sedate patients rather than simply control pain, and that staff setting up the syringe drivers were not all trained to an adequate standard. Among other staff, the nurses named a clinical assistant, Dr Jane Barton, in their complaint.

Some families of patients also complained about the level and method of opiate administration. The complaints included patients being administered diamorphine when they were not in pain and doses being doubled without discussion. Several families were concerned about the sudden death of relatives without apparent explanation. Some of these patients were on the ward following routine operations, or otherwise uncomplicated conditions. The nurses' concerns were investigated, but the management team failed to deal with the complaints properly, instead shifting the tone of their investigation to that of 'disruptive criticism' by the nurses, who were then regarded as a small group making waves and whose complaints had 'upset Dr Barton'. It seems that for some reason the management team felt that more harm would be done by 'rocking the boat' than by responding to the nurses' concerns and putting in place more stringent protocols for use of diamorphine. One nurse was also dismissed for breaching patient confidentiality when he wrote to his local MP to express his alarm.

What followed was a series of missed opportunities and unheeded warnings.

2 Background and Events

In 1997, changes to the NHS were put in place, making NHS Trusts formally accountable for their own clinical quality, including setting up monitoring systems to assure patient safety. However, individual Trust responses to these changes was varied, and it appears that Portsmouth HealthCare NHS Trust, which administered Gosport Hospital, was particularly slow on the uptake. It is clear from the report that record keeping and auditing in relation to the use of diamorphine was poor and non-existent in many cases.

In 1998, concerns started to be raised about the number of deaths at the hospital, and the family of one patient, Mrs Gladys Richards, approached the police after she died following a hip replacement, claiming that Mrs Richards had died after being prescribed too much morphine.

In 1999, a complaint by another family led to an external review of the use of morphine within the elderly care unit. The external reviewer wrote to the chief executive stating that the use of wide ranges of morphine doses on syringe pumps was ‘poor practice and could indeed lead to a serious problem’. In response, the trust produced a draft protocol for the use of opioids by syringe drivers, but there are no records of whether this was ever implemented.

The police investigation into the death of Gladys Richards was initially dropped and found that, while there had ‘been a great deal of neglect, and mistreatment’, inconsistencies in the family’s evidence made a prosecution difficult. After the case was dropped, the family made a number of complaints about the conduct of the investigating officers and a subsequent internal report found some failings in the investigation, including that there was no attempt by the investigating officer to secure witness statements or medical notes, consider any forensic evidence, or look at other patients’ records for similar issues.

The case was therefore reopened in August 1999 and on this occasion the police obtained evidence from Professor Brian Livesley, an expert in geriatric care. Professor Livesley’s report concluded that ‘It is most probable if not certain that the cause of Mrs Richards’ death was respiratory depression as a consequence of the large doses of drugs she continuously received by syringe driver’. Hampshire Constabulary therefore opened a major enquiry under the name Operation Rochester to investigate. In a follow up report into Mrs Richards’ death, Professor Livesley wrote ‘It appears probable, therefore, that this has been an institutionalised practice that may have led to the premature and unlawful death of other elderly people’. Despite this report, Hampshire Constabulary did not open its enquiry further at this stage to investigate any other cases.

However, in April 2001, details of the police investigation were leaked to journalists, and a local newspaper article stated that up to 600 deaths could be reviewed as part of the investigation. Having read the article, a nursing auxiliary who had been working in the elderly care unit approached the police to give her recollection of another elderly patient who had died shortly after being put onto a syringe driver. She alleged that the hospital had a ‘culture of euthanasia’ and that 'troublesome patients were given overdoses of diamorphine'. By this stage, nine families had approached the police with concerns over the death of a relative. With the potential for further deaths to be investigated, Professor Livesley suggested that the statisticians involved with the Shipman case should be asked to assist. Following further investigations, the police submitted 10 cases to the CPS for

consideration. Despite Professor Livesley's assertions and the multiple complaints from families, and the investigation that had been carried out, the CPS concluded in 2006 that there was not sufficient evidence to bring any charges of unlawful killing. Hampshire Constabulary felt that 'further investigation would not be appropriate as it would necessitate the investigation of up to 600 deaths and would raise massive public concern with no certainty of outcomes in respect of criminal investigations'. The families were not satisfied, and after further complaints about the police investigation, an internal report by Hampshire Constabulary again admitted that the second police investigation was inadequate. Between 2002 and 2006 a third police investigation was undertaken. This considered the death of 91 patients.

Public concern and complaints from families continued, and the Commission for Health Improvement, the NHS body set up to improve clinical outcomes, was approached to investigate. The review of the previous internal investigations concluded that there were a number of failings, and that poor prescribing practice had not been identified due to the lack of supervision. The routine high levels of prescribing opiates were for some reason not being questioned. The Chief Medical Officer at the time responded to this report by saying that he was concerned that Dr Barton's practice and the wider team had not been investigated thoroughly.

By this stage, the GMC was asked by Mrs Richards' daughter to investigate Dr Barton's practice. An initial review did not find that Dr Barton's fitness to practise was impaired. A second investigation was carried out when the police informed the GMC that further complaints had been made by families in August 2001. By then, Dr Barton had resigned her position at the hospital and had voluntarily agreed with the local authorities to a restriction on her ability to prescribe opiates. Therefore, the GMC again did not impose any restrictions or order upon her ability to practise.

By 2003, the GMC had received the police reports into 62 cases, which concluded that in a number of cases, Dr Barton's care had been negligent (although not necessarily criminal). The GMC investigated again, and on this occasion, because Dr Barton had voluntarily agreed not to prescribe opiates, the investigating committee found that no restriction was necessary. In 2008, a fifth investigation by the GMC did impose an interim order, preventing Dr Barton from prescribing diamorphine or diazepam.

At a final hearing by the GMC in 2009, 12 cases, including that of Mrs Richards, were considered. The evidence was heard for 37 days and included 195 testimonials, many of which were in support of Dr Barton's current ability and prescribing practice. In the hearing, Dr Reid, another doctor who had worked on the ward was asked "Can you recall a single instance in your year on Dryad Ward where a patient was put on a mix of opiates or syringe driver who did not die?" His response was "No, I cannot."

At this hearing, the GMC regarded Dr Barton's position as presenting a continuing danger to patients and found her guilty of serious professional misconduct. However, she was not struck off but allowed to continue to practise with a number of restrictions imposed. The case was referred and on appeal, the Council for Healthcare Regulatory Excellence (CHRE) found that Dr Barton should have been erased from the medical register. Dr Barton subsequently retired.

Further investigations were carried out into the actions of nurses involved in the care of various patients, and the investigation was critical of some for failing to challenge Dr Barton's inappropriate prescribing. The Gosport Independent Panel Report found that the NMC was 'extremely cautious' in seeking not to undermine the other investigations that were taking place, and is clearly critical of the NMC's failure to follow up the concerns of other nurses that were raised at various stages.

Between 2002 and 2006 Hampshire Constabulary updated the coroner into its investigations. An inquest took place into the deaths of ten patients after the CPS cleared the way. The families, several of the lawyers and even the coroner had been pushing for a public inquiry rather than an inquest, so that their concerns could be fully investigated, but the Department of Health, on the advice of the Ministry of Justice did not agree to this, initially concluding that there had been 'no evidence of foul play'.

The inquest, opened in 2008, eventually heard 21 days of evidence, and while the experts involved were very critical of the management of patients overall in the unit, and the over-prescribing of opiates, the limited scope of the inquest process meant that blame could not be attributed to any particular party. The coroner hinted at dissatisfaction at the failure of the Government to hold a public inquiry in his verdict. Action against Medical Accidents (AvMA), a charity which supported a number of families through the process, issued a statement saying that the verdicts had 'failed to satisfy the families'. Clearly, AvMA felt that the refusal to hold a public inquiry was another failure. At this stage, however, the Department of Health maintained its stance that a public inquiry was not necessary.

It did however publish a clinical audit, carried out by Dr Richard Baker in 2003, which concluded that a practice of almost routine use of opiates before death had been followed in the care of patients of the Department of Medicine for Elderly People at Gosport Hospital. The practice almost certainly had shortened the lives of some patients, and it could not rule out that a small number of these would otherwise have been eventually discharged from hospital alive. Following the publication of this report, after the unsatisfactory inquest, the decision by the CPS not to bring any prosecutions, and the GMC decision not to strike Dr Barton off the register, local and national press coverage increased, and after consistent lobbying by the families involved, the Gosport Independent Panel was formed in 2014, to investigate the deaths in Gosport War Memorial Hospital, with a 'families first' approach. This was funded by the Department of Health and panel members included a QC, investigators, journalists, accident investigators, medical and nursing experts.

3 Outcome of the Panel's Findings.

Following an extensive enquiry the panel found in summary that:

- there was a disregard for human life and a culture of shortening the lives of a large number of patients;
- there was an institutionalised regime of prescribing and administering 'dangerous doses' of a hazardous combination of medication not clinically indicated or justified, with patients and relatives powerless in their relationship with professional staff;
- when the relatives complained about the safety of patients and the appropriateness of their care, they were consistently let down by those in authority – both individuals and institutions;

- the senior management of the hospital, healthcare organisations, Hampshire Constabulary, local politicians, the coronial system, the Crown Prosecution Service, General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) all failed to act in ways that would have better protected patients and relatives.

4 Safeguards already in place

- The report has been widely shared with clinical managers throughout both Trusts and also with Haven Court.
- Checks have been made and confirmation has been sent to NHS Improvement / NHS England that there are no old style Graseby syringe drivers in use across both Trusts in the Healthcare Alliance. These have all been replaced since 2011 with McKinley T34 syringe drivers which incorporate all relevant safety requirements.
- Clinical guidelines are in place for use of McKinley T34 syringe pumps for continuous subcutaneous infusion in palliative care.
- Medical devices training is in place for staff as part of their mandatory training to ensure staff are competent to use the McKinley syringe drivers.
- At South Tyneside the accountable officer for controlled drugs undertakes reviews of pharmacy data regarding unusual patterns of prescribing or supply of all controlled drugs on a monthly basis. Any concerns are raised with nursing and medical managers and these are all logged. This process is being replicated in CHS on prescribing and pharmacy data as part of the medicines governance process. All controlled drug prescribing by prescribers in the community is also reviewed by the South Tyneside accountable officer for controlled drugs.
- A Medicines Management Policy and Controlled Drug Management Protocol is in place.
- At Sunderland the Palliative Care Consultant delivers annual training to F1 and F2 doctors around end of life care and safe prescribing /symptom control. Specific guidance has been drafted for F1 and F2 doctors around symptom control with the implementation of this planned. Ward based pharmacy review of prescriptions, including review of clinical appropriateness is carried out. Whilst there are currently no active audits, previous audits have looked at Opioid titration in end of life patients. Previous audits of syringe driver prescribing showed inconsistent prescribing patterns and this was the driving force for the introduction of electronic prescribing of syringe drivers.
- A bereavement survey is being rolled out to carers / families to identify any concerns they may have regarding care at end of life.
- Incidents and complaints are monitored monthly via the Quality Report. A review of end of life care complaints has been undertaken at both Trusts with only 1 complaint received at South Tyneside as a result of the Gosport Report. Unfortunately it was not possible to investigate this as records were no longer available due to the length of time since the death of the patient involved.
- Additionally, there are no old style Graseby syringe drivers in use at Haven Court, which also has syringe driver guidance in place aligned to the Trust's guidance. An audit of cases where syringe drivers have been used, carried out by the Haven Court Manager, confirms that families were involved in the decision to use the syringe driver and this is documented both in individual resident's records and on EMIS. All of these residents had a food and fluid chart in place. No complaints have been received at Haven Court relating to end of life patients.

- Organisational systems and processes in place to enable staff to articulate concerns.

5 Recommendations

The Board of Directors is asked to receive this report for information.

Melanie Johnson
Executive Director of Nursing, Midwifery and AHPs