**Significant Clinical Event/CQC Responsiveness Review – Havant War Memorial**

**Hospital**

A patient, Mrs JW was admitted to Havant War Memorial Hospital on 8 March 2011 with sudden

onset diarrhea/vomiting and dehydration. She was transferred to Queen Alexandra hospital on

12 March 2011 where she died later that day. The cause of death had been identified as Renal

failures and dehydration classifying this as a Significant Clinical Event. There was a delay in

HPFT being notified of Mrs W’s death which we were only made aware of when we were invited

to contribute to the safeguarding meeting in reference to this death. Safeguarding procedures

were initiated by QA Hospital and the Police notified the CQC on 1 April 2011. The

safeguarding meeting was held on 7 April 2011.

The CQC contacted the Trust on 14 April 2011 requesting what action the Trust had undertaken

in response to this and requested the following information:

♦ Training records for ward staff for safeguarding vulnerable adults, avoidable malnutrition and

protected meal times

♦ Policies on these areas, noting that the policies on the website were dated 2009

♦ Terms of reference for the clinical investigation, including who is leading this

This information has been provided to the CQC. The Trust internal investigation started on

11 April 2011 and is anticipated to be completed within 4 weeks. Further updates will be given

to the Trust Board at the meeting.