



PRESS RELEASE

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GOSPORT HOSPITAL DEATHS - WHAT CAN BE LEARNT?

This Wednesday 18th March the inquest into ten of an original 92 suspicious deaths at the Gosport War Memorial Hospital in the late 1990's begins. Amidst disappointment that a full public inquiry has so far been rejected by the Government, there is also hope that the inquest will at last uncover to what extent systemic problems at the hospital or individual malpractice by health professionals contributed to the deaths. It may also provide wider lessons for the NHS on patient safety in relation to the use of strong pain killing and sedative drugs ('opioids') and for the system of health professional regulation including the General Medical Council. The national charity Action against Medical Accidents (AvMA) is spearheading efforts to ensure that these opportunities are not lost and providing support to families who lost loved ones at Gosport – whether or not they are included in the inquest itself.

The deaths at Gosport involve the use of diamorphine and other opioids on elderly and very ill people. The NHS is not blind to the dangers of opioid drugs. In 2008 the National Patient Safety Agency issued a rapid response report with actions required by January 2009, following receipt of 4,200 reports of patient safety incidents involving opioids. 880 of these are known to have caused harm, including five deaths. However, this could be the tip of an iceberg. The NHS reporting system is entirely voluntary and it is known many incidents are not reported. AvMA suspect that in cases involving elderly and very ill people it is much less likely that errors and their consequences will be recognised.

Years after it was castigated by the Shipman inquiry, the General Medical Council (GMC) does not come out of this at all well. Although the GMC was aware of the concerns raised about the doctor at the centre of the allegations surrounding Gosport in 2000 at the latest, it took no action to place restrictions on her practice in order to protect the public until 2008. If it was necessary to protect the public in this way last year, it suggests that the public may have been left at unnecessary risk for at least eight years. This is not the more proactive GMC that we were all led to believe we would see after the Shipman inquiry. Just last month in a high court hearing where the charity Action against Medical Accidents (AvMA) won permission for a judicial review of another dubious GMC decision - not even to investigate allegations against doctors of forgery and perverting the course of justice, the GMC's representative actually argued that its role was 'reactive' rather than 'proactive', and that in order to investigate concerns about doctors information about those concerns had to be accompanied by a request for them to investigate.

AvMA has made arrangements for local specialist solicitors Blake Laphorn to represent families at the Inquest. Their help and that of barristers from Outer Temple Chambers is having to be provided largely on a pro bono basis due to the problems with obtaining Legal Aid for inquests. AvMA is also advising and supporting families not directly involved in the inquest.

AvMA chief executive Peter Walsh said:

“As well as providing insight to the individual deaths, the opportunity must be seized to learn lessons for patient safety and for reviewing the way that the GMC makes decisions. The GMC should be more proactive in protecting patients than protecting doctors”

“It is a pity there is not a public inquiry and that the authorities are not being as open as they might be, which has added to the families’ hurt and suspicions. We have had to make a Freedom of Information request to try to get an important Department of Health commissioned report on Gosport released”

ENDS

1. For further information contact Peter Walsh on **Code A** or **Code A**
2. Website: www.avma.org.uk
3. AvMA is a registered charity no. 299123 and a limited company registered in England No 2239250 and in Scotland SCO39683