Code A
29/07/2002 12:51

To: Marcia Fry/CQEG/DOH/GB
cc: Code A
Code A Janet Walden/ Code A
Code A
cc: Code A
Code A Janet Walden/ Code A
Code A
Subject: Restricted: Investigation - Gosport War Memorial Hospital

RESTRICTED - Investigation

IN STRICT CONFIDENCE

Marcia

Please find attached a further note from Sir Liam on the situation at Gosport War Memorial Hospital.

Code A Sir Liam's note of 16 July 2002 is attached below for ease.

thanks very much

Code A
PS/CMO

tel: Code A

FryM10 - Gosport War Memorial Hospital follow up note.d
----- Forwarded by Rachel Dickson/PR-OFF/DOH/GB on 29/07/2002 12:54 -----

Code A
16/07/2002 15:08

To: Marcia Fry/CQEG/DOH/GB
cc: Code A
Code A
Subject: Restricted: Investigation - Gosport War Memorial Hospital

RESTRICTED - Investigation

Code A

Please see the attached note from Sir Liam. He would like to discuss with you as soon as

possible.

thanks very much

Code A
PS/CMO

tel: Code A

FryM9 - Gosport War Memorial Hospital.do

RESTRICTED - INVESTIGATION

Marcia Fry CQEG

From: Sir Liam Donaldson

Date: 29 July 2002

Copy: Code A

Professor Ian Philp
Janet Walden CQEG

Code A

GOSPORT WAR MEMORIAL HOSPITAL

Issue

1. A further note to follow the minute of 16 July 2002. I am now firmly of the view that we should initiate an NHS investigation initially examining data to look for evidence of excess mortality or clusters of deaths.

Further developments

2. Following my note of 16 July 2002 I called in Professor Livesley the retired geriatrician who had acted as an expert witness for the police.

3. In short he believes that the police did not investigate adequately and were wrong to drop their investigation.

4. The CHI investigation did not look at individual cases.

5. The GMC investigation may take a couple of years (on past experience) and they have not suspended the doctor concerned.

6. Professor Livesley's report which I have seen in confidence makes worrying reading but only deals with one case. He told me that there had been mention of other cases in which death had been hastened but he had not been asked to look any more widely.

7. Locally there is a high degree of concern amongst a number of relatives.

RESTRICTED - INVESTIGATION

Professor Richard Baker

8. The most obvious person to take this task on for us is Professor Richard Baker who did the Shipman medical audit for me. This would clearly raise the temperature locally and nationally but he is very sound and we cannot risk a poorly conducted methodology.

Conclusion

9. Allegations have been made of a 'culture of euthanasia' at Gosport War Memorial Hospital.

10. Attention has focused on a particular doctor (a general practitioner who does hospital services there).

11. Local NHS investigations, a police investigation and a Commission for Health Improvement review have found no grounds for further investigation.

12. None of these approaches has audited the death rate or the nature of deaths systematically.

13. Confidential information from a senior doctor who looked at one case in depth shows serious cause for concern.

14. The GMC is looking at the doctor's practice but could take two years to finish its work.

15. I believe we need an urgent audit and review of deaths.

16. I would propose I commission Professor Richard Baker to do it.

SIR LIAM DONALDSON
CHIEF MEDICAL OFFICER