RESTRICTED - INVESTIGATION

Marcia Fry

From: Janet Walden

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Cc: Mike Evans

GOSPORT WAR MEMORIAL HOSPITAL

1. We spoke briefly. I thought it might be helpful to update you on the progress of the different inquiries.

2. The police have referred the 5 cases on which they have expert opinions, the CHI Report and the 1991 dossier to the CPS. It is not clear what advice they are seeking and how long it will take to receive any decision. In the meantime they have issued a notice to the PCT that they are investigating the unlawful killing of 1 patient, malfeasance, corporate culpability and conspiracy to pervert the course of justice. Having reviewed their earlier witness statements in the light of the 1991 dossier, they are now preparing to interview hospital staff. This may be a fishing expedition for further cases.

3. The local helpline has now received about 40 calls. Of these 11 or so are from families whose relatives died between 1991 and 1998, and where complaints were made at the time. A further death incurred in 2000. All have indicated that they wish to have access to the medical records, make a formal complaint and have their details passed to the police.

4. Ann Alexander has established a web-site which lists the public bodies with responsibility for Gosport since 1991 and their perceived failures to take action.

5. In addition to the police investigation and Baker audit, the SHA has redeployed two senior managers pending further independent investigation and possibly disciplinary action. The relatives group are aware of this and are awaiting an announcement on what other action, if any, is to be taken.

6. Our view, shared by the SHA, is that whatever the outcome of the Baker audit and the police investigation there is a need to address the apparent serious management failures at Gosport following complaints by staff in 1991, until at least 1998, the starting point for the CHI investigation during this period.

7. Even if the other investigations do not provide enough evidence to support the allegations of excess deaths, the CHI Report has already established that no adequate systems were in place in 1998. Given that serious concerns appear to have been raised in 1991 and there were a series of complaints throughout the 1990s there is a prima facie case to answer for lack of appropriate management action. I would suggest that this in itself will need some form of independent review if public confidence is to be restored and the new SHA is not to lose credibility with the local population. This view is supported by the SHA. This is much wider than the disciplinary action taken for the two redeployed senior members of staff.

8. The other investigations may however throw up concerns about excess deaths without providing sufficient evidence for a prosecution. In this event there will be a duty under Section 2 of the Human Rights Act to investigate the individual deaths at Gosport. Any such investigation should involve the relatives and may best be done as a modified private inquiry.

9. There is growing pressure from the families and their lawyer for some action. The SHA has bought some time by their immediate actions and by indicating that it is considering how best to proceed.

10. It seems to me that we have a number of options for action open to us. These have been discussed with Gill Aitken, SOL who agrees the conclusions reached and with the SHA: -

    i) a decision not to hold an inquiry - this is likely to be legally challenged;
    ii) an announcement that an independent inquiry will be established after the conclusion of the police investigation. Its terms of reference and scope would include the management review mentioned at paragraph 6, but would be finally determined by the outcome of the Baker audit and police investigation. Depending on the issues raised it seems likely that a private or modified private inquiry would be defensible if legally challenged;
    iii) no decision is announced about future actions until the Baker audit and police investigation are concluded. This will almost certainly lead to significant pressure from the relatives group and will put us on the back foot in determining the eventual way forward.

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11. You may wish to discuss further and meet the SHA CE, Gareth Cruddance and DPH, Simon Tanner who are anxious to work with you on determining the best way forward.

Janet Walden
Branch Head
CQEG-IIU