

CMO if content
PS(H)

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Cc: as covering email

GOSPORT WAR MEMORIAL HOSPITAL (GWMH)

Issue

1. To update you on recent developments in the Gosport War Memorial Hospital case and to ask you to agree possible lines in response to anticipated PQs and correspondence.

Timing

2. Pressing. We expect the GMC to conclude its Fitness to Practise hearing in the case of Dr Jane Barton later this week (although the decision might not be announced immediately). We expect that this will prompt renewed interest in the whole Gosport case.

Recommendation

3. That you note the current position and agree the proposed actions.

Background

4. You are familiar with the general background to the Gosport case and Professor Richard Baker's report. In brief, a higher number of elderly patients than might have been expected died in certain wards at GWMH in the late 1990s. Dr Jane Barton was a clinician at the hospital at the time and some of her actions and prescribing practices came under suspicion. Starting in 1998, there were various police investigations with subsequent referrals to the Crown Prosecution Service, which decided that there was insufficient evidence to prosecute. In June 2002, the Commission for Health Improvement (predecessor of the Healthcare Commission) published a report into GWMH indicating that there were no current concerns about prescribing practices at the hospital.

5. CMO commissioned Professor Richard Baker (who undertook the audit of Dr Shipman's patients) to carry out a review of patient deaths at GWMH. Professor Baker concluded that "...the findings tend to indicate that the finding of a statistical excess of deaths among patients admitted to Gosport would be unlikely".

6. There were further police investigations over the next few years but proceedings were never taken against Dr Barton or anyone else. The Portsmouth coroner conducted inquests on ten patients who had died in the hospital. The verdicts, returned in April 2009, were that: all ten died of natural causes; in five cases prescribing did not contribute to death and was for therapeutic reasons; in two cases

prescribing did contribute to the deaths but medication was appropriate for the condition and for therapeutic reasons; in three cases prescribing did contribute to the deaths but medication was not appropriate for the condition and for therapeutic reasons.

The current position

7. A GMC hearing into Dr Barton's fitness to practise began in the summer of 2009 but was not completed. The hearing resumed on 18 January and is expected to conclude this week; additionally, the Portsmouth coroner has decided to hold an inquest into the death of Mrs Gladys Richards, a patient at GWMH. MoJ colleagues have told us that a date for the inquest has still to be set and have added that the hearing is still some way off as the coroner has now referred the case back to the Hampshire police as Mrs Richards' daughter has raised concerns about the death.

Freedom of Information requests to see the Baker report

8. There have been several FOI requests to see the Baker report, particularly since the inquests in April 2009. Ministers have agreed that these requests should be rejected. Consistent advice from Legal Group has been that releasing the report before the conclusion of all proceedings involving Dr Barton, including the GMC hearing and, depending on the verdict, any appeal period, might be prejudicial to the administration of justice. The anticipated new inquest would also fall under the "administration of justice" heading. The line on calls for a public inquiry has been that Ministers do not consider that a public inquiry would add anything to what is already known but would wait for the (original) inquest verdicts and the outcome of the GMC hearing, consider these, and decide what, if any, further action should be taken.

Parliamentary activity, correspondence, media interest

9. We expect the conclusion of the GMC hearing in Dr Barton's case to prompt renewed interest in the whole GWMH affair. Norman Lamb MP, who has previously asked to see the Baker report, has already tabled an Early Day Motion supporting calls for a public inquiry. There has so far been one letter from a GWMH relative.

Lines to take

10. If asked to comment on the GMC decision expected shortly, we suggest that Ministers respond along the lines described in paragraph 8 above:

I am aware of the GMC's decision in Dr Barton's case. I understand that the Portsmouth coroner will be holding an inquest into the death of another patient who died at Gosport War Memorial Hospital. It would be inappropriate to comment further until after the inquest.

If pressed on a public inquiry:

I do not believe that a public inquiry would add anything to what we already know. At the conclusion of the inquest we will consider the verdict and whether any further action is appropriate.

Recommendation

11. Officials' view is that it would still be inappropriate to take any final decision on a public inquiry before the outcome of the GMC hearing and the further inquest, particularly as the death of the patient concerned has been referred to the police. We also suggest that any FOI requests to see the Baker report remains covered by the "prejudicial to the administration of justice" exemption.

Conclusion

12. You are asked:

1. To note the most recent developments in the GWMH case, particularly the reconvened GMC hearing, expected to conclude this week, and the further inquest into the death of a GWMH patient;
2. to agree to the suggested response to any calls for an inquiry into events at the hospital;
3. to agree that any further requests under the Freedom of Information Act to release the Baker report into deaths at the hospital should, as before, be rejected on the grounds that legal proceedings (the GMC hearing/any appeal period and the anticipated further inquest) are still incomplete.

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