FAM001918-0001

MARK HOBAN M.P.

HOUSE OF COMMONS
LONDON SW1A 0AA

Charles Stewart-Farthing Esq

Code A

27 February 2009

Dear Mr Stewart-Farthing

As you know, I wrote to Ann Keen MP once again following receipt of your email to her of 30 January, to ask for her further comments on the matters that you raised about the Gosport War Memorial Hospital and I have now received her enclosed reply.

With regard to your concern that the coroner was denied access to counsel's advice, you may wish to consider contacting the Chief Crown Prosecutor in Hampshire, Nick Hawkins, as Ann Keen has suggested, to see if he can offer you any insight into this.

The Minister has confirmed that the Chief Medical Officer has not suppressed any of the reports relating to this matter and seems clear to me that they are waiting for the outcome of the inquests before assessing if further actions need to be taken.

Yours sincerely

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Enclosure

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From Ann Keen MP
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Mark Hoban MP
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Dear Mark

24 FEB 2009

Thank you for your letter of 3 February enclosing further correspondence from your constituent Mr Charles Stewart-Farthing of Code A Code A about the investigation into deaths at Gosport War Memorial Hospital.

As explained in my previous letter, we believe that a public inquiry into this issue would merely duplicate work currently being undertaken and that already undertaken by, among others, the police, the Health authorities, the Nursing and Midwifery Council (NMC), the General Medical Council (GMC) and the Healthcare Commission. We will await the outcome of the inquests and then assess if there remain matters outstanding which require further resolution.

The Chief Medical Officer (CMO) has not suppressed any of the reports relating to this issue. The CMO actually initiated the whole investigation including tasking Professor Baker. The Baker report has been given to both the police to assist their enquiries, and to the GMC who used their powers under the Medical Acts to obtain it. The work of the GMC and the NMC on this case have not involved the CMO.

I note that Mr Stewart-Farthing is concerned that the coroner has been denied access to the counsel's advice. Any decision to deny the coroner access to the advice would have been made by the Crown Prosecution Service (CPS), which comes under the remit of the Attorney General rather than the Ministry of Justice or the Department of Health. Should Mr Stewart-Farthing wish to raise this issue directly with the CPS in Hampshire, the contact details are:

Nick Hawkins
Chief Crown Prosecutor

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Turning to Mr Stewart-Farthing's concern about the powers of the coroner, he may be interested to know that the coroner is an independent judicial office holder and the conduct of the inquests, including the scope of the investigation, is a matter solely for him. There is no authority for Ministers or anyone else to intervene. The coroner cannot, however, determine civil or criminal liability, but he can make a report if he thinks it would help to prevent future, similar deaths occurring. The powers of the coroner are outlined in Rules 36, 42 and 43 of the Coroners Rules 1984, which are detailed below:

36. Matters to be ascertained at inquest

(1) The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely--
(a) who the deceased was;
(b) how, when and where the deceased came by his death;
(c) the particulars for the time being required by the Registration Acts to be registered concerning the death.
(2) Neither the coroner nor the jury shall express any opinion on any other matters.

42. Verdict

No verdict shall be framed in such a way as to appear to determine any question of--
(a) criminal liability on the part of a named person, or
(b) civil liability.

43.—(1) Where—
(a) a coroner is holding an inquest into a person's death;
(b) the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and
(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,
the coroner may report the circumstances to a person who the coroner believes may have power to take such action.

(2) A report under paragraph (1) may not be made until all the evidence has been heard except where a coroner, having adjourned an inquest under section 16 or 17A of the 1988 Act, does not resume it.

(3) A coroner who intends to make a report under paragraph (1) must announce this intention before the end of the inquest, but failure to do so will not prevent a report being made.

(4) The coroner making the report under paragraph (1)—
(a) must send a copy of the report to—
(i) the Lord Chancellor; and

(ii) any person who has been served with a notice under rule 19; and

(b) may send a copy of the report to any person who the coroner believes may find it useful or of interest.

(5) On receipt of a report under paragraph (4)(a)(i), the Lord Chancellor may—

(a) publish a copy of the report, or a summary of it, in such manner as the Lord Chancellor thinks fit; and

(b) send a copy of the report to any person who the Lord Chancellor believes may find it useful or of interest (other than a person who has been sent a copy of the report under paragraph (4)(b)).

I hope this reply clarifies the Government's position.

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ANN KEEN