



Ministry of JUSTICE

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8 January 2009

Dear Mr Bradley

OPERATION ROCHESTER – DEATHS AT GOSPORT WAR MEMORIAL HOSPITAL

I refer to your letter of 6 January to **Code A** about concerns you have in connection with the above inquests that you are handling as assistant deputy coroner to Mr Horsley.

Any decision about a public inquiry into the deaths at Gosport War Memorial Hospital would be a matter for the Department of Health. We have raised your concerns with that Department, but their view remains that given the variety of investigations that have already been undertaken and the powers you have to inquire into all the circumstances leading up to the deaths, the inquests should now proceed – as directed by the Secretary of State under section 15 of the Coroners Act 1988 in seven of the cases.

If on conclusion of the inquests there remain any issues that need further attention, the Department of Health will review the position.

Yours sincerely

Code A

Coroners and Burials Division

David C. Horsley LLB
Her Majesty's Coroner
for Portsmouth and
South East Hampshire

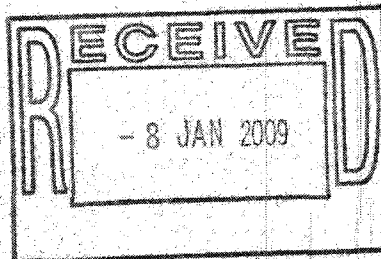


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The Guildhall
Guildhall Square
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PO1 2AJ

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Coroners Unit
Ministry of Justice
8th Floor
102 Petty France
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7 January 2009



Code A

Dear **Code A**

Deaths at Gosport War Memorial Hospital:

Andrew Bradley has forwarded to me a copy of his letter dated 6 January 2009.

For my own part, I wholly endorse what he says to you regarding this matter. When I initially made representations to the Ministry of Justice in 2007 about the scale of Inquests in relation to the Gosport deaths, I was concerned principally about the resource implications of holding up to 92 Inquests. Since then, as Andrew has proceeded with the 10 cases in which I opened Inquests it has become apparent that the Inquest process is not going to deliver the sort of investigations and conclusions which are envisaged by the families involved. It is also not clear what the other 82 families are expecting to happen as regards their relatives' deaths.

At the meeting held at the Ministry of Justice in August 2007, you will recall that I raised the possibility that a public inquiry could be held into all 92 deaths rather than a number of Inquests as being a more appropriate way of allaying public concerns regarding the deaths. I was told by the representative from the Department of Health that a public inquiry would not be an option because the Department considered that the Gosport deaths did not raise any issues of national concern. I pointed out that although the two situations were not entirely parallel, in the public mind what happened at the hospital in Gosport would be linked with the Shipman case and there was a nationally important issue involved, namely the administration of morphine – possibly unnecessarily – in a NHS hospital. The representative from the Department of Health rejected this.

As events have panned out, I consider that a public inquiry into all the deaths is needed to allay public concerns about what happened and will do so in a way which the limited scope of the Inquest could never do so.

Hence, I would ask that the question of a public inquiry into what happened at Gosport War Memorial Hospital be reconsidered as a matter of urgency.

Yours sincerely

Code A

David C Horsley

Code A

cc Mr A M Bradley

From Ann Keen MP
Parliamentary Under Secretary of State

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Mark Hoban MP
House of Commons
Westminster
London SW1A 0AA

Richmond House
79 Whitehall
London
SW1A 2NS
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Thank you for your letter of 3 February enclosing further correspondence from your constituent [redacted] Code A of [redacted] Code A [redacted] Code A about the investigation into deaths at Gosport War Memorial Hospital.

As explained in my previous letter, the Department of Health and the Ministry of Justice believe that a public enquiry 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 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 [redacted] Code A is concerned that the coroner has been denied access to the counsel's advice. ~~The Any~~ decision to deny the coroner access to the ~~counsel's advice would have been made by had to come from 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 [redacted] Code A wish to raise this issue directly with the CPS in Hampshire, the contact details are:

Nick Hawkins
Chief Crown Prosecutor
3rd floor
Black Horse House
8 - 10 Leigh Road
Eastleigh
SO50 9FH

Turning to Code A concern about the powers of the coroner, he may be interested to know that the coroner can look at any background information he thinks is relevant, not just to the case before him, but to the environment in which the events of the case took place. The coroner cannot determine civil or criminal liability. 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—*

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(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.

ANN KEEN

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