Skye Sue - Legal Services Manager

From: Deeks, Mary [Code A]

Sent: 27 August 2008 16:41

To: andrew.bradley[Code A]

Cc: val.maddison[Code A]

Subject: Gosport War Memorial Hospital - Coroner's Inquests

Dear Mr Bradley

I have today posted a hard copy of the attached letter to you at the Coroner's Office in Portsmouth, but I am sending it via email as well to avoid delays.

With best regards

Mary Deeks
Project Officer - GWMH
Hampshire Primary Care Trust

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27 August 2008

Mr Andrew Bradley
c/o Her Majesty's Coroner for Portsmouth and South East Hampshire
Guildhall
Guildhall Square
PORTSMOUTH
PO1 2AJ

Dear Sir

Gosport War Memorial Hospital ("GWMH")

I write in my capacity as Chair to the GWMH Steering Group that has been set up by the NHS organisations whose predecessor organisations were involved with the provision of care and treatment to the 10 patients who died at Gosport War Memorial Hospital in the 1990's and in respect of whom inquests have recently been opened and adjourned.

Staff and responsibility for provision of services including patient care have transferred to the organisations below following the dissolution of Portsmouth Healthcare NHS Trust on 31 March 2002. It is with a view to ensuring the co-ordination of information and documentation across all successor bodies as well as the facilitation of information to you, that the four principal NHS bodies have set up the Steering Group and agreed that I should be your first point of contact in relation to any information required by you in connection with the inquests.

The four principal NHS bodies are: Hampshire Primary Care Trust (incorporating the former Fareham and Gosport and East Hampshire PCTs); Hampshire Partnership NHS Trust (formerly West Hampshire NHS Trust); Portsmouth Hospitals NHS Trust; and Portsmouth City Teaching Primary Care Trust.

By way of background, it may assist you to know that whilst I currently hold the post of Director of Performance and Standards at Hampshire PCT, between 2001 and 2004 I held the post of Assistant Chief Executive at the Hampshire and Isle of Wight Strategic Health Authority. That role included responsibility for the commissioning of inquiries and investigations and consequently I do have first hand knowledge of the investigation into events at GWMH as I was responsible for liaising with the Police and the Commission for Healthcare Inspection around their respective investigations into the care and treatment of the 10 patients.

As I understand it, contact has been made with the families of the patients whose deaths are subject to inquiry although contact is yet to be made with the NHS organisations on whose behalf I write. I am not sure whether it is your intention to meet with the NHS bodies involved as you have with family members to outline the process and to identify what information you require and how you intend to proceed, or whether you intend to call a pre-inquest review meeting to address these matters, particularly on the question of witnesses as a number have since moved or retired and in some instances are themselves deceased.

Any indication you can give as to how you intend to proceed would be appreciated. In the meantime, if you need any information from any of the four NHS bodies identified above please do not hesitate to contact me.

Yours faithfully

Richard Samuel
Director of Corporate Affairs
Hampshire PCT
for and on behalf of GWMH Steering Group