# Gosport War Memorial Hospital - The Baker Report - A Review of the Deaths of Patient at Gosport War Memorial Hospital

**Due to be published 2 August 2013**

**Background:**

Inquiry report due to be published by the Department of Health into deaths at Gosport War Memorial Hospital at the end of July. The report was commissioned by the CMO, Sir Liam Donaldson, in 2002 and finished in 2003 and completed by Dr Richard Baker, Clinical Governance Research and Development Unit, University of Leicester.

Below outlines our actions in circulating the reporting and responding to any press and media enquiries.

**Action plan:**

| Action | Status update | Lead |
|---|---|---|
| **Engage with CCG on approach and agree how to take forward** | • **NB to speak with Sara Tiller and Sarette Martin**<br>• Sara Tiller (CCG) is speaking to Gail Rossiter (NHS England) as it is not thought that the CCG should be fronting any response as it was a different organisation who commissioned the hospital in 2002 and the report was written so long ago. Feelings are that they will not agree to front it.<br>• Sarette Martin to update NB on outcomes of conversations.<br>**OUTCOME: NHS England will front any media for the publication of the report but we still may be contacted for comment.** | **NB** |
| Holding statement | **No holding statement will be prepared. All media requests will be directed back to NHS England** | **Comms team** |
| **Circulate report to interested parties when published** | **NB to monitor DoH website and speak to CCG colleagues to find out when due to be published**<br>**OUTCOME: Report due to be published 2 August. Embargoed copy circulated to colleagues 31 July.** | **NB** |

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| NB to lialise with Jude Diggins, CCG, Gethin Hughes around lines and actions and report back | NB to prepare briefing and circulate for feedback **OUTOME: NB circulated briefing 31 July 2013.** | **NB** |

**Risks and concerns:**

Although the paper makes a number of recommendations to the level of care and processes, it must be noted that these have been either implemented over the last ten years or that clinical practice has changed making the recommendations obsolete. Jude Diggins to advise further should we be asked about specific recommendations. Although we will not be responding to media interest it is likely that we will be associated with the report which is a potential reputational risk. All coverage will be logged and monitored throughout.

**Potential Media Interest:**

- The Portsmouth News has spoken to Gillian Mackenzie (daughter of Gladys Richards - last inquest) so it is likely that they will be running with this story and will look for comment. We were not approached by Portsmouth News directly following the last inquest, but they did attend and cover it.
- In the past the cases and inquests have attracted a lot of regional and national media attention and this report has been pushed for by families so we should expect quite a lot of interest.
- CCG are looking for NHS England to front the response to the report and are claiming no involvement. Portsmouth Hospitals NHS Trust did not attend the last inquest and have remained quiet throughout. Therefore it is likely that if media cannot get a response from those more directly involved they may come to us for comment.

**Potential media angles to be aware of:**

- "Trust did not listen to staff concerns around the pre-prescribing of diamorphone." Could link with recent news around whistleblowing in the NHS.
- "Inappropriate use of diamorphine in pain control and end of life care". Could raise questions around the current use of diamorphine and processes in place to assess pain and deterioration.
- "End of life care not delivered well in NHS" could raise questions around Liverpool Care Pathway and how we deliver end of life care.
- Incomplete record keeping
- Some patients considered in the review it is believed could have made a full recovery and returned home.