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**Sent:** 17 October 2013 15:18

**To:** Ward Ursula - Chief Executive; Harriman, Sue **Subject:** Gosport War Memorial Hospital Update

Importance: High

Follow Up Flag: Follow up Flag Status: Flagged

Categories: Urgent

#### Ursula / Sue

Please find below a briefing note that I have shared internally to the CCG, which you might find useful to share within your Trusts. I will convene a meeting at some point in the near future to progress the actions listed below.

Regards

Richard

### Dear Colleague

I had a very useful discussion with Kiran Bhogal (CCG legal advisor) this morning with regards to the prospect of further enquiry or investigation into the care and treatment of patients at Gosport War Memorial Hospital between 1988 and 2000.

You will recall that following the release of the Professor Baker Audit by the Department of Health on 2 August 2013 (see link <a href="https://www.gov.uk/government/publications/gosport-war-memorial-hospital-deaths-of-patients">https://www.gov.uk/government/publications/gosport-war-memorial-hospital-deaths-of-patients</a>), Norman Lamb, Minister for Care and Support, met with the relatives of individuals who died at the Hospital and (as reported in the Independent) stated "I am exploring options for how we can establish all the facts in relation to this scandal. I am deeply concerned by the findings off the Baker report." He added: "I am also conscious that a lot of documents remain unpublished. I want openness so we can establish all of the facts."

The Portsmouth News reported that families were 'told they could ask for a full public inquiry, a full independent investigation, or an independent panel, similar to the Hillsborough investigation. I have always said there should be a full-on public inquiry and a criminal investigation, added Mr Wilson. A full inquiry would be very long-winded and expensive, so I don't know which way it will go.' Gosport MP Caroline Dinenage said: 'I would prefer option two or three, rather than a full inquiry. It would be expensive and distressing for families.'

In the light of this reporting, it is prudent to assume that there will be further scrutiny of matters relating to GWMH. The three reported options are:

#### **Public Inquiry**

A Tribunal of Inquiry (Public Inquiry) is an official review of events or actions ordered by the government. A public inquiry accepts evidence and conducts its hearings in a public forum. Interested members of the public and organisations may not only make (written) evidential submissions as is the case with most

inquiries, but also listen to oral evidence given by other parties. Recent inquiries have included Mid-Staffordshire Hospital, Contaminated Blood Products and the Iraq War.

# **Independent Investigation**

These are most often used in the NHS to undertake an independent investigation 'when a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, or specialist mental health services in the six months prior to the event'. A small independent investigatory team is established which conducts their evidence gathering in private but ultimately makes the findings of the report public (example reports attached <a href="http://www.england.nhs.uk/publications/invest-reports/">http://www.england.nhs.uk/publications/invest-reports/</a>)

## **Independent Panel**

The most notable of these in recent years has been the Hillsborough Independent Panel (<a href="http://hillsborough.independent.gov.uk/">http://hillsborough.independent.gov.uk/</a>). The panel was established by UK government to oversee the release of documents related to the 1989 Hillsborough football disaster. The Panel's role is to <a href="ensure that the Hillsborough families and the wider public receive the maximum possible disclosure of all relevant information relating to the context, circumstances and aftermath of the tragedy. It is also the Panel's role to research and analyse the documents and provide a comprehensive report on what their disclosure adds to public understanding. Throughout its work the Panel has consulted with the families of the deceased and its work has been informed by their views and priorities. Disclosure will take place first to families and then to the public.

Of these, the Independent Panel seems by far the most likely option given the Minister's intent to ensure there is openness so we can establish all of the facts.

In preparing for any such process, the following actions are underway:

- 1. We will ensure that the NHS commences the process of identifying the location and collating all relevant material that would be required to support such processes
- 2. We will convene a meeting of all relevant parties (PHT, Wessex Area Team, Southern health and F&G CCG) and their legal representatives to definitively agree legal liability and leadership in the event of any further formal proceedings
- 3. We will convene a meeting of the communications leads to ensure that the NHS has some collectively agreed lines to take in the event of an announcement from the Minister without prior notification
- 4. We will work with the Wessex Area Team to ensure we are briefed / sighted on any future announcements relating to GWMH.

I hope that this update is useful. I hope that we can pick up any issues or questions at the Governing Body development session next week. Of course if anything breaks in the meantimne, you will be the first to know.

Regards

Richard

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