The Baker Report – A review of deaths of patients at Gosport War Memorial Hospital between 1988 and 2000

The Baker Report sets out the findings of the review of deaths of patients at Gosport War Memorial Hospital (GWMH) between 1988 and 2000. The then Chief Medical Officer, Professor Sir Liam Donaldson, asked Professor Richard Baker of Leicester University to carry out the review in 2002 because of concerns about the care of patients at GWMH. The concerns were first raised in 1998 and were the subject of a police investigation when the review was commissioned.

Professor Baker completed the review in October 2003. The report could not be released at the time as it formed part of the evidence for police investigations and other legal proceedings. The final inquest into the deaths considered in the review ended in April 2013. The report was released in full on August 2, 2013. .

Professor Baker's review presents an audit of care drawing upon clinical records, medical certificates of cause of death, admissions books, controlled drugs registers, and the work of a sample of GPs.

Professor Baker made the following five recommendations in his report. These have been largely overtaken by developments since the review was carried out.

1. Investigations should continue into the deaths of individual patients. The findings of this review reinforce concerns about what may have occurred in these cases
2. In the continuing investigation into deaths in Gosport hospital, information about the rota followed by Dr Barton and her partners should be obtained and used to explore patterns of deaths
3. Hospital teams who care for patients at the end of life should have explicit policies on the use of opiate medication. These policies should include guidance on the assessment of patients who deteriorate, and the indications for commencing opiates. The development of national guidelines would assist the development of local policies
4. The findings reported in this review should not be used to restrict the use of opiate medication to those patients who need it. Indeed, there are reasons to suspect that some patients at the end of life do not receive adequate analgesia
5. In this review, evidence has been retrospectively pieced together from a variety of sources. Continued monitoring of outcomes at a local level might have prompted questions about care at Gosport hospital before they were raised by relatives, but continued monitoring is difficult with current data systems. Hospital episode statistics are an important resource, but continued prospective monitoring of the outcomes achieved by clinical teams requires a more detailed set of codes.

The CCG has undertaken a retrospective review of the services, organisational changes and relatives' complaints that had resulted in a number of investigations over the preceding fourteen years. This review has concluded that all recommendations from the original Commission Health Improvement report have now been fully implemented.

The CCG had one direct media enquiry about the publication of the Baker Report. This came from the health correspondent at BBC South, David Fenton, who was keen to know if the report was going to be released by the Department of Health that day. The link to the report, and the CCG statement, was emailed to him that afternoon following publication. The CCG's statement was also sent to Wave 105 late afternoon after coverage was heard on one of its drivetime bulletins. No other media enquiries were received on the issue.