Code A

**From:** Tiller, Sara
**Sent:** 17 February 2009 14:10
**To:** Samuel, Richard; Code A
**Cc:** Code A
**Subject:** Sing off of GWMH media pack and staff pack.
**Attachments:** FINAL STAFF Comms pack Inquests.doc; FINAL GWMH Inquests Information Pack.doc

Hi, please find attached the (hopefully) final versions of the GWMH Media pack and Staff pack for your sign off please. There are a couple of comments and highlighted bits still to be resolved with PHT,

kind regards,

Sara

Sara Tiller
Assistant director - communications
Hampshire Primary Care Trust

T: Code A
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Omega House, 112 Southampton Road, Eastleigh, Hampshire, SO50 5PB

Portsmouth Hospitals NHS
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**DRAFT**

# CONFIDENTIAL

## Gosport War Memorial Hospital
## Patient Inquests
## Staff Briefing Pack

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Introduction

On 18th March a coroners inquest into the deaths of ten patients at Gosport War Memorial Hospital (GWMH) from 1996 – 1999 will commence.

The inquests are scheduled for six weeks from 18th March 2009 and ten separate verdicts will be delivered at the close of proceedings. The coroner is AM Bradley, HM Assistant Deputy Coroner Portsmouth and South East. The inquests will take place at Portsmouth Combined Court, Winston Churchill Avenue, Portsmouth.

It is likely that there will be media interest in the process. A communications team is in place to liaise with the media. This pack is designed to provide you with some background information and importantly the steps you should take if approached for information by the press and members of the media. If you have any questions please call the communications team on 023 8062 7434.

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## 1. Gosport War Memorial Hospital Inquests

HM Coroner has ordered inquests into the deaths of ten patients at Gosport War Memorial Hospital (GWMH) from 1996 – 1999.

The inquest is concerned with the deaths of people who were in-patients on Dryad and Daedalus wards at GWMH.

The inquests are scheduled for six weeks from 18th March 2009 and ten separate verdicts will be delivered at the close of proceedings. The coroner is A.M. Bradley, HM Assistant Deputy Coroner Portsmouth and South East. The inquests will take place at Portsmouth Combined Court, Winston Churchill Avenue, Portsmouth.

Listed Inquests:

- Leslie Pittock ( Code A ) Dryad Ward
- Elsie Lavender ( Code A Daedalus Ward
- Robert Wilson ( Code A Dryad Ward
- Helena Service ( Code A Dryad Ward
- Ruby Lake ( Code A Dryad Ward
- Arthur Cunningham ( Code A Dryad Ward
- Enid Spurgeon ( Code A Dryad Ward
- Geoffrey Packman ( Code A Dryad Ward
- Elsie Devine ( Code A ) Dryad Ward
- Sheila Gregory Code A ) Dryad Ward

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## 2. Timeline of key events

- In 1998 the police undertook an investigation into the death of a patient whose family were not happy about the circumstances of their death at Gosport War Memorial Hospital (GWMH). This death is not the subject of an inquest.
- In March 1999 the Crown Prosecution Service (CPS) decided that there was insufficient evidence to bring a successful prosecution.
- In 1998 there was a complaint to the NHS Commissioner (Ombudsman) about the care of a different patient. This death is not the subject of an inquest.
- In 2001 there was an independent NHS review panel into the care of a third patient which was subsequently referred to the NHS Commissioner. The Commissioner concluded that the prescribing was appropriate in the circumstances. This death is the subject of an inquest.
- In 1999 following publicity surrounding the initial investigation, the Police looked at the notes of four more patients who had died at GWMH. Two of these deaths are the subject of inquests, Arthur Cunningham, and Robert Wilson.
- In February 2002 the police decided there was no evidence for a prosecution and they were not going to investigate further.
- In the course of their investigation the Police alerted the Commission for Health Improvement (CHI) in August 2001 and CHI commenced an investigation in October 2001.
- In July 2002 CHI published a report with recommendations.
- In November 2002 Fareham and Gosport and East Hampshire PCTs produced a joint action plan to address the recommendations made in the CHI report.
- In January 2004 the Fareham and Gosport Clinical Governance group took over responsibility for overseeing the CHI action plan and ensuring objectives were met.
- In September 2002 the Police began a third investigation into the deaths of patients at GWMH.
- In October 2006 Portsmouth Hospitals NHS Trust took over the management of services for Medicine for Older People throughout South East Hampshire including those provided at Gosport War Memorial Hospital.
- Following detailed investigation which included expert reports the Police handed the outcome of their investigation into ten deaths to the CPS in July 2006.
- In October 2007 the CPS concluded that there was insufficient evidence to prosecute any health care staff.
- This Police report was passed to HM Coroner in early 2008.
- Following discussion with the Police and representation from families of the deceased, the Coroner met with the Minister for Justice, the Department of Health and the Assistant Chief Constable in August 2007 to discuss the potential of opening inquests on 10 cases.

- Following this meeting the Coroner (SE Area) opened and adjourned Inquests on 10 named cases in May 2008.

## 3. Details of investigations

**Background**

In 1996 Mulberry Ward at GWMH comprised 40 beds split into A (13 beds), B (13 beds) and C (14 beds) areas. All areas were run by Portsmouth Healthcare NHS Trust (a predecessor of PCTs and a separate organisation from Portsmouth Hospitals NHS Trust).

In January 2000 Mulberry A, B and C became Ark Royal ward (13 beds) and Collingwood Wards (27 beds). Later these numbers became 17 beds on Ark Royal and 17 beds on Collingwood.

In April 2002 Fareham and Gosport PCT took over responsibility for management of Dryad, Daedalus and Sultan wards at GWMH. East Hampshire PCT took over responsibility for managing the older people's mental health service in Ark Royal and Collingwood wards and employed consultants for this service at GWMH.

In April 2006 responsibility for Dryad and Daedalus wards and the employment of the nursing and medical staff transferred to Division of Medicine for Older People (DMOP) at Portsmouth Hospitals NHS Trust. Nursing staff on Sultan Ward transferred to Hampshire PCT, but medical input was provided by the local GP consortium. Hampshire Partnership NHS Trust took over responsibility for Older People's Mental Health Services in Ark Royal and Collingwood wards.

In line with national guidance the mental health service was transferred to Dryad and Daedalus wards on the ground floor in Feb 2008.

**Early Police investigations**

Between 1998 and 2002, Hampshire Constabulary undertook two investigations into the potential unlawful killing of patients at Gosport War Memorial Hospital.

These investigations did not result in any criminal prosecutions, but the police shared their concerns about the care o older people at Gosport War Memorial Hospital (GWMH) with the then Commission for Health Improvement (CHI) (a fore-runner of the Healthcare Commission) in August 2001. These concerns centred on the use of some medicines, particularly analgesia and levels of sedation, and the culture in which care was provided for older people at the hospital.

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**Commission for Health Improvement investigation**

In 2001, CHI commenced an investigation into the management, provision and quality of healthcare at Gosport War Memorial Hospital managed by Portsmouth Healthcare NHS Trust (the predecessor of the then Fareham and Gospo PCT and East Hampshire PCT and a different organisation to Portsmouth Hospitals NHS Trust).

On 1st October 2006, responsibility for the provision of inpatient care at GWMH transferred to Portsmouth Hospitals NHS Trust as part of a service reorganisation involving both elderly medicine and elderly mental health services in th area.

CHI concluded that in the late1990s there had been a failure of the then PCT systems to ensure good quality patient care, including insufficient local prescribing guidelines, lack of a rigorous, routine review of pharmacy data, and the absence of adequate Trust-wide supervision and appraisal systems.

CHI also concluded that by the time of their investigation, in 2002, the successor PCTs had addressed these. CHI reported that the reconfigured PCTs (Fareham and Gosport PCT and East Hampshire PCT) had adequate policies and guidelines in place governing the prescription and administration of pain relieving medicines to older patients anc that these policies and procedures were being adhered to.

**Outcome of the final Police investigation**

The publicity accompanying the announcement of the findings of the CHI investigation prompted a number of relative of patients who had died at GWMH to contact the Hampshire and Isle of Wight Strategic Health Authority regarding the care and treatment of their relatives between 1998 and 2001. Following these contacts the police initiated anothe investigation into the deaths of patients at GWMH in September 2002.

Following detailed investigation and expert reports ten cases were passed to the Crown Prosecution Service (CPS) for review once the police investigation was complete. The CPS concluded that there was insufficient evidence to prosecute and that there was no realistic prospect of any conviction.

Following the CPS' decision, the police met with the General Medical Council (GMC), the Nursing and Midwifery Council (NMC) and H.M. Coroner to determine whether general 'standard of care' issues in respect of the deaths required further examination. The Police, however, reiterated that their investigation was now closed.

**Coroner**

Following the meeting with the Police and representation from families of the deceased, the Coroner met with the Minister for Justice, the Department of Health and the Assistant Chief Constable to discuss the potential of opening inquests on 10 cases. Following this meeting the Coroner (SE Area) opened and adjourned Inquests on 10 named

cases. The Coroner held a pre-inquest review meeting with the families in August 2008. No NHS representation occurred at the pre-inquest review as the invitation did not reach the appropriate people within the NHS.

The Coroner has announced that he intends to conduct separate inquests into each death, and has set aside six weeks for the inquests to take place. Verdicts into each death will be reached when all inquests have been concluded.

**General Medical Council (GMC) and Nursing and Midwifery Council (NMC)**

The Police forwarded papers to the General Medical Council and Nursing and Midwifery Council and each organisation is undertaking its own inquiries.

## 4. What happens at the Hospital now?

Since the time of these deaths over ten years ago and the subsequent CHI review in 2002 much has changed at Gosport War Memorial Hospital, in line with developments in clinical practice across the country.
1991 saw the commencement of a £10.5 million, two-phase development which was complete in 1995. This was followed by a £6m redevelopment in the last year.
The Hospital now houses:

- 20 bed GP ward
- 32 beds for older peoples' mental health
- 35 beds for stroke and general rehabilitation
- Blake birth centre
- Physiotherapy department
- Two day hospitals for older people
- X-ray and ultrasound
- Red Cross
- Minor injuries unit
- Endoscopy unit
- Community health clinics
- GP Out of Hours Service

By the time of the CHI investigation in 2002 the regulator was satisfied that GWMH had adequate policies and guidelines in place governing the prescription and administration of pain relieving medicines to older patients and that these policies and procedures were being adhered to. This remains the case and there have been no incidents subsequently which have required external investigation by CHI or its successor the Healthcare Commission or the Police.

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Policies and procedures at the Hospital are reviewed regularly and staff receive mandatory training every year. Details of the policies in place on Sultan ward can be found at:
http://www.hampshirepct.nhs.uk/index/documents/policies-home/policies-clinical.htm
Details of policies in place on Ark Royal and Collingwood wards are available from Portsmouth Hospitals NHS Trust on request.

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The Patient Environment Action Team inspection last year rated the Hospital as good on cleanliness, excellent for food and good for privacy and dignity. Patient experience surveys are conducted regularly and feedback is very positive, with comments including 'privacy and dignity is well respected' and 'cleanliness impeccable'.

There were six complaints for the whole of the Department of Medicine for Older people, Stroke and Rehabilitation last year (this includes GWMH and QAH) and five for the other wards at GWMH. All complaints are taken very seriously and investigated internally in line with the PCT and Trust's complaints policy. All complaints in 2007/2008 were resolved locally.

The Hospital also receives many thanks and compliments from patients and their families, with over 200 cards and letter last year.

Staff at the Hospital received a Chairman's award from Portsmouth Hospitals NHS Trust Chairman in 2007 for their professionalism and dedication.

In 2008 Portsmouth Hospitals NHS Trust's modern matron at GWMH received a Clinical Governance Award from the Trust's Patient Experience Council. This award of £9773 contributed to the installation of cushioned floor in both wards, to minimize injury if a patient should experience a fall during rehabilitation.

In February Ark Royal, Collingwood and Sultan wards have benefitted from anti microbial curtains and new bedside lockers and tables which are much easier to clean. Overhead hoists are available over every bed and in bathrooms and the Trust have increased call bells in day room areas enhancing patient safety.

In 2008/09 Portsmouth Hospitals NHS Trust was independently assessed as providing an 'excellent' quality of services by the Healthcare Commission (formerly CHI) and Hampshire PCT was assessed as providing a 'good' quality of services by the Healthcare Commission.

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## 5. Questions and Answers

Q. What is the purpose of an Inquest?

A. The purpose of an inquest is for the coroner to determine how an individual met his/her death, the cause/ nature of the death and the circumstances around that person's death.

Q. What is this inquest concerned with?

A. This inquest is concerned with the deaths of people who were in-patients on Dryad and Daedalus wards, at Gosport Ward Memorial Hospital (GWMH) between 1996 and 1999. These deaths came to police and public attention following one complaint made by a relative in 1998.

Q. Isn't it rare to have an inquest 10 years after the death of a person and in the absence of a body or post mortem reports?

A. Yes it is. The decision to conduct these inquests was taken by the Coroner following representation from families of the deceased and a meeting with the Minister for Justice, the Department of Health and the Assistant Chief Constable.

Q. Why has an inquest into these deaths been called when the police investigations found no evidence of wrong doing?

A. The police investigations focused on whether there was any evidence of criminality with respect to patient deaths at Gosport War Memorial Hospital. The purpose of an inquest is to determine how a person met their death and potentially the circumstances surrounding that death.

Q. Were any staff disciplined as a result of the police investigations?

A. No. At the time two senior members of management were redeployed for six months, while internal investigations took place. However both internal investigations and the CHI review concluded that there was no evidence to suggest that any individual should be disciplined and the staff members returned to their substantive posts.

Q. What measures have been put in place since these incidents?

Following the CHI investigation in October 2001, CHI concluded that the PCTs had addressed the issues raised and had put in place adequate policies and guidelines governing the prescription and administration of pain relieving medicines to older patients and that these policies and guidelines were and are being adhered to.

Four NHS organisations providing services in the south east Hampshire area have also undertaken their own more recent reviews of compliance with the recommendations CHI made. The Board of each organisations has

received assurances that all policies are correct and current and that the quality of care being provided is of the highest standard and in line with modern Clinical Governance standards. Assurances have also been provided to South Central Strategic Health Authority (SHA) as the organisation responsible for monitoring quality within organisations in its area. The SHA will in turn will provide assurance to the Department of Health.

Since the deaths at GWMH all NHS organisations now work to modern clinical governance standards which require risk management systems and clinical audit departments. These are integral to the delivery of health services in a modern NHS and have been part of NHS evolution over the last decade.

Q. What is CHI

A. CHI – is the Commission for Health Improvement. This organisation was replaced by the Healthcare Commission (in April 2004). The Healthcare Commission is the independent watchdog for healthcare in England. It assesses and reports on the quality and safety of services for patients and the public. From April 2009 a new "super-regulator", the Care Quality Commission will combine the functions of the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission.

Q. What is Clinical Governance?

A. Clinical Governance is essentially a term used to describe the way the NHS manages the delivery of health services within a structure of accountability and responsibility. It is intended to ensure that clinical care is delivered on the basis of agreed standards and that outcomes are measured against these standards of care.

**6. Organisation structure in South East Hampshire 1994 – present**

| Date | Organisation | Function |
|---|---|---|
| April 1994 | Portsmouth Healthcare NHS Trust established.<br>SI 1993/2569 | Department of Medicine for Elderly People provided acute care, stroke care, continuing care, rehabilitation, day hospitals, and outpatient department at QAH and St Mary's Hospitals. Provided both medical and nursing staff on wards at GWMH. Service at GWMH was for continuing care, intermediate care, day hospital and outpatients department. |
| From 1994 | Portsmouth Hospitals NHS Trust | Provided care at QAH but at this stage was not providing any care at GWMH. |
| March 2002 | Portsmouth Healthcare NHS Trust dissolved *<br>SI 2002/1323 | |
| April 2002 | Fareham & Gosport PCT established<br>SI 2002/1120<br>East Hampshire PCT established<br>SI 2001/331 | F&G responsible for management of wards at GWMH. Employed ward nurses on Dryad and Daedalus.<br>East Hampshire managed Medicine for |

NHS Hampshire

| | | |
|---|---|---|
| | | Elderly People service. Employed consultants for this service at GWMH. |
| 2005 | Fareham & Gosport and East Hampshire PCTs merge to form one 'cluster'. | Cluster retains responsibilities and roles from both PCTs as above. |
| Sept 2006 | 'Cluster' PCTs dissolved along with five others in Hampshire | |
| October 2006 | Hampshire PCT established SI2006/2072 | Hampshire PCT assumes responsibility (commissions) for services at GWMH. Responsibility for Dryad and Daedalus wards and the employment of the nursing and medical staff goes to Division of Medicine for Older People (DMOP) at Portsmouth Hospitals NHS Trust. Nursing staff on Sultan ward is provided by Hampshire PCT, but medical input is from local GP consortium. |

* Portsmouth Healthcare NHS Trust is not the same organisation as Portsmouth Hospitals NHS Trust

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Media Enquiries Information

In event of media enquiry please notify your duty manager who will contact the relevant communications team. The communications team are proactively managing media enquiries around the GWMH inquests and will co-ordinate responses to the media.

Press should identify themselves to you and will have a press badge. They are not permitted to film on NHS premises without prior consent.

**Office hours Communications Team numbers**

Hampshire PCT Communications Team: 023 8062 7434

Sara Tiller - mobile 07798 732193

Code A - mobile Code A

Code A mobile Code A

Code A mobile

Portsmouth Hospitals NHS Trust Communications Team: 023 8062 288517

Code A - mobile

- mobile

Trimedia: 02380 382970

Caroline Searle - mobile Code A

Julie Dean mobile - Code A

Royal College of Nursing

Helen Wigginton (SE Press officer): 07739 875081

National press office: 0207 647 3633

GWMH Press Office Number

02392 794854 / 864

**Out of office hours**

Hampshire PCT: 07017 362430

Portsmouth Hospitals NHS Trust:

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Dealing With Media Enquiries

If you are approached at home or at work either in person or on the phone, please politely refer the press to the communications team:

*Thank you for your interest - can I direct you to our communications team who are managing media enquiries during the inquests proceedings and who will be able to give you more information and arrange for you to speak to or interview the appropriate person.*

Dealing with Media Enquiries (reception staff)

- When taking a media enquiry, please be helpful and polite.
- You do not need to respond to any questions that the media put to you, however innocuous or 'off the record' they may be
- Please politely pass the enquiry on to the communications team.
- We have identified staff who are briefed to act as spokespeople and are clear on the messages that we will be disseminating to the media.
- Please use the following guide to take details from the journalist and pass them onto the Communications Team who will deal promptly with the enquiry or alternatively please offer the following contact details:

  - Hampshire PCT Communications Team - 02380 627434
  - Portsmouth Hospitals NHS Trust Communications Team - 02392 288517
  - GWMH Press Office Number - 02392 794854 / 864
  - Hampshire PCT out of hours - 07017 362430

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| |
|---|
| Name: |
| Publication / Media title: |
| Phone number: |
| Nature of enquiry: |
| Response required by: |

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Media Statement

**Inquest into deaths at Gosport War Memorial Hospital**

A coroner's inquest is being held into the deaths of ten patients at Gosport War Memorial Hospital in the late 1990's. The inquests are due to commence on 18th March 2009.

The local NHS has been working closely with HM Coroner over the last few months to ensure that all the relevant information is available to support the Coroner's investigation.

We co-operated fully with the previous police investigations and with an earlier independent review by the Commission for Health Improvement.

Many procedures at Gosport War Memorial Hospital were revised as a result of the earlier enquiries. We are very confident that it provides safe, high quality care to all its patients and will continue to play an important role in local healthcare services for many years to come.

If you have any further enquiries, please contact the Hampshire PCT Communications team on 02380 627434.

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What is an Inquest?

An inquest is a limited fact-finding inquiry to establish the answers to

- **who** has died,
- **when** and **where** the death occurred, and
- **how** the cause of death arose

An inquest is not a trial. It is an inquiry into the facts surrounding a death. It is not the job of the coroner to blame anyone for the death, as a trial would do, and there are no speeches. However, the Coroner does have the power to investigate the main cause of death and also "any acts or omissions which directly led to the cause of death".

Gosport War Memorial Hospital Inquests

The coroner has ordered inquests into the deaths of ten patients at Gosport War Memorial Hospital (GWMH) from 1996 – 1999.

The inquest is concerned with the deaths of people who were in-patients on Dryad and Daedalus wards.

The inquests are scheduled for six weeks from 18th March 2009 and ten separate verdicts will be delivered at the close of proceedings. The coroner is AM Bradley, HM Assistant Deputy Coroner Portsmouth and South East. The inquests will take place at Portsmouth Combined Court, Winston Churchill Avenue, Portsmouth.

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Listed Inquest Patients

- Leslie Pittock (Code A) Dryad Ward - aged 83
- Elsie Lavender (Code A) Daedalus Ward - aged 84
- Robert Wilson (Code A) Dryad Ward - aged 73
- Helena Service (Code A) Dryad Ward - aged 99
- Ruby Lake (Code A) Dryad Ward - aged 85
- Arthur Cunningham (Code A) Dryad Ward - aged 79
- Enid Spurgeon (Code A) Dryad Ward - aged 92
- Geoffrey Packman (Code A) Dryad Ward - aged 68
- Elsie Devine (Code A) Dryad Ward - aged 88
- Sheila Gregory (Code A) Dryad Ward - aged 91

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Brief overview of key events

- In 1998 the police undertook an investigation into the death of a patient whose family were not happy about the circumstances of their death at Gosport War Memorial Hospital (GWMH). This death is not the subject of an inquest.
- In March 1999 the Crown Prosecution Service (CPS) decided that there was insufficient evidence to bring a successful prosecution.
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- In 1999 following publicity surrounding the initial investigation, the Police looked at the notes of four more patients who had died at GWMH. Two of these deaths are the subject of inquests, Arthur Cunningham, and Robert Wilson.
- In February 2002 the police decided there was no evidence for a prosecution and they were not going to investigate further.
- In the course of their investigation the Police alerted the Commission for Health Improvement (CHI) in August 2001 and CHI commenced an investigation in October 2001.
- In July 2002 CHI published a report with recommendations.
- In November 2002 Fareham and Gosport and East Hampshire PCTs produced a joint action plan to address the recommendations made in the CHI report.
- In January 2004 the Fareham and Gosport Clinical Governance group took over responsibility for overseeing the CHI action plan and ensuring objectives were met.
- In September 2002 the Police began a third investigation into the deaths of patients at GWMH.
- In October 2006 Portsmouth Hospitals NHS Trust took over the management of services for Medicine for Older People throughout South East Hampshire including those provided at Gosport War Memorial Hospital.
- Following detailed investigation which inlcuded expert reports the Police handed the outcome of their investigation into ten deaths to the Crown Prosecution Service (CPS) in July 2006.

- In October 2007 the CPS concluded that there was insufficient evidence to prosecute any health care staff.
- This Police report was passed to HM Coroner in early 2008.
- Following discussion with the Police and representation from families of the deceased, the Coroner met with the Minister for Justice, the Department of Health and the Assistant Chief Constable in August 2007 to discuss the potential of opening inquests on 10 cases.
- Following this meeting the Coroner (SE Area) opened and adjourned the Inquests.

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Gosport War Memorial Hospital Investigations – Summary

**Background**

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CHI concluded that in the late 1990s there had been a failure of the then PCT systems to ensure good quality patient care, including insufficient local prescribing guidelines, lack of a rigorous, routine review of pharmacy data, and the absence of adequate Trust-wide supervision and appraisal systems.

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The publicity accompanying the announcement of the findings of the CHI investigation prompted a number of relatives of patients who had died at GWMH to contact the Hampshire and Isle of Wight Strategic Health Authority regarding the care and treatment of their relatives between 1998 and 2001. Following these contacts the police initiated another investigation into the deaths of patients at GWMH in September 2002.

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**Coroner**

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# Gosport War Memorial Hospital Patient Inquests

## Media Briefing Pack

**Office hours Communications Team numbers**

Hampshire PCT Communications Team: 023 8062 7434

Portsmouth Hospitals NHS Trust Communications Team: 023 8062 288517

Trimedia: 02380 382970

**Comment [A1]:** Can we be clear about directions for journalists? There ought to be one 'route' in – i.e. either GWMH press office number or Trimedia/Hants PCT. All approaches should be logged in one place. Only specific issues should be passed to PHT/other trusts for answering.

**Out of hours Communications Team numbers**

Hampshire PCT: 07017 362430

Portsmouth Hospitals NHS Trust: 023 9228 6000

**Comment [A2]:** PHT's out of hours is for emergencies only, so we wouldn't want to advertise it here.

**GWMH Press Office Number**

(to be advised)

**Communications Team Mobile numbers**

Hampshire PCT

Sara Tiller - 07798 732193

Code A

Code A

Portsmouth Hospitals NHS Trust

Code A

**Comment [A3]:** As above

Trimedia

Caroline Searle - Code A

Julie Dean mobile - Code A

NHS Hampshire

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To be confirmed on sign off

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