Deaths at Gosport War Memorial Hospital

Issue/accusation:
(i) Will there be prosecutions in the light of the inquest findings? (ii) Why won't the Government hold a public inquiry into the series of deaths at Gosport War Memorial Hospital 1989 - 2001?

Facts
Between 1998 and 2006 a number of criminal and medical investigations were undertaken into a total of 92 deaths of elderly patients at Gosport War Memorial Hospital between 1989 and 2001, centring on the actions of 1 doctor (Dr Jane Barton). 78 cases did not meet the threshold of negligence required for a criminal investigation and 4 were attributed to natural causes. In the remaining 10 cases the CPS decided there was insufficient evidence for any prosecution for criminal culpability or gross negligence.

Section 15 of the Coroners Act 1988 enables a coroner to report to the Secretary of State if he has reason to believe a death has occurred in or near his jurisdiction, in circumstances in which an inquest ought to be held, and owing to the destruction of the body by fire (which is interpreted to include cremation), or it lying in a place from which it cannot be recovered, no inquest can be held.

The coroner for Portsmouth and South East Hampshire first reported to the Justice Secretary in June 2007 on 7 of the 10 cases in which inquests were recently held (in the other 3 the bodies had not been cremated, so did not require a report to the SofS).

In August 2007, following the coroner's report, a meeting was held between the coroner and representatives of Hampshire County Council, Hampshire Constabulary, the MoJ and DH to discuss a number of issues surrounding these cases. At that meeting DH's view was that a public inquiry into the deaths was unnecessary because the doctor at the centre of allegations about improper conduct was under investigation by the General Medical Council. Inquests could take place once those investigations were complete. Moreover, DH felt that a public inquiry would be of limited value, given the passage of time since the events in question, and other enquiries and investigations which had been undertaken.

In November 2007 the coroner provided additional information about the cases and a direction to hold inquests was given in February 2008.

The inquests commenced on 18 March and on 20 April the jury gave a narrative verdict, finding that in 3 of the cases the deceased were given inappropriate medication and in a further 2 cases the correct medication was given in inappropriate doses. Inquest verdicts cannot make findings of civil or criminal liability on the part of a named person.

(A further case was reported by the coroner in November 2008 and a direction was made in January. That inquest will be held separately.)

Further consideration of any criminal prosecution in the light of the inquest verdicts is for the CPS and Hampshire Police.

DH has consistently refused to hold a public inquiry into these events, on the grounds that it would merely duplicate the inquests and other investigations already undertaken (by, among others, the police, the Health authorities, the Nursing and Midwifery Council, the General Medical Council and the Healthcare Commission). DH said it would await the outcome of the inquests and then assess if there remained matters outstanding which required further resolution. Any further consideration of a public inquiry therefore remains a matter for DH.

Lines to take

- In June 2007 the Portsmouth and South East Hampshire Coroner first reported to the Secretary of State (under section 15 of the Coroners Act 1988) the facts about seven deaths which occurred at Gosport War Memorial Hospital over a number of years where the bodies had been cremated.
- In the light of the facts, in February 2008 the Secretary of State decided that it was desirable that inquests should be held into these seven deaths and directed the coroner to hold them.
- The Coroner is an independent judicial officer and the MoJ cannot comment on the verdicts of the inquest jury in these cases.
- Inquests verdicts cannot determine criminal or civil liability on the part of a named person (rule 42 of the Coroners Rules 1984 Rules).
- It is a matter for the CPS and Hampshire Constabulary whether they investigate further in the light of the inquest verdicts.
- The MoJ facilitated a meeting of interested parties in August 2007, at which the question of a public inquiry into the deaths was discussed. The decision to refuse was taken by DH and it is for DH now to consider whether there are grounds for a public inquiry in the light of the inquest verdicts.

Contact of Lead Official

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