Hampshire Partnership NHS
NHS Trust

Report to Clinical Governance and Risk Committee: 11 February 2009

Coroner's Inquest into ten deaths at Gosport War Memorial Hospital

1. Introduction

1.1 In the summer of 2008 the Portsmouth Coroner announced that he would be holding inquests into the deaths of ten patients from Gosport War Memorial Hospital who died between 1996 and 1998. At this time, GWMH was managed by Fareham and Gosport PCT, now Hampshire PCT.

1.2 The Coroner has subsequently confirmed the inquests will commence on 18 March 2009, he expects the duration to be approximately six weeks. He has indicated which members of staff he will be calling as witnesses. At the time of writing, it is anticipated that no members of HPT staff will be called.

1.4 In order to prepare for the forthcoming inquests, a meeting was convened in July 2008 attended by the four NHS organisations who are/were responsible for providing services at Gosport War Memorial Hospital. The group have continued to meet as a steering group. Whilst our staff were not responsible for care to the wards where the deaths occurred, in order to learn lessons and demonstrate partnership working, the Trust has been a member of the group and taken part in the decision making and supported the principles to reassure the public and the Coroner that practices have improved. Our staff were called in to those wards to assess pts showing m.h. problems.

2. Review of CHI Action Plan from 2002

2.1 A number of the deaths were subject to both a police investigation and a CHI review which resulted in a CHI Report and Action Plan being published in 2002.

2.2 In preparation for the forthcoming inquests, each organisation has been asked to review the recommendations outlined in the CHI report of 2002 and to submit an updated response to the Steering Group and Strategic Health Authority which has been signed off by the organisation's own board.

2.3 HPT has informed the Steering Group and SHA that Trust's recent review will be considered by the Trust's Clinical Governance and Risk Committee, on behalf of the Trust Board.

2.4 Eileen Spiller from the HA has reviewed all updated action plans and has no comments or issues with this Trust's documentation.

3. Conclusion

4.1 The CG&RC is asked to receive and note the Trust's response to the CHI report together with the evidence that the organisation has been continually improving its services, and that sufficient safeguards are in place to ensure that the events being investigated could not happen again now.

Catherine Watson
Litigation and Information Governance Manager

29 January 2009

Enc: CHI Action Plan and HPT responses and evidence (hard copies in A3 size will be tabled at the meeting to assist with legibility of the attachment).