A Review and Commentary on the Report of the Gosport Independent Panel

Justin Valentine

Published on 8th July 2020

The Gosport Independent Panel was set up to investigate the long-running concerns of a number of families that the lives of their loved ones had been shortened whilst patients at the Gosport War Memorial Hospital ("the Hospital"). In June 2018 the Panel produced their report ("the Report"). At the outset there were eight families. By the end of the enquiry it was found that over 450 patients were affected.

The Report concludes that the families were let down by all those in authority, not only the Hospital but also the police, the coronial system and the relevant regulatory organisations. These bodies subordinated the interests of the families to those of the Hospital and the professionals involved.

The key medical finding is that there was a culture of shortening lives by prescribing and administering "*dangerous doses*" of opiate medication not clinically-indicated. Patients were, in effect, put on a terminal care pathway on admission. The Report is clear that not all those patients affected were terminally ill. As is noted in the final chapter of the Report:

It may be tempting to view what happened at the hospital in the context of public debate over end of life care, what a 'good death' is, and assisted dying. That would be a mistake. What happened at the hospital cannot be seen, still less justified, in that context. The patients involved were not admitted for end of life care but often for rehabilitation or respite care.

In broad terms the Report deals with two matters. Firstly, what actually happened at the Hospital and secondly, why it took so long for the truth to be uncovered.

What Happened at the Hospital

The Report focusses on events that occurred on the Daedalus, Dryad and Sultan wards at the Hospital as well as the Redclyffe Annexe which was closed in 1993/1994 with patients and staff moving to the Dryad ward. These wards were for the care of elderly patients. The Sultan Ward was a designated GP unit, Dryad was a continuing care/rehabilitation ward and Daedalus was a rehabilitation ward for elderly patients.

Dr Barton's Role

Dr Jane Barton was a GP. She worked as clinical assistant in the Hospital for 12 years from 1988 until April 2000 when she resigned. The role was intended to provide 24 hour medical cover on the wards identified. She was responsible for the day to day medical management of the patients and prescribed drugs for the patients. The title

"*clinical assistant*" refers to a doctor, usually a GP, who provides care at a level below that of a consultant who retains overall responsibility for the patient's care but delegates elements of day-to-day care to the clinical assistant. The Report notes "*Either supervision was not carried out effectively or the consultants approved of the care given by the clinical assistant*". Dr Barton's own statements, provided to Hampshire Constabulary, confirmed that in practice she generally had the sole medical input.

Over Prescription

The Report examines the prescription of opioids often by syringe drivers (a small battery-powered pump that delivers medication at a constant rate commonly used for people with a terminal illness for pain relief). There is a narrow threshold between a therapeutic dose and a harmful dose; a relatively small dose would cause death in an elderly, non-habituated patient. The accepted approach is to "*start low and go slow*" which the Report found was not pursued. There was a systemic failure at the Hospital to adopt the principles of the analgesic ladder. Further, the Report found there was a failure by the pharmacists to undertake appropriate reviews of prescribing patterns on the wards in question.

The Report's findings in relation to the prescribing and administering of drugs included that the usage of opioids was without appropriate clinical indication, that continuous opioid usage was started at inappropriately high doses, that the opioid prescription practice conflicted with national and local guidance and that few patients survived long after starting continuous opioids.

The Report found there was an absence of justification as to why patients should be treated palliatively ("*made comfortable*"). There was an absence of evidence that patients needed such extensive pain relief. Discussion of treating decisions with family members or with consultants did not take place. The nurses did not scrutinise, question or challenge the administering of high doses of diamorphine. Further, the Report found, not surprisingly, that record-keeping was generally poor.

Based on statistical analysis of actual deaths compared to expected deaths, the Report concluded that for the period 1987 to 2001 the overall total of patient deaths where there was prescribing without appropriate clinical justification was around 650.

A witness statement prepared by a nursing auxiliary for Hampshire Constabulary in April 2001 noted:

Despite my experience in elderly care I had never heard of a syringe driver prior to working at the War Memorial Hospital. I was later to learn that it was a device used for pain relief in seriously ill patients, the driver delivers a constant dosage over a period of time. It was also clear to me that any patient put onto a syringe driver would die shortly after. During the whole time I worked there I do not recall a single instance of a patient not dying having been put onto a driver.

Communication with Families

The Report notes that communicating clinical decisions to patients and families is a key aspect of care. There was no evidence of engagement with families in relation to end of life care. The Report concludes in relation to communication:

There is a pattern across the cases reviewed by the Panel. On admission or close to admission, there is an assumption, not shared with the family, that the patient is close to death regardless of the purpose of their admission or the clinical management plan in place. So when the clinical staff said to families that they were making their loved ones "comfortable", that expression was a euphemism for embarking on the pattern of prescribing which would lead to death in almost every case.

The Report comments that when complaints were raised, they were poorly dealt with. In one case an Independent Review Panel (part of the NHS complaints process) concluded that the clinical response was appropriate. The Report notes that the conclusion, "*which explicitly condones the use of large doses of diamorphine simply to control symptoms of confusion and agitation … was contrary to all relevant guidance*".

Key Findings

The key findings of the Report are as follows:

1. There was a disregard for human life and a culture of shortening the lives of a large number of patients.

2. There was an institutionalised regime of prescribing and administering "*dangerous doses*" of a hazardous combination of medication not clinically indicated or justified, with patients and relatives powerless in their relationship with professional staff.

3. Nurses did not discharge their responsibility to challenge prescribing where it was clear it was not in the interests of the patient.

4. Dr Barton was responsible for the practice of prescribing.

5. The consultants were aware of how drugs were prescribed and administered but did not intervene to stop the practice.

6. The pharmacists did not challenge the practice of prescribing which should have been evident at the time.

7. The concept of "*clinical freedom*" assists in understanding how and why highly-questionable clinical practices were not challenged. "*This held that medical decisions could not be questioned by other clinicians and managers, because they were based solely on individual professional judgement. In theory, this should have been entirely supplanted by evidence-based practice, but in many places this was slow to happen, and the documents suggest that it did not happen in the hospital in the period in question. … in accepting the medical judgement made most often by the clinical assistant [Dr Barton], the consultants effectively supported rather than challenged the practice of prescribing and the nurses were themselves involved.".*

As noted, the Report deals not only with what actually happened but with the failure of the various statutory and regulatory bodies properly to investigate the events.

Unheeded Warnings

The issue of the overuse of diamorphine and syringe drivers was formally raised by nursing staff in 1991 in relation to the Redclyffe Annexe of the Hospital though unofficial concerns had been raised as early as 1988. At the outset the nurses specifically named Dr Barton, who attended the annexe daily. The nurses were worried, however, as to the repercussions of raising the issue. Their worry was justified. At a subsequent meeting an RCN (Royal College of Nursing) representative noted that "*The issue of the syringe drivers had "upset" Dr Barton*". The RCN representative thereafter conveyed his apologies to Dr Barton adding that her clinical judgement had not been in question. She was described as "*a very caring GP*".

In the event, there was, the Report notes, "*a sharp shift in tone towards the nurses, from apparently open and interested, to critical and patronising*" from the Patient Care Manager, Mrs Evans. It was decided that the only way of resolving the issue was to use the grievance procedure. This was not pursued.

At a later meeting, led by Mrs Evans, it was noted that "all staff had a great respect for Dr Barton and did not question her professional judgment". Nurses were invited in the future to approach Dr Barton or Sister Hamblin. They were told to keep any concerns within the ward and hospital.

The Report notes this formal raising of concerns in 1991 as a missed opportunity.

Absence of Clinical Governance

The Report details the development of "*clinical governance*" during the period under review noting that until the 1980s hospital administrators were there to facilitate the work of clinicians and not expected to challenge them. Clinical professional bodies consistently took the view that clinicians were accountable only through professional self-regulation which view has persisted. It was not until 1997 that the expression "*clinical governance*" was introduced making NHS Trust Boards formally accountable for clinical quality with the requirement to set up monitoring systems. The Report notes that NHS Trusts varied markedly in their readiness to adopt these arrangements.

The Report notes that neither the Health Authority nor the Trust, nor their successor organisations, conducted any systematic investigation of complaints received. Management investigations were subsequently put on hold pending police investigation. They were never restarted.

In 2002, the Chief Medical Office, Professor Liam Donaldson, commissioned Professor Richard Baker to conduct a statistical analysis of mortality rates at the Hospital including an audit of the use of opioids. He submitted his report to, by then, Sir Liam on 11th June 2003. Based on a detailed analysis of 81 medical records, Professor Baker summarised his conclusions as follows:

On the basis of these sources of evidence, I have concluded that a practice of almost routine use of opiates before death had been followed in the care of patients of the Department of Medicine for Elderly People at Gosport hospital, and the attitude underlying this approach may be described in the words found in many clinical records – 'please make comfortable'. It has not been possible to identify the origin of this practice, since evidence of it is found from as early as 1988. The practice almost certainly had shortened the lives of some patients, and it cannot be ruled out that a small number of these would otherwise have been eventually discharged from hospital alive.

The Baker Report pre-empted many of the conclusions of the Report. However, following advice from Government lawyers, publication of the Baker Report was withheld at the time although copies were provided in confidence to Hampshire Constabulary, the GMC, the Strategic Health Authority and Dr Barton.

Despite attempts by various bodies (including AvMA) to obtain copies of the report, publication was delayed by the Department of Health using Freedom of Information Act exemptions, until July 2013.

Police Investigations

Between 1998 and 2010, Hampshire Constabulary conducted three investigations into the events at the Hospital. The first investigation was prompted by the daughters of Mrs Richards in 1998. The police's initial reaction, prior to any investigation, was that this might be a case of negligence better dealt with by the GMC. The Report comments:

Their tone would prove to be an example of the mindset of the police throughout this investigation, as disclosed by the documents reviewed by the Panel. There is no record of any investigative, evidential or reasoned basis for forming the view that the case seemed to fall short of unlawful killing at this stage.

The Report notes that one of the detectives commented "*I have no idea why these two sisters are so out to stir up trouble*". This was within 11 days of raising their concerns. Medical evidence was sought from a nurse on the use of palliative care which resulted in a one-page statement which had no application to Mrs Richards' case. The CPS returned the file to the police advising that there was insufficient evidence for a prosecution. Medical evidence was then sought but from the Hospital itself. The Report notes:

The file note shows that neither Hampshire Constabulary nor the Trust recognised the shortcomings of providing "properly qualified medical evidence" from within the hospital. There had already been a reference to possible corporate culpability in Sgt Dadd's note of 15 October 1998. Despite this reference, Det Con Maddison's approach led to the police relying on the hospital and its consultant, who were both potential defendants, to provide the crucial and determinative evidence in the case. This led to a complete failure by the police to secure any evidence relating to corporate conduct.

The Report observes that Dr Barton was not only informed of the investigation but was privy to several documents produced by the Trust produced in response.

The file was passed back to the CPS who concluded, again, that there was no evidential basis to justify a prosecution thereby ending the first investigation.

A second investigation was undertaken between August 1999 and April 2001. The initial remit was to remedy the failings in the first investigation but it soon expanded to the status of a Force Major Enquiry with an increase in resources and the title of Operation Rochester. During this investigation supportive medical evidence was obtained from a consultant physician, Professor Brian Livesley. In his initial draft report he concluded:

It is most probable if not certain that the cause of Mrs Richards' death was respiratory depression as a consequence of the large doses of drugs she continuously received by syringe driver from 18th August 1998 until her death on 21st August 1998 and or the effects of dehydration.

Professor Livesley stated that he would support allegations of assault and unlawful killing by gross negligence against nursing staff and Dr Barton. Subsequent to steps taken in the investigation following this supportive report, in April 2000 Dr Barton resigned from the Hospital but not from her work as a GP.

Professor Livesley had also recommended that "*further enquiries be made to determine if other patients at the Gosport War Memorial Hospital have been affected in a manner similar to that of Mrs RICHARDS and particularly those who have been under the care of Dr BARTON".* Notwithstanding Professor Livesley's concerns, the investigation was not widened.

Following a newspaper article a number of witnesses contacted the police. Pauline Spilka, a nursing auxiliary, made a statement which included the following passage:

Indiscriminate use of Syringe Drivers on Patients in the Daedalus Ward at Gosport War Memorial Hospital is my main concern. It appeared to me then and more so now that euthanasia was practised by the nursing staff. I cannot offer an explanation as to why I did not challenge what I saw at that time.

Despite these developments, Professor Livesley's stance came under criticism from the police; a letter from Det Ch Supt Akerman to the CPS noted that he was "*disturbed by the unequivocal nature*" of Professor Livesley's evidence.

On 31st May 2001, treasury counsel provided an advice for the CPS. He stated that the "*evidence does not reveal the commission of any offence*". At a conference with inter alia, Professor Livesley and treasury counsel, Professor Livesley commented that: "*I was verbally abused, bullied, and attacked by [treasury counsel] so much so that I complained loudly that this was not professional*". In a subsequent advice treasury counsel concluded that Professor Livesley's position was untenable and that he could not be relied upon as an expert witness.

In the event, the decision was reached to close the investigation. The reasons given were the lapse of time since the initial report, the lack of evidence of unlawfulness, conflict between experts, the lack of certainty and the fact that other agencies, such as the GMC, had a role. It was also observed that "*To proceed on basis of current information would necessitate investigating up to 600 deaths*".

Ongoing complaints by family members of and to Hampshire Constabulary led to a third investigation which took place between 2002 and 2006. The Report comments that upon review "*the investigation was a process of collation but not exploration or analysis of the evidence*". Treasury counsel was asked to advise again and concluded that there was insufficient evidence to prosecute. His view was that the experts presented an equivocal picture. However, the Report notes that treasury counsel did not consider the possibility of offences under health and safety legislation. In any event, this marked the end of the third investigation.

The General Medical Council

The first time events at the Hospital were brought to the attention of the GMC was in 2000. They were not notified in 1991 subsequent to the nursing complaints, nor by Hampshire Constabulary nor the Trust when concerns were expressed about the death of Mrs Richards.

Dr Barton appeared before the Interim Orders Committee ("IOC") of the GMC for consideration of an interim suspension on 21st June 2001 and again on 21st March 2002. On the first occasion, the IOC were not even provided with Professor Livesley's report and declined to make any order. On the second occasion, Dr Barton gave evidence. She informed the IOC that she was not prescribing opiates, having resigned from the Hospital. The IOC appeared sympathetic in relation to arguments concerning workloads, though the Report notes that workload concerns were never raised by Dr Barton until the commencement of investigations. In any event, the IOC determined that it was not necessary to make an interim order.

Further information provided to the GMC, in particular from the police, led to the decision to refer Dr Barton to the Professional Conduct Committee. The GMC therefore decided that a further application should be made for an interim order. Dr Barton therefore appeared before the IOC for a third time on 19th September 2002. The IOC were informed by Dr Barton's solicitor, from an attendance note of a conversation with the police, that the police were "*back-covering*" and "*had no concerns*". Counsel for the GMC did not ask for time to confirm the accuracy of this submission. The IOC determined that in the absence of any new material it would be unfair to make an interim suspension order.

Dr Barton thereafter returned to work as a GP although she entered into an agreement with the PCT (Primary Care Trust) restricting her ability to prescribe opiates.

In October 2002 the GMC considered the nurses' dossier from 1991 but found that there was insufficient material to go back to the IOC. They also considered that an expert should be instructed. However, this was put on hold to await the outcome of Operation Rochester.

On 7th October 2004, Dr Barton appeared before the IOC for a fourth time. Again, the IOC decided it was not necessary to impose an interim order. The reasons given were that there had been no concerns about Dr Barton's work in general practice and that there was a voluntary undertaking in place in relation to prescribing.

There was a considerable delay whilst the GMC awaited full disclosure from the police and then a further delay whilst the GMC considered the material. A fitness to practise hearing was provisionally listed for September 2008. However, it was then agreed that it was inappropriate for the hearing to take place before the inquests and the hearing was set aside.

Dr Barton appeared before the IOC (now IOP) for a fifth time on 11th July 2008. For the first time, an interim order was imposed placing conditions on her registration that Dr Barton "*must not prescribe diamorphine and you must restrict your prescribing of diazepam in line with BNF guidance*". The restriction was put in place due to concerns that the previous agreement was voluntary and the absence of any formal arrangement to monitor compliance. The Report notes that the reason given for the imposition of an interim order had applied since 2002. It notes "*The interim order actually recognising these weaknesses did not come into effect until eight years after the GMC was made aware of the concerns in 2000.*".

The Report also notes that by accepting the police's request that the GMC investigation be delayed until after their investigation, there was a six year delay until the GMC investigation and a 10 year delay until the sanctions hearing. The Report states:

The Panel notes this as one of a number of examples of a process of accountability being undermined by deferring to another organisation.

On 8th June 2009, a fitness to practise hearing commenced in relation to 12 patients. Evidence was heard over 37 days. The Report sets out in detail the findings in relation to each patient. In the event, the Fitness to Practise Panel found that there were sufficient findings to support a finding of serious professional misconduct.

A sanctions hearing was listed for 20th January 2010. However, in mitigation the panel accepted Dr Barton's counsel's submission "*that the response of hospital management and senior colleagues against Dr Barton was such that she did, quite reasonably, feel that she was acting with the approval and sanction of her superiors.*"

The panel decided that an order for three years was appropriate with 11 conditions. This included non-prescription of opiates by injection and that Dr Barton must not undertake palliative care.

The families were understandably extremely disappointed by this outcome. The Report notes that Dr Barton had effectively benefited from the 10 year delay as this was "*interpreted as ten years of good practice to weigh in the balance*". Although the GMC expressed their frustration with the outcome the Council for Healthcare Regulatory Excellence ("CHRE"), the only body with a right to appeal, concluded that the test "*undue lenience*" had not been met.

The Nursing and Midwifery Council

The Nursing and Midwifery Council ("NMC") is the statutory regulator for nurses and midwives in the UK. The NMC replaced the United Kingdom Central Council for Nursing, Midwifery and Health Visiting ("UKCC") in 2002. As with the UKCC, the NMC is responsible for dealing with cases of alleged misconduct by nurses and midwives.

The UKCC were informed of the police investigation in September 2000. They were not informed of the concerns raised in 1991. The UKCC, subsequent to prompting by the Department of Health, met with the police on 15th May 2001. The police disclosed to the UKCC, material about nurses who might have had criminal culpability as identified by Professor Livesley in relation to Mrs Richards.

The Preliminary Proceedings Committee ("PPC") of the UKCC convened on 18th September 2001 and commenced an investigation into three nurses involved with Mrs Richards in relation to alleged misconduct. The PPC decided to take no further action. The Report notes "*that the PPC relied upon the Trust's findings and upon the decision not to take criminal proceedings rather than conducting its own enquiries. Mrs Richards' family were not informed of the decision of the PPC because they were not considered to be the complainants*".

Family members contacted the NMC directly in 2002 expressing concerns about the Hospital. Some of the complaints were referred to the PPC which, on 24th September 2002, considered the cases against four nurses. However, shortly before the PPC was due to convene, Hampshire Constabulary initiated Operation Rochester and the PPC adjourned its own consideration pending the outcome of the further police investigation.

After the end of Operation Rochester, further disclosure was provided by the police to the NMC. They concluded that there was insufficient evidence to proceed. However, the Report notes that expert evidence was not obtained and that the relevant lawyer Clare Strickland, by her own acknowledgement, did not have the medical expertise to identify evidence of misconduct.

In the event, five complaints concerning seven nurses were referred to the PPC to be considered on 11th April 2010. In respect of all the allegations against each nurse, the PPC declined to proceed. The PPC found that even if the facts were proven, it would not lead to removal of the nurse from the register.

The Inquests

Subsequent to the CPS decision that there would be no criminal prosecutions in December 2006, the inquests were set in motion. Mr Horsley, the Coroner for Portsmouth and South East Hampshire, first met with the police on 11th April 2007. He was provided with a file of material which focussed solely on the 10 deceased in the Category 3 cases (the most serious ones) identified by the police. The Report notes that the coroner was given very little information by the police in relation to the other 81 deaths but made no further enquiries himself.

The Report notes Mr Horsley's concerns at an early stage that the inquests would put considerable strain on the relevant Coroner's Office both in financial and staffing terms. Mr Bradley, a solicitor recently-retired from private practice, was appointed to undertake the inquests on Mr Horsley's behalf though he was not appointed until April 2008.

At a meeting in August 2007 between Mr Horsley, the Ministry of Justice and Department of Health, Mr Horsley is noted to have:

... deep misgivings about handling these cases as inquests. The conduct of the doctors concerned was an issue, but so too was the management of the hospital. In his view that aspect went beyond the remit of an inquest. He also had concerns, if the inquest route were taken, about the enormous quantity of evidence and the large number of expert witnesses ... He suggested that the public inquiry route would be a better way to address the public expectations. Its terms of reference could be set so as to achieve everything that inquests could.

Inquests can proceed through a public inquiry where public concern extends significantly beyond a death itself to wider related issues. However, this must be established by a government minister. In the event, the Department of Health declined to order a public inquiry. The Report notes that:

The decision not to hold a public inquiry into the deaths at the hospital was a missed opportunity. As a result, the inquests into the deaths at the hospital were not able to consider in sufficient detail matters relating to the management and history of events at the hospital dating back to 1991, or the culture of proactive prescribing and end of life care more generally.

The inquests commenced on 18th March 2009 and ran for 21 days. Mr Bradley determined at a pre-inquest hearing in January 2009 that Article 2 of the European Convention on Human Rights was not engaged (when it is engaged the inquest will look at the broader circumstances of the death).

The coroner declined to leave open to the jury a verdict of unlawful killing in respect of four of the deaths on the basis of gross negligence by Dr Barton on the basis of insufficiency of evidence. The coroner also noted that the issue of causation could not be satisfied but declined to adjourn the inquests to obtain such evidence. The coroner also refused to leave to the jury the possibility of verdicts of neglect or an open verdict.

The jury gave verdicts that in all cases that medication was given for therapeutic purposes and that in three cases only was it not given appropriately. The families were unhappy with the inquest verdicts and called for a fresh police investigation.

The Report notes that representation for the families for the initial 10 inquests was initially pro bono with a view to obtaining "*exceptional funding*" from the Legal Services Commission. In the event, funding was obtained at 10am on 18th March 2009, the day that the inquests began. The Report notes that this significantly impaired the ability of the the lawyers properly to prepare for the inquests.

The Report notes the initial coronial view that Article 2 was engaged which view appears to have changed subsequent to conversations with the Trust solicitor in the absence of the legal representatives of any other interested parties. The Trust's view was that it was not since all the individuals had died before the Human Rights Act (which brought into UK law the European Convention on Human Rights) became law. This matter was not substantively raised with the other interested parties. Subsequent to this decision, in the case of *McCaughey* the Supreme Court confirmed that in respect of a death that occurred before the Human Rights Act came into force, if the inquest takes place after the operative date, then Article 2 could be engaged, ie the coroner was wrong and the matter was not properly argued.

Comment

The Report, including appendices, runs to nearly 400 pages. This article is accordingly a necessarily highly-truncated summary of the Report. The scale of wrongdoing and subsequent inability of the various statutory and regulatory bodies properly to investigate the wrongdoing as set out in the Report is staggering. Interested readers are referred to the Report itself which can be found online here.

As practitioners working within clinical negligence it is perhaps humbling to appreciate that civil litigation appears to have played no role in the events described. It is assumed, though not mentioned in the Report, that some families did contact solicitors for advice after the death of their family members but the events complained of, shortening or ending the lives of elderly patients, do not result in significant financial settlements and there is no indication that they were pursued. There is clearly public interest in uncovering wrongdoing, of whatever extent, and this should be borne in mind when facing arguments of proportionality.

Other lessons which can be drawn from the Report, it is suggested, are:

1. The extent to which the individuals and organisations are, by nature, self-preserving and without the intention actively to conceal, generally put their own interests first. The nature of that opposition to challenge may, as with the nurses' complaints in 1991, be to deprecate those complaining, ie to complain about the complainer. The first practice tip is, accordingly, to be critical and not to accept assertions made by those in authority whoever they may be unless properly evidenced.

2. The second practice tip is to listen to the lay client. The Report is unequivocal in its support for and of the families who despite concerted opposition over decades persisted with their assertions that something was dreadfully wrong with the care received by their loved ones. Although not supporting any sort of conspiracy theory or collusion between the various bodies involved, the Report is categorical that the families were, in the end, correct.

3. The third practice tip is to acknowledge just how limited and imperfect the coronial system is. It is an inescapable conclusion, within the context of the wider findings of the Report, that the inquests held in relation to the deaths at Gosport were largely ineffectual. Bearing in mind the costs incurred and the legitimate expectations of family members in such processes this is deeply

unsatisfactory. Partly, this was due to an inequality of arms but it is also clear that financial constraints of the relevant coroner's office significantly affected the inquest process. Errors of law were made (in relation to the scope of the inquests) and there were obvious evidential defects (particularly in relation to causation). As practitioners we often set great store by inquest procedures but it is suggested that such confidence is often misplaced.

4. A recurring theme within the Report is the inappropriate use of evidence. Assertions are made at GMC hearings which are unevidenced. Letters are written confidently asserting facts which are unproven. Experts are not provided with the full evidence. Evidence is withheld. In the context of such a complex and large picture, lack of resources may influence the extent of investigation but often the evidential failures appear to be conceptual not just resource driven. The extent to which conclusions are drawn on faulty evidence is clear within the Report and as practitioners we should always be alert to evidential failings.

5. Perhaps the final lesson to be drawn from the Report is that of avoiding delay. Many of the families' frustrations arose out of the deferring of investigation until another body had concluded its investigations. It is suggested that within the civil litigation context delay should not be tolerated at the behest of some other organisation completing their own enquiry. It is particularly noteworthy that despite all other organisations deferring to the police investigation, the police themselves always appeared to consider the issues raised were a matter for the Hospital and the regulatory authorities.

Update

It is over two years since the Report was published. In April 2019, Kent and Essex Police launched a new investigation, Operation Magenta, into the deaths at Gosport. At the launch Assistant Chief Constable Downing said that a medical panel would be set up to "*prove or disprove the causational links between opioids being administered and deaths*". In a recent statement Deputy Assistant Commissioner Neil Jerome said: "*Police officers are currently reviewing more than 700 patient records as part of the ongoing criminal investigation into deaths at Gosport War Memorial Hospital, Hampshire, between 1987 and 2001*".

What, if any, prosecutions or convictions will result from the new investigation is difficult to predict. Convictions, even corporate convictions, may provide some sense of justice for the families. However, perhaps the more damning indictment in the whole affair is just how poorly statutory and regulatory bodies understood the breadth of the crisis in care at the Hospital and how imperfectly such failures were then investigated. Little comfort can be taken from the Report that such a disregard for human life and such widespread failure by statutory and regulatory bodies to act upon that disregard could not happen again.