



Learning from Gosport

The Government response to the report of the Gosport Independent Panel

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Foreword by the Secretary of State for Health and Social Care

The Gosport Independent Panel has made us see with great clarity a terrible and shameful episode in our history. To read the Panel's report is to understand how doctors, nurses, and leaders in healthcare - those we most want and need to trust - can fall away from acceptable standards of practice, with awful consequences for patients. The report also describes with quiet anger the many struggles and frustrations of the families of those who died at Gosport. For the families, the Panel's report marks an important milestone rather than an end point and, while the Government cannot express a view about any subsequent process that may take place, we would like this response to be, in part, a tribute to the Gosport families and those who have supported them for their resilience, perseverance and courage in the face of many obstacles and delays.

The Panel's report has made us think and reflect hard in Government and the NHS and in other agencies. This response document describes our initial actions and areas where we plan to do further work. I am sure, however, that this will not be the last word on the matters raised by the Panel's report. Where we see opportunities now or in future years to act to both improve the safety of care and to honour those who were so badly let down in Gosport, we will seize them, and we will act on them.

1. Introduction

- 1.1 The report of the Gosport Independent Panel is shocking. It is a devastating account of failures in care and in the supervision of care. The report shows the terrible cost of those failures for those who died but also for their families who have waited far too long to understand what happened to their loved ones.
- 1.2 The role of the Gosport Independent Panel was to describe as clearly as possible what happened at Gosport War Memorial Hospital. They have done this with great dedication, skill and effort and, while their role was to establish the facts rather than to make recommendations for policy and practice, there are a number of messages and lessons that can be drawn from the report for Government, the NHS and others.
- 1.3 The purpose of this document is to capture those messages and lessons and to set out the actions to follow. The Panel report has already led to the establishment of Operation Magenta by the Eastern Police Region to assess the evidence brought to light and gathered by the Panel. It is important that we let that process run to completion without further commentary. This document is therefore about policy and system issues but it is not about individual or corporate liabilities or culpabilities.
- 1.4 The Panel report allows us to see the failings of care in the context of the practices and expectations of the time. Although much has changed since then, there are still lessons for today and things we need to take action to improve.
- 1.5 This response describes three types of action:
 - a. Measures already in place and established, such as the controlled drugs regime;
 - b. Reforms that are in place and developing, such as the measures to support whistleblowers and 'freedom to speak up'; and
 - c. Changes where we need to go further, such as the better alignment between types of investigation.
- 1.6 This response document also describes the work of a number of national organisations and services to identify and apply specific lessons from the Panel's report.
- 1.7 We know that for those people closest to what happened at Gosport War Memorial Hospital, questions of policy may be a distance away from what concerns them

most immediately, and that they will be very interested in the outcome of the current police assessment process, 'Operation Magenta'. We hope, however, that they and others will recognise our determination to learn all we can to prevent future failings of this kind, and to act on that learning.

2. Listening to patients, families and staff

'Over the many years during which the families have sought answers to their legitimate questions and concerns, they have been repeatedly frustrated by senior figures ... The obfuscation by those in authority has often made the relatives of those who died angry and disillusioned ... When relatives complained about the safety of patients and the appropriateness of their care, they were consistently let down by those in authority – both individuals and institutions' - Bishop James Jones, Foreword to the Panel Report.

Key Actions

1. The Government will consider how best to strengthen protection for whistleblowers within the NHS in order to support patients, families and staff to raise concerns.
2. The Government is committed to ensuring that where staff speak up (including 'whistleblowers') their concerns are investigated; and to making it more transparent in the way individual NHS Trusts manage these cases. We will legislate, subject to Parliamentary time, to make all NHS Trusts in England publish Annual Reports on concerns of this type.
3. The National Guardian will continue to champion those who speak up through her Network of Freedom to Speak Up Guardians, and will publish an independent, annual report to be laid before Parliament to showcase best practice, hold the Government and the system to account and advocate for change.
4. The National Guardian has started to take a more active approach in looking at how organisations handle concerns raised by staff who speak up and will continue to implement its approach for staff in NHS Trusts.
5. CQC is reviewing how it assesses the statutory duty of candour.
6. We will place listening to and learning from feedback at the heart of care and improving care with a new strategy to be published this year.

Lessons and Messages from the Report

- 2.1 The report of the Gosport Independent Panel is a story of opportunities missed and of voices unheard. If those voices had been heard sooner, a great deal of the

harm that was suffered at Gosport War Memorial Hospital could have been avoided, and lives could have been saved.

- 2.2 The Panel's report also illustrates how clinical authority and a culture of hierarchy and silence was used to stifle the voices of staff and families. Nursing staff first raised concerns about the prescribing and administration of drugs in Gosport War Memorial Hospital in 1991. They were marginalised, and this was the first lost opportunity to prevent so many avoidable deaths. The report helps us to see that ignoring the voices of patients, families and staff can cost lives; and while the NHS has changed a lot since these events, that basic truth remains valid and important.
- 2.3 Patients, families and staff were also, as the report makes clear, frustrated and at times angered by many of the investigatory processes both within and beyond the NHS that took place during and after the events described in the report. Those in authority failed to hear them when they raised concerns about safety; and it failed to hear them when they sought answers.
- 2.4 The Gosport Independent Panel was commissioned by the Government in 2014 to provide the families with a better understanding of what happened to their loved ones, and of how the wider system failed to identify and deal with failings in care. It has done so with great thoroughness. The Panel was not, however, put in place until 2014 when very many years had passed since the events in Gosport, and this has added to the distress and frustration of the families.
- 2.5 The experience of families, patients and staff at Gosport teaches us the following:
 - a. The concerns of patients, their families and of staff are a vital resource in avoiding harm and improving patient safety - they must be properly valued and not be treated as a nuisance or in a defensive manner;
 - b. Staff who speak up and all of those raising concerns must feel safe and supported when doing so, they should have confidence their concerns will be investigated;
 - c. Those providing care, overseeing it, inspecting it or investigating failures in it must recognise the importance of listening carefully to and supporting people raising concerns.

Freedom to speak up and raising concerns

- 2.6 The importance of supporting patients, families and staff to raise concerns has been driven home in recent years by the cases of Mid Staffordshire and Morecambe Bay. While these cases occurred after Gosport, the reports into them

came before the Panel's conclusions. This means that many of the measures taken after the earlier reports are also relevant to Gosport. The appointment of a National Guardian to act as a champion for those speaking up brings a national focus to this issue; and the establishment of a network of Freedom to Speak Up Guardians means that there are local champions and agents of cultural change in place up and down the country as a result of the commitment to learn from tragedies such as Gosport. It is important to recognise that many cases where staff speak up or those involving whistleblowing can be complex and multi-faceted, which makes it all the more vital for organisations and those leading them to learn from good practice, and to remain open to the potential lessons for them and their organisation when concerns are raised.

The National Guardian has, as part of her role, the job of advising Government and holding it to account so that it continues to support those raising concerns. To further increase transparency, accountability and to promote culture change the Government has requested the National Guardian to produce an annual report to be laid before Parliament. In the year 2017-18, Freedom to Speak Up Guardians reported 7087 cases of speaking up within NHS Trusts. Of these, 32% of cases related to patient safety. Of those individuals who provided feedback, 87% reported that, given their experience, they would do so again.

- 2.7 Those who do Speak Up deserve our gratitude and our protection. The Government has put in place a range of protections for those staff raising concerns or 'blowing the whistle' in recent years. The Department of Health and Social Care recognises the calls that have been made by some to further strengthen the protections for those Speaking Up at the point a concern is raised or during an investigation, and to improve the ways in which the issues raised are investigated. The Government will consider how best to strengthen protection for whistleblowers within the NHS in order to support patients, families and staff to raise concerns.
- 2.8 We also want NHS Trusts to be more transparent about the way they manage these speaking up cases to demonstrate to their staff as well as patients and the wider public that those staff who want to highlight poor practice and are concerned about patient safety are valued and will be supported to speak up without suffering detriment. Subject to Parliamentary time, we will legislate so every NHS Trust in England is required to publish information on cases of speaking up and an overview of how the matters raised have been addressed.

A culture of candour and consent

- 2.9 The culture at Gosport was the opposite of candid. It was defensive, hierarchical and ignored the concerns of patients and families. The co-existence of closed cultures and poor and unsafe care is not a coincidence. Where a healthcare organisation lacks interest in the views and concerns of those it treats, it can quickly become lost in a cycle of excessive self-confidence, labelling problems as external attacks or threats rather than as learning opportunities. Even in the best organisations, there can be a strong temptation to seek to explain away failings in care rather than taking the harder but more rewarding road of looking deeply into what the causes of the problem really were.
- 2.10 This is why the Government, as a matter of patient safety, put in place a statutory duty of candour. This means that organisations must be candid with patients and families when things go wrong. The CQC inspects against this requirement and providers of care are expected to implement the duty of candour through staff across their organisations - including educating, training and ensuring there is a 'just culture' approach to support and challenge organisations, teams and individuals as is needed. As well as being the right thing to do for patients and families, the duty requires providers of care to take a step that is vital to learning from mistakes: being honest with those who have been harmed also compels organisations and those in charge of them to be honest with themselves.
- 2.11 In addition, all regulated healthcare professionals working in the United Kingdom (UK) have an individual professional duty of candour, which is a responsibility to be open and honest. This responsibility is set out in their respective professional codes of conduct.
- 2.12 The professional regulators have published a joint statement on the professional duty of candour, which was promoted to health professionals, students and patients. Professional regulators have also included the duty of candour in the standards and guidance that health professionals are expected to meet at all times and have worked to embed these standards and guidance in practice. The professional regulators continue to work with other regulators, employers and commissioners of services to help develop a culture in which openness and honesty are shared and acted on.
- 2.13 The two duties of candour are mutually reinforcing and aim to help to create a culture of candour in the NHS. We know, however, that some believe that these need to be more effective, and it is clear that much remains to be done so that the spirit as well as the letter of the duty is observed. The CQC and the Government will continue to monitor progress and encourage the NHS to go further, faster.

The CQC is currently reviewing how they regulate duty of candour in order to identify if their approach can be strengthened further.

- 2.14 Linked to candour is the critical matter of consent. One of the consequences of placing a clear and strong responsibility on organisations and clinicians to be open with patients and families when things go wrong is that it reinforces the need, wherever possible, to obtain clear consent from the patient, rooted in a well-structured discussion, before care or treatment are provided.
- 2.15 The role of the CQC as the inspector of care providers is described in more detail in chapter four, but it is important to emphasise in this chapter how important patient experience is to the work of the CQC since it was significantly reformed following the Francis report. The CQC is committed to listening and acting on experiences of care in its inspections and throughout its work. The CQC's inspection teams include 'Experts by Experience' – people who have personal experience of care and who can assess the quality of the services received from the patients and/or carers perspective. The CQC invites people to pass on concerns and feedback about individual providers either on its website, by telephone, or in writing to its National Customer Service Centre. The CQC has developed a regulatory approach to monitoring and inspecting all NHS Trusts that seeks to listen more to feedback from patients, families, carers and staff. This includes receiving information on 23,544 experiences of care directly from people through their on-line form in 2017/18 which led 562 inspections to be brought forward and 147 urgent inspections being carried out.
- 2.16 All whistleblowing concerns raised with the CQC are forwarded to the local inspector for consideration. This allows the CQC to spot problems or concerns in local services that it may need to act upon.

A culture that listens, learns and changes

- 2.17 Among the many things that went wrong at Gosport was a failure of systems and of culture. The protections against poor care that organisations should bring to bear did not work; nor did those that should have been rooted in the behaviour and professionalism of those working in and running the hospital. The systems and culture at Gosport failed to stop care from moving to an unacceptable place, leading to tragic outcomes for patients and their families.
- 2.18 Culture is powerful but it can also be changed by the people within it. Where organisations, leaders and individuals have a genuine commitment to listen to difficult messages and to seek out problems rather than ignoring them; and where they have an accompanying willingness to change, we have seen real improvements in care, including in the most challenged organisations.

- 2.19 There are a number of themes in the Panel's report that are common to other reports in recent years that have identified failures in hearing the voices of patients, staff and families:
- concerns are not treated seriously;
 - the quality of investigations is patchy; and
 - lessons are not consistently being learned or implemented.
- 2.20 For too long, these issues have been allowed to continue, with those responsible not being sufficiently challenged or held to account. This Government believes now is the time for a different approach - an approach that delivers on all feedback being taken seriously, whether that feedback:
- is prompted or unprompted;
 - involves raising concerns, making complaints or Speaking Up;
 - is raised by service users, their families or staff; or
 - is identified independently by, for example, organisations like the Care Quality Commission, the Healthcare Safety Investigation Branch, or NHS Resolution.
- 2.21 This means working to ensure all care organisations encourage and welcome speaking up, whether by service users, their families or staff. And, when someone does speak up, according them respect by treating what they say seriously, investigating it appropriately, and ensuring subsequent action is taken to implement any lessons learned. The voices of patients, staff and families are a precious resource, but all too often they have been treated as a nuisance or dealt with defensively. While the NHS has made some progress in listening to these voices in recent years, we need to do more. The NHS needs organisations, cultures, clinicians and leaders that listen carefully and with an open mind because they want to learn and do not become defensive when challenged. The potential benefits to care quality from getting this right are significant: careful listening can save lives. The Department therefore plans to publish a strategy for improving the way that feedback is managed and used in the NHS later this year.
- 2.22 The Department has asked the National Guardian to take a more active approach in looking at how organisations are handling concerns raised by staff, and whether the National Guardian's Office might further support individual staff who speak up, and ensure their concerns are being dealt with appropriately. This will include continuing to implement the National Guardian Office's case review process in the health sector. The purpose of these case reviews is to identify any areas that do

not follow good practice in that handling, not to adjudicate on disputes or to apportion blame but, by so doing, it supports organisations to identify areas for improvement at an earlier stage, enables them to address them effectively, and provides lessons to be learnt by other organisations and the system as a whole.

2.23 We believe it important to provide greater support to those staff who do ‘Speak Up’, and we shall work with the National Guardian Office to investigate the appropriateness of engaging with ‘these cases at an earlier stage.

2.24 If someone has experienced poor care or believes that poor care is being provided, they are able to report it to the CQC. The CQC carries out regular checks on health and social care services and this information helps it to decide when, where and what to inspect, including undertaking unplanned inspections if deemed necessary. Information on concerns raised and 'whistleblowing' is made publicly available in the CQC monthly Board's quarterly Performance Reports, available online.

Putting families first when things go wrong

2.25 The case of Gosport has illustrated how all public agencies, within the NHS but also the police and other criminal justice agencies need to do more to ensure that when there are serious failings in care, families are properly engaged and understand what is happening.

2.26 The Government has also recently (in September 2018) published a victims' strategy, and the measures set out in this strategy will also serve to address some of the issues that have affected the Gosport families.

3. Ensuring care is safe

From: Summary and conclusions- Report of the Gosport Independent Panel, p316

'...during the period between 1989 and 2000 at Gosport War Memorial Hospital...There was a disregard for human life and a culture of shortening the lives of a large number of patients. 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'.

Key Actions

1. NHS England review this year on the Controlled Drug Accountable Officer role, local reflection on the Panel Report, and on anticipatory prescribing.
2. Continued implementation of and support for the Learning from Deaths programme, and of the commitment to put Medical Examiners in place for non-coronial deaths.
3. A new Patient Safety strategy this Autumn to make it easier for staff to report risks and for action to be taken.

Lessons and Messages from the Report

- 3.1 As the report of the Panel shows, the care for many patients at Gosport War Memorial Hospital was not safe. The Panel has found that 'records show that 456 patients died where medication - opioids - had been prescribed and administered without appropriate clinical justification'. While it would be wrong to draw any conclusions about responsibility or liability at this stage given that there is an active police assessment of these issues currently underway, it is clear that the care provided at Gosport was, for a number of patients, not safe and that this was caused by a number of factors. Beyond the specific issues about the prescription and administration of opioids set out in chapter two of the report, chapter three makes clear that there was also a number of failings in the standards of care that are 'disquieting when assessed against the standards prevailing at the time'.
- 3.2 There are two important messages for patient safety from the report. First, the management of the prescribing, dispensing, administration and monitoring of powerful drugs is a central component of patient safety. Second, while it is vital we get the technical and regulatory defences against unsafe care right (and there will be more on these mechanisms in the following chapter) we know that it is the

norms, professionalism and willingness of clinicians and managers to stand up for safety along with the support of their organisations that will make the biggest difference to safety in the long term.

- 3.3 This chapter sets out what has changed and what remains to be done on controlled drugs specifically and on medication safety more widely. It also sets out what the NHS and the Government is doing to ensure a culture of safety takes root in our hospitals and other care settings. Patient safety is not a technical problem that can be fixed once and for all - it is a continual challenge, and there is always room for improvement and a constant need to manage the risks of clinical care. The governance and oversight of care within a hospital is the most important line of defence against failures in care. While there is always a need for external challenge and support (the subject of the next chapter) it is important that we continue to recognise that the safest organisations are those which take safety seriously and manage it for themselves, not those which need to be externally directed or regulated.

Controlled drugs and medication safety

- 3.4 The poor use of controlled drugs at Gosport War Memorial Hospital was central to the failures in care that led to the terrible consequences described in the Panel's report. Since the period analysed by the report there have been significant changes in the governance arrangements for the use and management of controlled drugs.
- 3.5 Many of these changes were instigated as part of the Government's response to the Shipman Inquiry's Fourth Report. The Controlled Drugs (Supervision of Management and Use) Regulations 2006 (the 2006 Controlled Drugs Regulations) (as amended) mandate health care organisations to put in place standard operating procedures on the prescribing, supply and administration of controlled drugs and the clinical monitoring of patients.
- 3.6 Tighter controls were also put in place by the Home Office through Regulations covering prescribing, record keeping and safe custody of controlled drugs. The 2006 Controlled Drugs Regulations also require the appointment of a Controlled Drug Accountable Officer. This Officer has statutory responsibility for the safe management and use of controlled drugs within their organisation. These Officers are required to work with healthcare providers, regulators and enforcement authorities through local intelligence networks to share any concerns about the use and management of controlled drugs.

- 3.7 The Regulations also require the operation of a Local Intelligence Network where concerns about systems and / or individuals can be raised. This also links to the Responsible Officers for doctors' performance.
- 3.8 The Care Quality Commission (CQC) ensures that health and adult social care providers maintain a safe environment for the management of controlled drugs in England. They report their findings through individual local inspection reports and by means of published annual updates to Government. The National Institute for Health and Care Excellence (NICE) produced guidance in 2016 on the safe use and management of controlled drugs. This guidance aims to reduce the safety risks associated with controlled drugs by ensuring that robust governance processes are in place and that working practices comply with legislation.
- 3.9 While no system can ever completely prevent the mismanagement or misuse of controlled drugs, the measures that have been put in place mean that the inappropriate use of opioids and other controlled drugs can be detected more quickly and stopped, so that protracted poor practice is less likely to continue unchecked.
- 3.10 In addition to specific measures on controlled drugs, the NHS has taken important steps towards improving the safety of medication more generally. The chief pharmacist role, following the report 'Pharmacy in England' (2008) was identified as the organisational lead for medicines safety, and a Patient Safety Alert in 2014 required all organisations to identify the role of Medicines Safety Officer to coordinate local medicines safety processes and work collaboratively nationally; NHS Improvement and the MHRA jointly support a network of Medication Safety Officers and Medical Device Safety Officers. As part of the Government's response to the World Health Organisation's patient safety challenge on medicines safety, we are developing a programme of work led by NHS Improvement to improve medicines safety. Work is already underway to accelerate the roll-out of electronic prescribing and medicines administration, and to deploy more clinical pharmacists in primary care and care homes. We have also introduced monitoring of the highest risk prescribing practice linked to hospital admissions.
- 3.11 In addition, and following on from the publication of the Panel's report, NHS England has initiated the following actions, all of which are due to be completed by the end of the year:
- A review of the governance and leadership of the Controlled Drug Accountable Officer role in NHS England;
 - A review of the operation of the lead Controlled Drug Accountable Officers in NHS England, including the effectiveness of Local Intelligence Networks;

- An assurance process to assess how 'Designated Bodies' (which include NHS Trusts and Foundation Trusts) are reflecting on the learning from the report and reviewing arrangements in their organisation in the light of it.
- An assurance process focused on the appropriateness of anticipatory prescribing guidelines and that they are being followed.

A culture of safety – learning, staff engagement and continuous improvement

- 3.12 The Panel's report shows that along with a number of unsafe practices, Gosport War Memorial Hospital also had a culture which did not create the right conditions for safe care. In part this flowed from an environment that made it difficult for staff, patients and families to question and to challenge decisions about care which were discussed in the previous chapter. The problems at Gosport also stemmed from a lack of oversight of quality and clinical governance within the hospital and the wider health system at the time.
- 3.13 While it would be wrong to assume that today's healthcare system is entirely free of these problems, it is true that significant progress has been made in placing the quality of care and the importance of safety higher up the agenda for providers and others in the system, and that this has made a real difference for patients.
- 3.14 Recent years have seen a great deal of work on quality of care in particular patient safety in the NHS. Each of these waves of reform have emphasised the importance of both clinical and managerial involvement in care quality throughout provider organisations. Changes have centred on learning, staff engagement and continuous improvement.

Learning

- 3.15 To start with learning, we know that gathering data is only part of what is needed: we are also taking action to ensure that there is careful analysis and pattern-recognition that then leads to action. The Learning from Deaths programme embodies a standardised and systematic approach to examining the care provided to people who die in order to identify improvements for future patients. This will be an important supporting mechanism for the development of Medical Examiners, a critical reform to ensure that patterns in non-coronial deaths are picked up and acted upon. Trusts have each published a policy on how they respond to and learn from deaths. Trusts are also required to review and publish locally the numbers of deaths thought to be due to problems in care on a quarterly basis, and evidence of what they have learned and the actions taken to prevent such deaths in future on

an annual basis. This new level of transparency is fundamental to a culture of learning and ensuring the safety of NHS services. The CQC has strengthened its assessment of Trusts' learning from deaths as part of its annual inspections of Trusts. CQC's approach to inspection will include monitoring implementation of new guidance for Trusts on working with bereaved families and carers published in July. In June, we announced that primary care and ambulance Trusts will be the next focus for reviewing deaths to help understand and tackle patient safety issues. By looking at how to extend the learning from deaths policy to GPs and ambulance Trusts, more parts of the NHS will be made safer by generating learning and enabling local health organisations to learn from one another.

- 3.16 A range of other data related to safety and quality, including the Friends and Family Test which gives patients the opportunity to feedback to providers of NHS funded care or treatment, are also published on a regular basis. Quality accounts, published annually by each provider, including the independent sector provide transparency about the quality of their services by reporting on patient safety, the effectiveness of care and patient feedback about the care provider. All of this helps Trusts and Foundation Trusts and their regulators build up a picture of the quality of care and of how the safety of services can be improved.

Staff engagement

- 3.17 Learning must be supplemented with action based on the recognition that it is staff who make all the difference in patient safety. We have therefore supported national efforts to encourage positive changes in culture. Sign up to Safety was launched in June 2014 to strengthen patient safety in the NHS. The campaign aims to help member organisations listen to patients, carers and staff, learn from what they say when things go wrong and act to improve the safety of care. Since 2017 the campaign has focused upon communication as key to improving patient safety.

Continuous improvement

- 3.18 Finally, along with measurement, we need governance and an inquisitive and programmatic approach. The Patient Safety Collaborative (PSC) is a joint initiative, funded and nationally co-ordinated by NHS Improvement, with the 15 regional PSCs organised and delivered locally by the Academic and Health Science Networks. The programme has both identified priorities for health improvement that will make a difference to local healthcare systems as well as define good clinical practice for national priorities. The PSC will continue to provide the capability and capacity needed to support both local and national safety improvement programmes.

- 3.19 These features of a safety culture are profoundly linked to the need for candour, openness and willingness to learn set out in the previous chapter. Without a commitment to learn, gathering information about what can go wrong will not change care; conversely, without measurement and governance to identify issues and drive change, the willingness to do something to make care safer may not resolve itself into clear action. Both are needed.

Further action

- 3.20 The Government and the NHS are committed to continuing to find new ways to promote and improve patient safety. NHS Improvement has developed and published a Just Culture Guide endorsed and supported by Royal Colleges, patient organisations, unions, and professional regulators. The guide supports managers to understand when an individual member of healthcare staff needs personally targeted support or intervention to work safely, and when there are wider issues with safety systems that require action.
- 3.21 Dr Aidan Fowler has recently been appointed as the new NHS National Director of Patient Safety and his appointment provides an opportunity to provide new leadership to this agenda across the system. Dr Fowler has also been appointed as a Deputy Chief Medical Officer and will provide advice to the Department of Health and Social Care in this capacity.
- 3.22 Dr Fowler will develop a new Patient Safety Strategy with proposals to be published in the Autumn alongside the long-term plan for the NHS. The strategy is aimed at ensuring the NHS is the safest healthcare system in the world and includes proposals for making it easier for frontline staff to report incidents and improving the way the NHS acts on patient safety risks. This work is underpinned by the principles of openness and transparency, considering how to support further development of a just safety culture in the NHS, and ensuring a focus on continuous learning and improvement. It is important that the development of this strategy takes account of what patients, clinicians, managers, healthcare providers, and other stakeholders think and so Dr Fowler will be presenting his ideas and inviting others' thoughts on how the NHS can deliver these aims. Once defined however, this work will become the blueprint for safety in the NHS, building on the legacy of 'An Organisation With a Memory', the Berwick Report 'A Promise to Learn – a commitment to act' and indeed the findings of the Gosport Inquiry.
- 3.23 Finally, a culture of safety is one that recognises, values and empowers the staff who make care safe for patients day in and day out. To help support this, a new national role of NHS Chief People Officer has been created and the recruitment process for this role is underway. This position will have responsibility for ensuring

that the NHS has a cohesive and deliverable people strategy reflecting strong values and championing people in the NHS.

Isolated Practice

- 3.24 One of the features of the care provided at Gosport War Memorial Hospital that the Panel's report brings out very vividly is the relative isolation of the organisation and of the staff who worked there. While there were some connections with the wider system, there is a strong sense from the report of a group of clinicians and an organisation that had become cut off from the norms and expectations that were in place elsewhere.
- 3.25 Isolated practice is not simply determined by geography, organisational structures or by the size of an organisation, but these factors seem likely to play a part in increasing the risk of such practice taking root. Isolated practice is also not necessarily a direct cause of poor care, though, again, it seems likely to be a risk factor for it. One of the lessons of the Panel's report and of a number of other reports (including the experience of a number of providers that have been through the Special Measures) is that the quality of care is in part dependent upon the strength of connections within and beyond the organisation and that poor care thrives where connections are weak. This is why the use of peer support or 'buddying' has been an important factor in helping providers in Special Measures to navigate their way back to an improved position. It is also why providers themselves, along with those inspecting and regulating them need to be alive to the potential risks of isolated practice as they do their work.

Syringe Drivers

- 3.26 Following the publication of the report of the Panel, there were a number of media reports referring to the use of syringe drivers. These devices are used to deliver a continuous, steady dose of pain-relieving medication. When used safely they can be highly beneficial to patients. Syringe drivers were used at Gosport War Memorial Hospital, and the report mentions them on a number of occasions. As the chair of the Panel, Bishop James Jones stated in a letter to the Sunday Times after the report of the Panel was published that 'The four clinicians [on the panel] and the whole panel were unanimous that syringe drivers were not responsible for the overprescription that led to the shortening of 456 lives'. Following the media reports, the Department of Health and Social Care has reviewed the evidence about syringe drivers, looking in particular at the patient safety alert that was issued in 2010 by the National Patient Safety Agency and subsequent action to implement it. This safety alert instructed providers to put in place a transition to new models of syringe drivers which had better safety features than those widely

available up to that point. In the Summer, NHS Improvement undertook a survey to assess whether any of the older model of syringe drivers remained in use. They found no evidence of their continued use, with the one exception of a patient using the driver to self-administer drugs at home for a long- term condition (they have now switched to a more modern device). While the Department's review of evidence did not establish any cause for concern about the 2010 alert or its implementation, it is undertaking further work with the NHS Improvement Patient Safety Team and the Medicines and Healthcare Products Regulatory Authority to assess what improvements could be made to ensure that safety issues linked to the design of medical devices or to the availability of safer alternatives are recognised and managed as effectively as possible.

Conclusion

3.27 Keeping patients safe requires a team effort. It needs us all to play our part and to support others in making care safer. It involves recognition of the human as well as the technical factors which can make all the difference. It requires speaking up and being heard, and it relies on commitment and vigilance at all levels of an organisation providing healthcare. While inspection and regulation are vital in identifying and addressing cases of poor or unsafe care, the best means of prevention lie in the hands of healthcare organisations and the people working in them. We will continue to be committed to supporting them to do all they can to learn from recent and less recent problems, and to continue to build a culture of safety.

4. Identifying and addressing problems in care

'The senior management of the hospital, healthcare organisations, Hampshire Constabulary, local politicians, the coronial system, the Crown Prosecution Service, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) all failed to act in ways that would have better protected patients and relatives, whose interests some subordinated to the reputation of the hospital and the professions involved.' - Panel report, p316.

Key Actions:

1. CQC review of its external oversight in the light of the Panel report, including looking at responding to feedback, its assessment of medicines management (including controlled drugs) and working with partners on prescribing issues.
2. As NHS England and NHS Improvement work more closely together, they are putting joint oversight of the quality of care at the heart of their new structures.
3. Government commitment to bring forward proposals to reform the framework for professional regulation.
4. GMC commitments to introduce a senior patient champion; and to review the relationship between its processes and those of the police.
5. NMC commitments to accelerate the introduction of its Public Support Service; and work with nurses to identify the key learning from the Panel report for the profession.
6. General Pharmaceutical Council commitment to work with the pharmacy representative bodies to develop a framework for pharmacy to assess what changes have already been made to help prevent a similar situation to that described in the Panel report happening again and encourage discussion across pharmacy on any further actions that could be taken.
7. Appointment of a National Medical Examiner to provide professional and strategic leadership and set quality standards for Medical Examiners.
8. Revision of the NHS Serious Incident Framework.
9. The Government will explore what more can be done to ensure that investigatory processes relating to serious concerns (whether on an organisational or individual

level) relating to healthcare are organised so that they both are fully compliant with the relevant statutory remits and the interests of justice while also recognising and addressing the concerns and priorities of patients and their families.

10. The Ministry of Justice will refresh its Guide to Coroner Services to make it better tailored to the needs of bereaved families.
11. The Government has committed to establish an Independent Public Advocate and published its consultation on the role on 10 September 2018.

Lessons and Messages from the Report

- 4.1 The Gosport families waited far too long for the answers and evidence set out by the Independent Panel. The different attempts to find answers undertaken by healthcare bodies, regulators the police and the coronial service, were unable to bring a full and clear picture of events to light. In addition, these different processes did not always interact well with one another, adding to the frustration and concern of the families.
- 4.2 The regulation and oversight of healthcare will always be required. This applies to both individual clinicians and to organisations. The combination of power, vulnerability and complexity as inherent, intertwined features of healthcare means that it is highly unlikely that leaving providers of care to manage all of these factors themselves would ensure safety and quality of care. Striking the right balance between self-improvement and external oversight and intervention is a perennial challenge for all healthcare systems. The best forms of regulation, oversight and intervention provide insight and support to allow healthcare organisations to learn and improve for themselves, even if that is not an immediate possibility.
- 4.3 At times it is necessary to go beyond regulation and oversight to investigate the conduct of individuals or organisations. The report of the Panel looks in detail at a number of investigatory processes that were undertaken in response to the events at Gosport War Memorial Hospital, and points to a number of shortcomings in many of these processes.

Identifying and addressing problems - inspection and improvement

- 4.4 The current system of inspection and provider oversight was not in place when the events described by the Panel's report took place. While there can never be an absolute guarantee that any such system will prevent failures in care, it is highly

likely that the current system of independent, clinically-led inspection and risk-based support, improvement and intervention would have been able to identify and address the issues described in the report at an earlier stage.

- 4.5 Inspection, regulation and oversight form part of the culture of the healthcare system. In the years following the publication of the Francis report into Mid-Staffordshire NHS Foundation Trust, these functions have been significantly reshaped to both foster improvement within providers but also to act as a 'critical friend' to them, telling hard truths when necessary and acting to intervene when the safety and interests of patients require it.
- 4.6 One example of this is the Special Measures regime for quality established following the Keogh Review into avoidable mortality in 2013. This ensures that Trusts where serious care quality failings have been identified by the CQC and where their leadership is unable to resolve the problems receive increased oversight and intensive support from NHS Improvement to help them turn around the quality of their care. NHS Improvement has built on this model to enable it to provide early intervention where it is needed, putting in place processes to identify 'challenged providers' with the potential to enter special measures ensuring early support is in place for these organisations. The progress of providers in special measures and of challenged providers is reviewed through a joint governance mechanism with other oversight bodies and regulators.
- 4.7 The CQC's inspection model has been shaped by the learning from failures in care from investigations and reviews such as Mid Staffordshire NHS Hospital, Winterbourne View, Morecambe Bay and Southern Health. In response, the CQC developed a regulatory approach to undertake comprehensive inspections of all NHS Trusts that sought to listen more to feedback from patients, families, carers and staff. The approach is structured around five key questions that are asked of all care services:
- i. Are they safe?
 - ii. Are they effective?
 - iii. Are they caring?
 - iv. Are they responsive to people's needs?
 - v. Are they well-led?
- 4.8 Having established baseline ratings of all NHS Trusts, starting in 2013, a more responsive approach to regulation was introduced for NHS Trusts in June 2017. A key element of the new approach is more use of wider intelligence as part of

monitoring and inspection. CQC's inspection teams have relevant expertise in the care sectors they inspect. This includes assessing the management of medicines, including controlled drugs. CQC has powers to take enforcement action when necessary, to ensure breaches of regulations are dealt with in a timely and proportionate way.

- 4.9 The CQC is undertaking a review of its external oversight in light of the Panel's report. This will include looking at issues such as how it listens and acts upon feedback from patients, families, carers and staff; the governance and oversight of doctors in community services; how the CQC assesses the management of medicines, including controlled drugs such as opioids; and how CQC works with partner organisations such as NHS England in sharing information and intelligence.

Working together for safety

- 4.10 The cases of Gosport, Mid Staffordshire and other failures in care have reinforced the need for national and regional oversight bodies to work closely together to share intelligence and insight. New forums and mechanisms, such as the Joint Strategic Oversight Group (JSOG), have been established to share intelligence, develop aligned approaches to support Trusts and exchange learning across the system. The JSOG currently operates at national level and consists of a group of senior representatives from NHS Improvement, NHS England, CQC, HEE and GMC who meet bi-monthly.
- 4.11 The new operating model being developed between NHS Improvement and NHS England is building in alignment of national and regional oversight and support, through a consistent structure at senior level across regions and across the national medical and nursing teams, and senior leadership accountable to both organisations. These new arrangements are intended strengthen the way the two organisations work together to oversee and support providers, including further improving intelligence sharing, identification of risks and co-ordinated support interventions.
- 4.12 NHS Improvement has been developing approaches to better use available resources in its central and regional teams, to ensure it reflects priorities and support needs across the country an example of this is the piece of work undertaken by NHS Improvement to identify risk in the provider sector. The Executive Medical Director and Executive Director of Nursing have conducted an organisation-by-organisation review using a broad range of information and metrics to identify if there are any early signals that quality is at risk.

- 4.13 NHS Improvement, working with other national organisation, plans to run regional exercises to stress test the approach to oversight. The purpose of these exercises will be to consider the following questions:
- a. What should we collectively have spotted earlier, and what would need to change to make sure that we do next time?
 - b. What additional information or intelligence would make it more likely that concerns are identified early in future?

Identifying and addressing problems - professional regulation

- 4.14 The system of professional regulation has changed significantly since the events described in the Panel report. Professional regulation has been reformed to make it more independent from both the professionals they regulate and from Government. The four United Kingdom (UK) governments consulted in 2017-18 on high-level principles for reform to ensure professional regulation is proportionate, more consistent, less costly and better supports the development of a flexible workforce.
- 4.15 The five aims set out in the consultation were to:
- support the development of a flexible workforce that is better able to meet the challenges of delivering healthcare in the future;
 - improve the protection of the public from poor professional practice;
 - deal with concerns about the performance of professionals in a more proportionate and responsive fashion;
 - provide support to regulated professionals in delivering high quality care; and
 - increase the efficiency of the system.
- 4.16 The Government recognises that the current framework for the regulation of healthcare professionals is prescriptive, inconsistent and bureaucratic and does not support the development of a modern, flexible workforce. Officials are analysing the responses and the Government will be setting out its proposals to take this work forward shortly.
- 4.17 In addition to this work to reform the system of professional regulation as a whole, the regulators themselves have been reflecting on the Panel's report to assess the

lessons to be learned and how other reforms in recent years have added to the system's resilience.

General Medical Council

- 4.18 A number of changes have been made to the General Medical Council's (GMC) legislative framework to increase the transparency, accountability and efficacy of the GMC's processes. These are set out below.
- 4.19 The GMC council which registers and regulates doctors has reduced from 104 registrant members in 2003 to 12 members now, split 50/50 between lay and registrant members, with the latter being appointed by the Privy Council rather than being elected by other registrants. This increases the GMC's independence from the profession that it regulates.
- 4.20 The Medical Practitioners Tribunal Service has been established to undertake fitness to practise adjudication for doctors. This provides for greater independence of decision-making.
- 4.21 Finally, in December 2012 the GMC introduced an ongoing system of revalidation to ensure that doctors remain up to date and fit to practise. As part of this, all licensed doctors must have an annual appraisal and collect, reflect and act on feedback from patients and their colleagues, as well as complaints about their practice.
- 4.22 In recent years, the GMC has made substantial changes to how it works with families, patients and witnesses that engage with their processes. For example, the GMC's Patient Liaison Service set up in 2015 invites complainants to discuss the GMC's processes and answer any questions that they may have so that they are involved in the investigation process. Having reflected on the Panel's criticisms, the GMC has decided to also introduce a patient champion role at a senior level at the GMC to improve further how they listen to and engage with the voices of patients, families and friends, and the wider public.
- 4.23 It is much easier for the GMC to ensure timely disclosure of any documentation or material deemed necessary for a fitness to practise investigation. These powers allow them to require any person who is able to supply information or produce a document that appears relevant to their enquiries to provide that information¹. Having reflected on the Panel's criticisms of how they interacted with the Police,

¹ The Williams Review into Gross Negligence Manslaughter in Healthcare recommended that the GMC's power to require information from registrants exclude records of reflective practise. The Government accepted all recommendations.

the GMC is reviewing its investigations processes where there is an ongoing police investigation to identify any changes they need to make to guidance for staff and decision makers and any other further improvements they can make. This will ensure they are doing everything they can to progress such investigations in a timely fashion and ensure that they can take action in a timely way where patients may be at risk. They will reflect with other regulators on any further lessons that can be learned as a result of events at Gosport War Memorial Hospital.

- 4.24 The GMC is also committed to working closely with other professional and systems regulators across the UK to ensure any improvements to information sharing protocols or other processes are implemented in a timely fashion.

Nursing and Midwifery Council

- 4.25 The Nursing and Midwifery Council (NMC) has changed significantly since the events described in the Panel report. The NMC has issued a new Code which sets very clear professional standards of practice and behaviour for nurses and midwives. A new system of nurse revalidation means that all nurses and midwives regularly have to demonstrate they are practising safely and effectively in line with the Code. The NMC has also published guidance to help nurses and midwives know when and how to raise concerns and what their professional duty of candour is when things go wrong.
- 4.26 The NMC has affirmed its commitment to improving the way it engages with and supports patients, service-users, and family members who raise concerns about nurses and midwives. It has set up a public support service to ensure that concerns raised by patients, service-users and family members are properly listened to and acted upon. It now also provides specialist support and help to patients, service-user, and families throughout the fitness to practise process.
- 4.27 The NMC has put in place measures to support it to protect the public more quickly and effectively. The NMC has significantly changed the way it works with employers to help them to identify risks and make sure they are supported to make appropriate referrals to the NMC at the right time. The NMC has also worked to improve its investigation processes and the time it takes to conclude fitness to practise proceedings has significantly reduced: more than 80% of cases are now resolved in 15 months. The NMC works closely with other regulators to share information and intelligence and make sure that risks are identified and resolved by the right organisations.
- 4.28 Following a public consultation, the NMC has recently launched a new approach to fitness to practise which aims to foster a culture of openness and learning in the health and social care sector.

- 4.29 The NMC is also, in the light of the Panel report, working to accelerate the introduction of its Public Support Service, which will put patients, families, carers and the public at the heart of their work, supporting people involved in their cases so that they are held as important partners through the process. The NMC has also committed to working with a group of nurses to review the Panel's report to identify the key learning for the profession.

General Pharmaceutical Council

- 4.30 The General Pharmaceutical Council (GPhC) was established in 2010 as the regulator for pharmacists, pharmacy technicians and pharmacy premises. The GPhC replaced the Royal Pharmaceutical Society of Great Britain, which had been both the professional and regulatory body for pharmacists. The GPhC works to assure and improve standards of care for people using pharmacy services, including through the investigation of concerns about pharmacy professionals and the inspection of registered pharmacy premises.
- 4.31 The GPhC has introduced a system of revalidation to provide greater assurance to patients that the health professionals they register remain up to date and fit to practise. These revalidation processes include requirements such as peer discussion, which is designed to encourage professionals to engage with others in their reflection on learning and practice and help reduce the potential for professional isolation.
- 4.32 The General Pharmaceutical Council has also been reflecting on the Panel's report and considering action in response. In July 2018, the GPhC reported on the work undertaken in response to the Panel report to its governing council at a public meeting. This discussion affirmed the importance of individual pharmacists to speak up when they have concerns, and the responsibility of pharmacy owners to create an environment in which their professional staff can meet the relevant standards. Further work is now underway to develop a framework to review all current pharmacy arrangements to prevent a similar situation to that described in the Panel report happening again, and to identify any necessary actions. The General Pharmaceutical Council is committed to work with the pharmacy representative bodies to develop a framework for pharmacy to assess what changes have already been made to help prevent a similar situation to that described in the Panel report happening again and encourage discussion across pharmacy on any further actions that could be taken.

Medical Examiners

- 4.33 One of the critical failings identified by the Panel's report was the failure of the hospital or the wider NHS to look at individual deaths or patterns of deaths to see whether there was learning, improvement or intervention required in response.
- 4.34 In addition to the work on learning from deaths described in the previous chapter, from April 2019 we will be introducing Medical Examiners to scrutinise all non-coronial deaths. Medical Examiners will provide a service to the bereaved, increasing transparency and offering them the opportunity to raise concerns. Medical Examiners will provide a new level of scrutiny to help deter criminal activity and poor practice. Medical Examiners will also report matters of a clinical governance nature which will support local learning and help to determine changes to practice and procedures. Once fully in place, the system will ensure that every death is scrutinised, either by a coroner or a medical examiner, so that any clinical issues and learning can quickly be identified, improving patient safety and informing targeted learning from deaths initiatives.
- 4.35 The system will have an independence, overseen by a National Medical Examiner, providing leadership to the system. The National Medical Examiner will provide professional and strategic leadership and set quality standards for Medical Examiners. Pilots of the Medical Examiner process, across a range of localities across England and Wales, have demonstrated that the process works efficiently and effectively, and is a crucial enabler for learning from deaths. The introduction of Medical Examiners will be achieved without imposing undue delays impacting on the bereaved or undue burdens on medical practitioners and the wider system.
- 4.36 A digital solution will be developed to ensure consistency of approach and a record of scrutiny by medical examiners. Training in the form of E-learning relating to the non-statutory medical examiner system has been developed. More details relating to the medical examiner system can be found on the Royal College of Pathologists website.

Healthcare Investigations

- 4.37 The case of Gosport, along with a number of other failings in care in recent years have highlighted the need for improved healthcare investigations in the interest of organisational and system learning. This is something that the Government remains committed to improving.
- 4.38 The NHS Serious Incident Framework describes the process and procedures to help ensure serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents.

happening again. Following an engagement exercise during summer 2018, the framework is currently being revised.

- 4.39 In 2016, the Government established the Healthcare Safety Investigation Branch (HSIB) to conduct high level investigations into selected patient safety incidents with the sole purpose of system wide learning and improvement. By only focusing on learning and not attributing blame, HSIB fosters an open and transparent approach to its investigations that aims to support all involved in their contributions to an investigation. The HSIB has been operational since April 2017 and has commenced 12 investigations. Each investigation is providing vital learning for the NHS and system bodies. The Government has demonstrated its commitment to HSIB and its principles by publishing the draft Health Service Safety Investigations Bill, which would enable the establishment of a new, independent body, with powers to carry out its investigative functions, that will take forward the work of HSIB.
- 4.40 The case of Gosport has also reinforced the importance of listening to the concerns of patients and their families. The Department of Health and Social Care is considering its policy regarding historical unresolved cases in the NHS so that we can ensure that patients and families have the right platform to have their voices heard.

Police investigations, criminal justice processes, Inquests and coronial processes

- 4.41 While the Panel report helps us to understand the distinct rationales for the different investigations, it is also clear that the cumulative effect from the perspective of the families was of a confusing, overlapping, under-co-ordinated and, for them, ultimately unsatisfactory set of investigations and assessments of the evidence. The different agencies did not always work well together and, while it is clearly important for each to operate faithfully within their own statutory remit, the consequences for the families were often difficult for them to understand or accept.
- 4.42 As Chief Constable Olivia Pinkney said of Hampshire police following the publication of the report, 'The force has always acknowledged that the first two police investigations were not of a high quality. The report makes clear a view from the panel that the third did not look widely enough. We accept the panel's findings and I would like to take this opportunity to apologise for our part in the distress caused to families for so many years'.

- 4.43 The Panel report highlights a number of challenges for the police when seeking evidence from healthcare professionals, particularly when investigating allegations relating to medical decisions in a healthcare setting.
- 4.44 It is critical that the police are able to feel confident when engaging with healthcare professionals as part of criminal investigations and for both parties to have an understanding of the expectations placed on them. Where the police feel that what they are getting falls short of these expectations, they should feel comfortable to seek further input from other medical professionals where appropriate. Moreover, in cases where there are wider concerns about practices in a particular location, seeking alternative expert advice from elsewhere in the health service should always be considered to be the norm. The Government will work with the National Police Chiefs Council (NPCC), Crown Prosecution Service and health authorities to better understand these challenges and to explore ways to ensure that both the police and health professionals are aware of expectations and of best practice in engagement during criminal investigations.
- 4.45 The Panel report also highlights a number of delays to processes caused by concern about interfering with other processes that were considered to have primacy. In addition, the audit commissioned by the Government that was produced by Dr Richard Baker was not published for ten years after it was completed. This was, as the report makes clear, on the basis of legal advice that such material should not be published while other processes were being carried out. While this was legally correct, the length of time that elapsed was considerable and compounded the suffering of the Gosport families.
- 4.46 There has been some progress in recent years in the co-operation and mutual understanding between the relevant investigatory and regulatory agencies. But this needs to be enhanced. The Government will explore what more can be done to ensure that the various investigations, whether on an organisational or individual level, and any associated criminal justice, or coronial processes that might follow relating to serious concerns about healthcare are appropriately sequenced or coordinated. We will look at how they can be organised so that they meet the interests of justice and are fully compliant with the relevant statutory remits; while also recognising and addressing the concerns and priorities of patients and their families.
- 4.47 It is clear that some people who attended the inquests into the deaths at Gosport found the process difficult and confusing. In the years since the shocking events at Gosport took place there have been important changes in the coroner system. In July 2013, we implemented reforms in the Coroners and Justice Act 2009 which changed the way coroner investigations and inquests are conducted. These reforms had the central aim of putting the needs of bereaved people at the heart of

the coroner system. Coroner services continued to be locally delivered but within a new framework of national standards to enable a more efficient system of investigations and inquests. Under the reforms, bereaved people have the right to request most of the documents seen by the court. They can expect the coroner's office to update them at regular intervals and explain each stage of the process, so that they can understand what is happening and why. And they can expect to be treated with compassion and respect.

- 4.48 The 2013 reforms saw the introduction of the Chief Coroner who provides leadership, guidance and support to coroners. The Chief Coroner oversees compulsory training for all coronial office holders. His annual report to the Lord Chancellor, on all inquests which take more than 12 months to complete and on other issues of note, is published in Parliament. Where a coroner has written a "report to prevent future deaths" (under Regulation 28 of the Coroners (Investigations) (Regulations) 2013) at the conclusion of an inquest, the Chief Coroner will publish it on his website together with the responses received to the report.
- 4.49 Much has been achieved since 2013 and there is evidence of excellent practice across the country. However, we know that there is more to be done and the Ministry of Justice is currently taking forward a number of workstreams to ensure that bereaved families are indeed at the heart of the coroner process and supported throughout.
- 4.50 In 2014 the Ministry of Justice published a *Guide to Coroner Services* which explained what any user of coroner services could expect from the coroner and their staff. We will be publishing a refreshed edition of the *Guide* which is specifically focused on the needs of bereaved families and which aims to answer questions they are likely to have. We are also considering other means of communication including leaflets for those attending inquests where the deceased died in state detention such as a prison or mental hospital.
- 4.51 The Ministry of Justice has re-established an inquest stakeholder forum to enable key stakeholders to come together to discuss issues on coroner services. The forum met for the first time in late October. Members include government departments, the Chief Coroner's office, representatives from senior coroners and coroner officers and three important third sector organisations - Cruse Bereavement Care, the Coroners' Courts Support Service and INQUEST. The forum will help us make sure that the work we do, such as revising communications and information, meets the needs of bereaved families.
- 4.52 The Ministry of Justice is considering extending support services for coroner's inquests to all coroner's courts so that bereaved families have access to practical

and emotional support when they attend inquests. Currently there are support services in 43 of the 88 coroner areas.

- 4.53 The Ministry of Justice has been engaging with the Chief Coroner's office both on training coroners - so that they have more confidence in controlling inquest proceedings and the lawyers who attend, and in keeping questions relevant - and on training coroner's officers, to make sure that the language they use with bereaved families is always sensitive and appropriate. Linked to this, the Ministry of Justice has been discussing the conduct and training of lawyers with the professional bodies (the Bar Standards Board and the Solicitors Regulation Authority), looking at what they might do to improve lawyers' conduct in inquests where improvement is needed.
- 4.54 Whilst we are confident that public bodies generally instruct their lawyers to assist the coroner and are keen to learn from inquest findings, the perception of families is sometimes different. The Ministry of Justice is therefore working with other government departments to develop a protocol consisting of key principles, to which we propose public bodies and their legal representatives will sign up, as to the approach that will be taken in inquests when a public body is represented. The aim is to help make sure not only that bereaved families are really at the heart of the process, but that the process is truly inquisitorial and seeks to identify lessons to be learned. Finally, the Government remains committed to the establishment of an Independent Public Advocate to act for bereaved families after a public disaster. The IPA will support them at public inquests, ensuring their voices are heard and that they are able to fully participate. A consultation on the role is underway and will close on 3 December, with a Government response to be published next year. We would strongly encourage all those with an interest in the issues raised in this report, including those most closely affected by them, to take part in the consultation.

5. Conclusion

- 5.1 The profound failings in care, governance oversight and investigations identified by the report of the Gosport Independent Panel represents both a warning to all of us involved in health and care, and a serious call to action.
- 5.2 In addition to the actions and commitments set out in this document, it is vital that all organisations and individuals involved in the health and care system continue to reflect on the events described by the report, and do all they can to avoid such a deep failure to occur again.
- 5.3 Much has changed for the better in recent years, making it much harder now for practices such as those described by the Panel's report to go undetected; but we must balance that conclusion with the need to avoid complacency. The Government will therefore continue to offer support and challenge to all of those involved in health and care, from providers through to system and professional regulators, so that we can to honour those that have suffered so much by continuing to listen, learn and improve.

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