Learning from Gosport

Last Updated: 29/10/2026

The Gosport Independent Panel was set up to address concerns raised by families over a number of years about the initial care of their relatives in Gosport War Memorial Hospital and the subsequent investigations into their deaths. It reported in 2018.

We know we let many people down in our response to failings in care at Gosport War Memorial Hospital – for that we are very sorry.

We recognise that we made mistakes when concerns were raised with us. In particular, we did not seek expert advice on some of the evidence in our possession when we should have done. We also know that our communication with those raising concerns was poor and we added to their continued distress.

Changes we've made

As the professional regulator of nurses and midwives in the UK, and nursing associates in England, we work to ensure these professionals have the knowledge and skills to deliver consistent, quality care that keeps people safe.

We've made some important changes since the tragic events at Gosport occurred.

These include launching a revised version of our Code and developing new standards for nurses and midwives, while strengthening the requirements on speaking up.

We've also taken a new approach to fitness to practise that encourages openness and learning, and created a public support service.

Learnings for those on our register

We've also identified key themes from the Gosport Independent Panel's report that we think are helpful for nursing and midwifery professionals to consider.

This learning tool sets out those learnings, for the benefit of the people on our register and those they care for. They are:

- Communication and the importance of listening to those in care and their families
- Speaking up when things go wrong or they have concerns
- Accountability for care given and any consequences
- Clear and consistent record keeping

We've included some activities for nurses, midwives and nursing associates at the end of each section.