The CPS incorporates RCPO

***PLEASE NOTE THIS IS NOT THE FINAL FORM OF THE RESPONSE BUT A DRAFT> I HAVE INCLUDED THE ORIGINAL FEEDBACK COMMENT TO CPS>***

***Your records will indicate the CPS's failure to prosecute Dr. (now Ms.) Jane Barton and others for their activities at the Gosport War Memorial Hospital from as early as 1988, despite several warning signs enroute. Not least were the whistle-blowing nurses in 1991 and then, towards the end of the decade, the many police complaints started by Gillian McKenzie and myself in September/October 1998.***

***My step-father, Arthur Denis Brian Cunningham was one of Barton's many victims when his life was unceremoniously terminated under her 'care' in 1998 due to being administered excessive and unnecessary drugs using a syringe-driver.***

***After several aborted attempts, the police eventually investigated this doctor and her staff, but the case failed when it got to the CPS. The person dealing with this case at the CPS was Paul Close, and he conducted an interview with some of the families concerned to say there was insufficient evidence to prosecute. He did, however, indicate that the case would be reopened upon the presentation of new evidence.***

***There was also a GMC investigation that found this doctor guilty of multiple charges of professional misconduct, but failed to strike her off their register, although she later resigned. Earlier still, there was an enquiry into the Gosport deaths by Professor R. Baker whose report was suppressed by government; this is the same person who did a similar study following Shipman's conviction.***

***After much pressure from families and prevarication by governement, the Baker Report was finally released last month, and without surprise to anyone, completely confirms the suspicions of families that irregular activities had taken place at that hospital.***

***I would like to know, please, if the CPS has any intention of revisiting this case in light of the new evidence, and also look again at what information was or (more to the point) was not passed by the police prior to Mr Close's decision.***

Dear Mr Farthing

I am a Specialist Prosecutor in the Special Crime Division and I have been passed your feedback comments relating to the sad death of your step-father at the Gosport War Memorial Hospital in 1998. It is clear from the protracted history of this matter that your family have experienced the ordeal of many hearings since the death of Mr Cunningham for which you have my sincere sympathy; it must make it very hard for you to achieve any closure. I am sorry that you are unlikely to regard this letter as contributing to your quest for justice but I hope you can be assured that I have approached your enquiry fairly and with an open mind.

**Comment [C1]:** Yes I think this needs rewording-any suggestions welcome

As you know the latest stage of this case was a letter to all the families in August 2010 which explained in some detail why there was not a sufficient case for prosecution of Dr Barton. I am attaching a copy of this letter and I don't intend to go through all the issues faced by the prosecution.

The reason I looked at this case again was to consider whether the recently published Baker Review from 2003 contained any evidence which could have a bearing on the CPS decision. I have asked two questions.

1 whether the CPS had access and had already considered the contents of this report when making its decisions on prosecution relating to the various victims and
2 If they did not consider the Baker Review then would the content have contributed to the evidence of prosecution and made a difference to the outcome of the decision to prosecute.

I have looked through all the correspondence and internal review notes but not the evidential material submitted by the police which was accidentally destroyed by the CPS Record Management Unit. Because I don't have the original police material I have not been able to say for certain that the CPS had the report.

I have found number of references to the Baker Review across the years by various parties involved including Blake Lapthorn, press reports and communications by CPS with the Police, Counsel. It is clear that parties are aware of the existence of the Baker Review and that this is a epidemiological study. I have been unable to fond any indications that the CPS considered the detailed content and conclusions. I have concluded that although the police appear to have used the report with other information to identify potential victims there is no evidence that the CPS had access to the detail of the report or relied on its conclusions when making decisions about the cases.

I have carefully considered the content of the full report, which is described as an independent clinical audit, to decide if the content contributes any evidence which could alter or affect the CPS conclusions in 2009. The considerations for the CPS relating to gross negligence manslaughter are set out in the copy letter I attach; in this case I was looking particularly for relevant evidence about any individual having their life shortened and/or being denied a chance of survival.

It should be noted that the main statistical conclusions when answering the scope questions in the report appear are that *"the finding of a statistical excess of deaths among patients admitted to Gosport is unlikely"* and that *"there were no clear clusters of deaths"*

I have concluded that while the Baker Review provides contextual information and was of assistance in identifying priorities and potential victims for in depth investigation the content would not assist the prosecution to answer the specific questions required when applying the code test to determine an offence of manslaughter.
The reasons for my conclusion include

- The report is based on historic statistical and documentary records only contains no evidence about the treatment of specific patients and
- The author makes very clear that the intention of the report was not to investigate individual allegations which was the role of the police, the report instead highlights questions and areas for further investigation and practical improvement in the NHS and
- The findings of the report were not put to those involved so, for instance, Dr Barton and her colleagues have not been asked if there are any explanations for the anomalies exposed; this not only potentially undermines the statistical findings but would also lead to admissibility issues in a criminal court and
- The judgements are general not specific to individual deceased so would not easily be admitted to a criminal court as relevant evidence and

- There are some acknowledged limitations in the audit due to incomplete data sources and, in some instances sample size which can lead to distortion from an unidentified variable.

I realise that you are likely to view my decision as a set back for you and your family. If you think I have failed to interpret the report correctly and that there is material evidence in the report then please let me know. I hope I have explained my reasoning and the sort of evidence which will affect the outcome of the decision.