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 uncerimoniously 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

Thank you for your letter/email dated.... relating to the tragic death of your step-father at the Gosport War Memorial Hospital in 1998.

You have requested that we reconsider the allegations against Ms Barton. In 2010, the CPS undertook ~~a detailed~~a detailed review of the issues and I attach a copy of the letter that you were sent as a result of that review. I do not consider it necessary to revisit that review as it considered many of the issues that you raise including the GMC proceedings and its findings. However, I fully appreciate your concerns regarding the Baker Report and have considered this ~~that issue~~ independently.

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Having reviewed the available material, I have been unable to find any indication that the CPS considered the detailed content and conclusions of the Baker Report during their review in 2010. Although, the police appear to have used the Baker 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.

Therefore, 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 new evidence -which could alter or affect the CPS conclusions in 2010.

Having reviewed the Baker Report I note that:

- The report is based on historic statistical and documentary records only and 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 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 have concluded that the Baker Report provides contextual information and was of assistance in identifying investigation priorities and potential victims ~~for the investigation~~, but that it does not have sufficient evidential certainty for conclusions to be drawn based on its findings. Indeed, its conclusions reflect this concern in that they 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"*

~~Therefore, the Baker report would not have a significant impact on the CPS decision.~~

It is my view that the Baker report would not have had any impact on the CPS decision taken ~~The~~in 2010 which was the result of a very ~~re has already been a~~ substantial review of the case. As the Baker Report does not provide any further evidence t~~and t~~here is no ~~jusitification~~justification to ~~to~~ revisit th~~is~~e decision made in 2010.~~case in light of the Baker Report which does not provide new evidence~~.

I appreciate that you may be unhappy with this decision, but I hope that I have explained ~~can understand~~ my ~~the~~ reasoning ~~behind it~~. If you wish to make a complaint about this decision, you are welcome to contact the Head of the Special Crime Division in London, Sally Walsh on [Code A] or on 020 3357 0047.