Ministry of JUSTICE

Submission

To: Bridget Prentice **Date:** 10 December 2008

cc: Peter Handcock, Code A
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Code A Special Advisers

From: Code A
Current Coroner Policy Team
Coroners and Burials Division
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Subject: **Section 15 Coroners Act 1988 – Gladys Richards**

Issue

1. A report under section 15 of the Coroners Act 1988 by David Horsley, the Coroner for Portsmouth and South East Hampshire, on the death of Mrs Gladys Richards on 21 August 1998 in Gosport War Memorial Hospital (**Annex A**).

Recommendation

2. That you agree we should issue the requested direction to hold an inquest.

Timing

3. Pressing: the coroner wants to ensure that if the direction is granted Mrs Richards' inquest can be heard with 10 related cases in March, and the appropriate arrangements will need to be made in advance.

Argument

4. Mr Horsley was previously given a direction under section 15 to hold inquests into seven related deaths at the same hospital. In those cases the findings of police investigations caused him to consider that he was under a duty to hold inquests because the provisions of sections 8 of the Coroners Act were met.

5. Mrs Richards' was the first case to be investigated by the police. Her death was not reported to the coroner at the time and she was subsequently cremated. Mr Horsley states that were her death to have occurred now in the same circumstances he would have opened an inquest.

6. In addition to the seven deaths that were previously subject to section 15 directions, Mr Horsley intended to hold inquests into a further three deaths at the hospital that came within section 8 of the Act as the bodies were buried in his district.

7. At the time of his previous report Mr Horsley indicated that if he held inquests in those 10 cases he was likely to come under pressure from family members of the other 82 patients whose deaths were investigated in Operation Rochester to hold

inquests into their deaths as well. He felt this would be difficult to resist, and that he would be likely to face legal challenge were he to do so.

8. Mrs Richards' daughter, Mrs Gilliam McKenzie, has been pressing for an inquest to be held. She has campaigned on her late mother's behalf since shortly after her death.

9. In the circumstances we recommend that a direction to hold an inquest should be granted. If agreed we will write to the coroner with the direction.

Background

10. Section 8 of the Coroners Act 1988 requires a Coroner to hold an inquest when he is informed that the body of a person is lying within his district and there is reasonable cause to suspect that the deceased has died a violent or an unnatural death, or has died a sudden death of which the cause is unknown.

11. Section 15 of the Act enables a Coroner to report to the Secretary of State if he has reason to believe a death has occurred in or near his jurisdiction, in circumstances in which an inquest ought to be held, and owing to the destruction of the body by fire (which is interpreted to include cremation) or otherwise, or it lying in a place from which it cannot be recovered, no inquest can be held. If the Secretary of State considers it desirable, he can then direct that an inquest should be held. There are no time limits for this.

12. The previous report under section 15 from Mr Horsley followed an operation by Hampshire Constabulary ('Operation Rochester'), in which – during the period 1998 to 2006 - they conducted three separate investigations into the deaths of elderly patients at Gosport War Memorial Hospital between 1989 and 2001. The police investigations focused on the actions of one particular doctor, Dr Jane Barton. Dr Barton was a General Practitioner who worked part-time at the Hospital as a Clinical Assistant in Elderly Medicine, and she was responsible for prescribing and administering opiates and other drugs via syringe drivers.

13. The first two investigations were solely into the death of Mrs Richards, who had been admitted to the Hospital on 11 August, under Dr Barton's care, for recuperation following a hip replacement operation at another hospital. On admission Mrs Richards was prescribed Oramorph and 48 hours later she fell from a chair, apparently whilst sedated. Her hip was dislocated and re-set at Haslar Hospital, following which she was returned to Gosport War Memorial Hospital on 17 August. Mrs Richards was given diamorphine and on 20 August she suffered a massive haemorrhage. Oramorph was administered by syringe driver and she died on 21 August. Following Mrs Richards' death her daughters complained to the police about the treatment she had been given. On conclusion of both investigations the CPS decided there was insufficient evidence for a prosecution.

14. Nursing staff subsequently provided to the Hospital's management copies of documents dating back to 1991, which recorded their concerns about the increased mortality rate for elderly patients and related matters. The third police investigation then considered whether patients admitted to the Hospital for rehabilitative or respite care were inappropriately administered opiate-based drugs, which hastened or caused their deaths. Of the 92 cases investigated, 78 failed to meet the threshold of negligence required for a criminal investigation, and 4 were attributed to natural causes. The remaining 10, in all of which Dr Barton was the attending doctor, were subject to full investigation. The CPS again concluded that in none of the cases could either criminal culpability or gross negligence be proven, and there was therefore no realistic prospect of conviction.

15. Other investigations into the deaths at Gosport War Memorial Hospital were undertaken by the General Medical Council and the Commission for Health Improvement.

Parliamentary handling

16. None from this submission.

Financial implications

17. None for the MoJ.

Presentation and Media Handling

18. Operation Rochester, and the other investigations into the deaths at the hospital and Dr Barton, attracted considerable media attention, both locally and nationally. Parallels with the Shipman case were drawn. The families of the deceased remained unhappy about the way in which the investigations were conducted, and that no criminal charges were brought. During the investigations, they formed an action group, and appointed to represent them Ann Alexander, the solicitor who represented the families of many of Dr Shipman's victims. It appears they are hoping that the inquests will lead to further action being taken. Should an inquest jury return verdicts of unlawful killing, this could lead to calls for the police investigation to be re-opened.

19. Our line should be that we do not comment on the details of individual cases.

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