IN THE PORTSMOUTH CORONER'S COURT

IN THE MATTER OF THE GOSPORT WAR MEMORIAL INQUESTS

SUBMISSIONS ONTHE PRE-INQUEST REVIEW

Introduction

1. These submissions are intended to assist HM Coroner at the Pre-Inquest Review to be held at 10am on 14 August 2008.
2. They are submitted on behalf of those relatives represented by Blake Lapthorn Tarlo Lyons (referred to as "the Blake Lapthorn group" for convenience). The Blake Lapthorn group consists of relatives of the following deceased:
    a. Elsie Devine;
    b. Sheila Gregory;
    c. Robert Wilson;
    d. Arthur (Brian) Cunningham;
    e. Leslie Pittock.
3. In particular, the submissions seek to address:
    a. Whether it would be appropriate for the matter to proceed as one inquest;
    b. Whether it would be appropriate for HM Coroner to sit with a jury;
    c. Whether the inquest should take place before or after any GMC hearing;
    d. Representation at the inquest;
    e. Documentation and witnesses;
    f. Venue;
    g. Time estimate.

Summary of submissions

4. The Blake Lapthorn group submits as follows:
    a. There should be a single inquest covering the deaths;
    b. The Coroner should sit with a jury;
    c. The inquest should take place after any GMC/NMC hearing;

d. Blake Lapthorn are content to represent the interested of any/all of the deceased, but that will be a matter for the individuals concerned;
e. Various documents (identified below) will be required and it is anticipated that most of the witnesses should give live evidence. Early and full disclosure is invited;
f. The inquest should take place in a convenient venue that is able to accommodate the large number of interested persons/witnesses;
g. It is probably premature for an accurate time estimate, but a working estimate of 6 weeks is considered appropriate.

Factual summary

5. The 10 deceased whose deaths fall to be investigated by HM Coroner were patients at the Gosport War Memorial Hospital ("the hospital"). Police investigations took place into an alleged unlawful killing of a patient at the hospital in 1998. Expert evidence was obtained in respect of 5 deaths. Although the police decided not to proceed with any prosecution, they were sufficiently concerned about the care and treatment of frail and elderly people at the hospital that they referred the issue to the Commission for Health Improvement ("CHI") for investigation. CHI duly investigated and reported in July 2002, in a report entitled "Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital" ("the CHI report").
6. Hampshire Constabulary also referred the experts' reports to the General Medical Council and the Nursing and Midwifery Council, amongst others.
7. CHI's terms of reference were to consider whether, since 1998, there had been a failure of trust systems to ensure good quality patient care. The investigation focused on a number of areas, including the arrangements for the prescription and administration of drugs and staffing, accountability, supervision and training (para 1.4). CHI's remit specifically excluded the investigation of any particular death or the conduct of any individual (Executive Summary, vii). CHI's investigation centred on the 3 wards at the hospital providing general medical care for patients over 65: Dryad, Daedalus and Sultan wards.
8. In relation to the administration of medications, CHI noted the concerns of the experts to include the following (p12):
    a. A lack of evidence of trust policy to ensure the appropriate prescription and dose escalation of strong opiate analgesia as the initial response to pain;

b. The inappropriate combined subcutaneous administration of diamorphine, midazolam and haloperidol, which could carry a risk of excessive sedation and respiratory depression in older patients, leading to death;
c. Confusion amongst staff about whether patients were being admitted for palliative or rehabilitative care;
d. A failure to recognise the potential adverse effects of prescribed medicines;
e. A failure of clinical managers to routinely monitor and supervise care on the ward.

9. It was not within CHI's remit to determine whether the said failures caused or contributed to any individual death.
10. In relation to staffing, CHI found that there was inadequate supervision of the clinical assistants providing medical support on the hospital wards (until July 2000), including a lack of review of any prescribing (pp29 and 33).
11. CHI's key conclusion was that there was a failure of trust systems to ensure good quality patient care in that:
    a. There were insufficient local prescribing guidelines in place governing the prescription of power pain relieving and sedative medicines;
    b. There was a lack of routine and rigorous review of pharmacy data, that led to high levels of prescribing on wards not being questioned;
    c. The absence of adequate supervision and appraisal systems meant that poor prescribing practices were not identified;
    d. There was a lack of adequate assessment of care needs of patients on admission (Executive Summary, vii).
12. HM Coroner has elected to conduct inquests in relation to 10 patients who died at the hospital. The criteria for the selection of those deaths are not clear at this stage. The Coroner is invited to note that Blake Lapthorn have been contacted by a number of other relatives of those dying at the hospital in the relevant period, who are keen for the deaths of their relatives to be considered.

One or more inquests

13. From the information currently available, it would appear that there are a number of generic issues that would apply to the Coroner's investigation of all 10 deaths. They include the lack of clarity as to whether palliative or rehabilitative care was required for patients, the prescription and administration of strong opiates, and the lack of

supervision of staff generally and in relation to opiate prescription and administration in particular.

14. Obviously, each death will raise separate issues and will require individual examination.
15. Given that there are generic issues that appear to apply to all 10 deaths, it is submitted that it would be appropriate for the cases to be heard together. This is likely to result in the best use of resources, including expert evidence, and it is anticipated that a single inquest will allow the generic issues to be considered in appropriate detail. Further, a single hearing is likely to result in closure of the matter for all of those involved – relatives and trust staff alike – and this is less likely to be achieved through a series of separate inquests.
16. Careful consideration will be required as how best to conduct the hearings. At this stage, it is submitted that it would be appropriate for there to be a phase of evidence regarding generic issues, with subsequent consideration of the individual deaths.
17. In terms of the organisation of evidence, it is submitted that it would be appropriate to have a bundle containing generic evidence, then separate bundles in respect of each of the deceased, containing medical records, witness statements and any expert evidence. This would circumvent the problem of disclosing information about each deceased to the relatives of other deceased persons.

Jury

18. It is submitted that it would be appropriate for HM Coroner to sit with a jury, either on a mandatory basis under section 8(3)(d) of the Coroners Act 1988 ("the Act") or on a discretionary basis under section 8(4) of the Act.
19. Section 8(3)(d) of the Coroners Act 1988 provides:

    "*If it appears to a coroner, either before he proceeds to hold an inquest or in the course of an inquest begun without a jury...(d) that the death occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public, he shall proceed to summon a jury in the manner required by subsection (2) above).*"
20. It is submitted that the facts of these cases disclose prima facie evidence that the deaths occurred in circumstances the continuance or possible recurrence of which is prejudicial to the public, in particular elderly hospital patients. The criteria of section 8(3)(d) are made out and the Coroner is obliged to sit with a jury.

21. Alternatively, the Coroner is invited to sit with a jury pursuant to section 8(4). Plainly, this is a case of significant public interest and it would be appropriate for the evidence to be weighed by a body of lay people.

Timing of the inquest: before of after the GMC hearing

22. As far as the relatives are concerned, there are competing arguments as to whether the inquest is to take place before any GMC or other disciplinary hearing.
23. Plainly, it is a long time since the deaths (around 10 years) and there is an interest in hearing the inquests as soon as practicable. Not only does this relate to the cogency of the evidence but also the general desire of the relatives to move on from the deaths. There may be Article 6 issues regarding delay.
24. Against that, the Blake Lapthorn group are concerned that, when the inquests are finally heard, the evidence should be as full, cogent and frank as possible. There are concerns that, with GMC hearings pending, the individuals involved may be distracted and more inclined to be guarded about the evidence they give. This may defeat the purpose of the inquest.
25. On balance, it is submitted that it would be preferable for the inquest to be adjourned pending the outcome of the GMC hearing/s. An element of further delay (provided it is not excessive) is unlikely to have any material effect on the cogency of the evidence – with a lapse of up to 10 years between the events and now, a further delay of a period of months is unlikely to make a significant difference to the recollection of witnesses. By contrast, it is submitted that the Coroner is more likely to be able to achieve the sort of full and frank investigation required by Article 2 if any disciplinary hearing has already been completed.

Representation

26. It is not clear at this stage whether any of the relatives of the other 5 deceased will join forces with the Blake Lapthorn group.
27. Blake Lapthorn are content to represent the interests of all of the deceased, but clearly the question of representation is a matter for the relatives of each deceased.
28. At this stage, representation of the Blake Lapthorn group is on a pro-bono basis. An application for exceptional public funding is to be made shortly.

Documentation/witnesses

29. A this stage, it is submitted that the following evidence is likely to be of assistance:

a. Generic witness statements from Trust staff dealing (inter alia) with the running/staffing of the hospital, supervision of staff, admission procedures, decisions regarding palliative/rehabilitative care and protocols for the administration of opiates.

b. Generic expert evidence regarding the prescribing and administration of opiates. Disclosure is invited of the expert evidence obtained by Hampshire Constabulary as part of its investigations. Alternatively, the Coroner is invited to obtain such evidence.

c. In individual cases:

    i. The medical records;

    ii. Witness statements from family members;

    iii. Witness statements from Trust staff caring for the deceased;

    iv. Expert evidence on the use of opiates in the deceased's case and whether that caused or materially contributed to the deceased's death.

    v. Where appropriate in any case, expert evidence on any other matter relating to the care of the deceased at the hospital which may have caused or materially contributed to the deceased's death[1].

30. Early disclosure of all documents is invited.

31. As indicated above, the Coroner is invited to collate a file of generic evidence and to create separate bundles in respect of each deceased.

32. It is anticipated that it will be appropriate to hear live evidence from most of the witnesses. Further submissions on this will be made at the appropriate time.

Venue

33. The Coroner is invited to sit in a venue that can cope with the likely number of interested persons/witnesses and can be booked for the requisite length of time (see below).

Time estimate

34. Until the evidence has been gathered, it is probably not possible to give an accurate time estimate.

35. As a very rough estimate, it may be thought that it would be appropriate to allocate 6 weeks to the inquest – a week or so for consideration of the generic issues, 2 days per

[1] This is suggested at this stage, because it the circumstances of the individual deaths are not clear.

individual death and a few days for any submissions, summing up and consideration of verdicts.

Further conduct

36. Given the size of the inquest and the likely number of issues to be raised, it is suggested that at least one further Pre-Inquest Review will be required.

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14 August 2008

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