PCO000250-0001

David C. Horsley LLB
Her Majesty's Coroner
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Mr Andrew Bradley
HM Assistant Deputy Coroner for
Portsmouth & South East Hampshire
Goldings
London Road
Basingstoke
Hampshire RG21 4AN

By Fax: Code A

24 July 2008

Dear Mr Bradley

Re: Gosport War Memorial Hospital:

Please find attached for your information two letters received today from:

- Blake Lapthorn Tarlo Lyons
- Bindmans LLP

Yours sincerely

Code A

Caroline Young
Coroner's Administration Assistant
Tel: Code A
Ema

Enc

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02392688331

BINDMANS LLP

Our ref: 51192.1/SC/CHH
Date: 22 July 2008

Mr David Horsley
HM Coroner for Portsmouth and South East Hampshire
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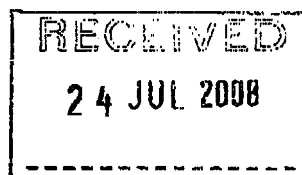

Dear Sir

Mrs Gladys Richards
DOB: Code A
DOD: 21 August 1998

We act for Mrs Gillian MacKenzie, the daughter of Mrs Gladys Richards. We understand that you have had some contact with Mrs Mackenzie and are familiar with the circumstances surrounding her mother's death.

We are informed that you are to hold inquests into the deaths of 10 of the patients treated at Gosport Memorial Hospital ("Gosport") between 1996 and 1999. We understand that these are the 10 cases which were sent to the CPS following the police investigation by Superintendent Williams. We are also informed that an inquest will not be held into the death of Mrs Richards.

The purpose of this letter is to make a formal request on Mrs MacKenzie's behalf for an inquest to be held touching upon her mother's death. Based upon the information that we have received there would appear to be some *prima facie* concerns about the events leading up to Mrs Richards' death, which may be highly relevant to the broader concerns about the Gosport Memorial Hospital. You may be aware that Mrs Mackenzie was the first relative of the deceased patients to contact the police in 1998.

Mrs Mackenzie has subsequently made complaints against the police regarding their investigation into her mother's death and these have been upheld by both the Police Complaints Authority and the Independent Police Complaints Commission, which accepted that there had been investigative failures.

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Background

Mrs Richards was a patient at Gosport Memorial Hospital in August 1998 and she died on 21 August 1998.The cause of death according to the death certificate was pneumonia. Mrs MacKenzie believes that the certified cause of death is incorrect and she states that this was subsequently confirmed by Superintendent Williams.

Mrs Richards suffered from dementia and lived at the Glen Heathers nursing home. On 30 July 1998, Mrs Richards was admitted to Haslar Hospital for an operation on her broken hip. Following her operation, Mrs Richards made progress and was able to walk the length of the ward using a walking frame, accompanied by a nurse on either side.

Once Mrs Richards was ready to be discharged, Mrs MacKenzie and her sister stated that they did not want their mother to return to Glen Heathers nursing home. It was agreed that Mrs Richards could be discharged to Gosport for rehabilitation while an alternative nursing home was found for her.

Mrs MacKenzie states that at the time of her discharge from Haslar Hospital, her mother was more alert, eating well and appeared to have improved. The hospital surgeon stated that Mrs Richards could stay at Gosport for 2 to 4 weeks before she would move to her new nursing home. Mrs Richards was discharged to Gosport on 11 August 1998.

On her second day at Gosport, Mrs Richard's other daughter, Lesley Lack, who is a retired nurse, became concerned as she felt that her mother was over medicated. Mrs MacKenzie subsequently discovered that her mother had been given OraMorph at Gosport even though she did not believe Mrs Richards was in pain and Mrs Richards had not been treated with any painkillers whilst she had been at the Haslar Hospital.

A few days later, Mrs Richards had a fall and had to be transferred back to the Haslar Hospital to have her hip manipulated back into place. After a few days, Mrs Richards made a good recovery and was more alert. She was transferred back to Gosport again on 17 August.

When visiting Mrs Richards on 17 August 1998, her daughters found her to be moaning in pain. She was in bed but her position was such that all her weight was on the hip which had recently been operated on. Following concerns raised by Mrs Richards' daughters, she was placed in a more comfortable position. At that stage, Mrs MacKenzie states that the nurse manager of Gosport, Phillip Beed, attended the room with a syringe, which he stated contained diamorphine. Mrs MacKenzie informed Mr Beed that she did not think this was appropriate for her mother given that it was a strong drug and that Mrs Richards had not been seen by a doctor. Mr Beed left the room and returned with another syringe, which Mrs MacKenzie assumed was an alternative pain medication. Apparently, this injection is not recorded on Mrs Richards' prescription chart. It is still not known what this second syringe

contained and the medical notes do not apparently record this medication.

On 18 August 1998, Mrs MacKenzie and her sister were informed by Mr Beed that their mother had developed a very large haematoma and there was nothing further that could be done for her. They were told by Mr Beed that the only thing to be done was to ensure that Mrs Richards had a painless death and proposed that Mrs Richards be placed on a syringe driver with diamorphine. Mrs MacKenzie was informed that if Mrs Richards was transferred back to Haslar Hospital that she might die in the ambulance and it was therefore decided that she should remain at Gosport. There was no mention of surgery or any treatment for the haematoma. Mrs Richards survived for 3 more days and died on 21 August 1998.

From 18 August 1998 to 21 August 1998, there are only two entries in Mrs Richards' clinical notes which were made by Dr Barton. Neither of these entries refers to the development of a haematoma or the decision not to treat this. We understand that there is also no mention of a haematoma in any of the nursing notes relating to Mrs Richards.

At the time that Ms Lack registered Mrs Richards' death she told the Registrar that she did not agree with the cause of death. However, Ms Lack was informed that if this was the case, a post-mortem would have to be carried out. Ms Lack was distressed at the death of her mother and felt she did not want anything further to be done to Mrs Richards' body and therefore, did not pursue this matter further. However, Ms Lack did accompany Mrs MacKenzie to report the matter to the police in October 1998.

Mrs Richards' funeral was held shortly after her death and she was cremated.

Subsequent Investigations

We understand that there have been several police investigations into a number of deaths at Gosport. These have taken place over approximately 10 years but we understand that it has now been decided that no charges will be brought against any of the clinicians at Gosport Hospital.

Mrs MacKenzie has instructed us that during the police investigation headed by Superintendent Williams, she was told by Superintendent Williams that he also accepted that, having interviewed Ms Lack, her mother had not died from pneumonia, but he informed Mrs MacKenzie that he had consulted with an expert who had concluded that her mother had died of dementia. Mrs MacKenzie does not agree with this cause of death either.

In addition, Mrs MacKenzie also believes that at the end of this investigation, her sister's second statement was not forwarded to the CPS for consideration. It is Mrs MacKenzie's view that this is particularly

important because she had set out her numerous concerns about her mother's care and it was her sister who registered her mother's death with the Registrar and had, at that stage, queried the cause of death. Consequently, Mrs MacKenzie believes that there has not been a full and through investigation into her mother's death.

In addition, an investigation into Gosport was carried out by the Commission for Health Improvement and the final report was published in July 2002. Mrs Mackenzie and her sister were interviewed as part of this investigation. The investigation made various findings including that:

a) There were insufficient local prescribing guidelines in place governing the prescription of powerful pain relieving and sedative medicines;
b) The lack of rigorous, routine review of pharmacy data led to high levels of prescribing on wards caring for older people not being questioned; and
c) There was 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 (we understand that Mrs Richards was prescribed these three medications whilst at Gosport).

All of these conclusions appear to lend support to Mrs MacKenzie's concerns that her mother was incorrectly prescribed diamorphine. They also indicate that at the time of Mrs Richards' death there were clear concerns about the care that patients were receiving at Gosport.

The police referred Mrs MacKenzie's case to the General Medical Council and we understand that Dr Jane Barton has been investigated and a full hearing to decide whether she is fit to practice was due to be held in September 2008 but this has now been adjourned due to the inquests. In the interim, we understand that Dr Barton is subject to restrictions including that she is not allowed to prescribe diamorphine.

Decision not to hold an inquest

Mrs MacKenzie would like to formally request that you report her mother's case to the Secretary of State, pursuant to section 15(1) of the Coroners Act 1988, on the grounds that there is reason to believe that her mother's death occurred in such circumstances that an inquest ought to be held.

There is evidence to suggest that there were, and remain, a number of concerns arising from the care of patients at Gosport from sources other than the family. In our view, this is a relevant factor which should be considered when making your decision (*R (on the application of Bicknell v HM Coroner for Birmingham/Solihull [2007] EWHC 2547 (Admin))*.

Although a police investigation has been carried out into Mrs Richards' death, Mrs MacKenzie believes that important evidence was not

considered by the CPS and that her mother's death has not been properly investigated. She is therefore concerned that there has not been an Article 2 compliant investigation into Mrs Richards' death.

For all of these reasons, it is our view that there is a compelling case that there is a reasonable cause to suspect that Mrs Richards died an unnatural death and that an inquest ought to be held.

Mrs MacKenzie has a number of papers relating to her case and Gosport which she would be happy to provide to you if these would assist in your investigation.

Please do not hesitate to contact Charlotte Haworth Hird of these offices if you wish to discuss any matters arising from this letter.

We look forward to hearing from you.

Y[redacted]hfully

Code A

B[redacted]S LLP