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12 November 2008

Dear David

Gosport War Memorial Hospital

As requested herewith the correspondence with the MoJ

Rega

Andr

Code A

Brian Patterson
Ministry of Justice
Coroners Unit
Steel House
11 Tothill Street
London SW1H 9LH

26 November 2007

Dear Brian

Deaths At Gosport War Memorial Hospital:

Thank you for your letter. I'm sorry for the delay in replying but as you know, I had surgery on my arm and things took rather longer to mend than anyone had expected.

I can confirm that all of the ten people mentioned in my letter of 15 June 2007 died at Gosport War Memorial Hospital which is within the administrative district of the Portsmouth and South East Hampshire Coroner's District. Of those ten, only three have been buried in the District (Sheila Gregory, Elsie Devine and Elsie Lavender), the other seven have been cremated. I interpret this as "destroyed by fire" as stipulated in Section 15 of the Coroners Act 1988.

I had attempted to describe in my earlier letter, and at the meeting we had in August, the reasons why I considered it desirable to hold Inquests into the deaths of the seven cremated people in addition to the three buried ones. In fact, precisely the same reasons would apply and I have enumerated these previously.

To assist you further, I enclose more detailed case summaries relating to each individual death which have been provided to me by the Police for your use. I hope you now have enough information for a Section 15 decision to be made.

As I explained at the meeting, the opening of Inquests into these ten deaths may well give rise to calls to open Inquests from the relatives of the other 82

persons whose deaths were investigated as part of Operation Rochester. None of the 92 deaths investigated by the police were ever reported to the then Coroner at the time of the deaths. All had elements to them suggesting that the circumstances of the deaths might not be entirely natural. It is obviously impossible to estimate how many other Inquests might have to be opened if relatives ask me for Inquests but the police share my concerns in this regard. Up to now, the families concerned have targeted the police with their concerns as they believed that the outcome of the investigations was going to be criminal prosecutions rather than Inquests and I have only had a small amount of contact – so far – with families. I enclose for your information copies of letters I have received so far from family members.

On the point of additional finance being made available by central government to supplement the resources of Hampshire County Council in staging these Inquests, I understand additional funding has been provided to Oxfordshire and Wiltshire County Councils to finance Inquests. Please could you confirm why Hampshire cannot be similarly assisted?

I look forward to hearing from you. Please contact me if you need any further information regarding the Section 15 consent.

Yours sincerely

David C Horsley
Tel: Code A
Email: Code A

Encs

Mr P Harris
Coroners Unit
5th Floor, Steel House
11 Tothill Street
London SW1H 9LH

15 June 2007

Dear Mr Harris

Hampshire Police Operation Rochester – Deaths at Gosport War Memorial Hospital, Gosport, Hampshire:

I have recently been passed a report by Hampshire Police on Operation Rochester which was an investigation they conducted between 1998 and 2006 into the deaths of some 92 elderly patients at Gosport War Memorial Hospital between 1989 and 2000. The investigation was commenced following allegations made to the Police that the patients had been inappropriately administered Diamorphine or other opiate drugs and that had caused or contributed to their deaths.

The final phase of this lengthy investigation was a review of the 92 cases by a team of medical experts with specialisms in toxicology, general medicine, palliative care, geriatrics and nursing. Of the 92 deaths, the team found that 78 of them failed to meet the threshold of negligence required to conduct a full criminal investigation. Of the remainder, the team reached the conclusion that four of the deaths could be described as being entirely natural. The ten others were then the subject of a full criminal investigation as the team had reached the conclusion on them that they were cases of "negligent care that is today outside the bounds of acceptable clinical practice and the cause of death is unclear".

A common denominator in these ten cases was the involvement of a Dr Jane Barton who at relevant times had been the attending clinical assistant at the hospital and responsible for the ten patients' initial and continuing care, including prescribing and administering opiates via syringe drivers. It should also be noted that none of the ten deaths (nor any of the remaining 82) had been reported to the then Portsmouth and South East Hampshire Coroner.

Full files on the ten cases were forwarded to the Crown Prosecution Service for consideration of criminal proceedings in relation to the deaths. Subsequently, the Crown Prosecution Service concluded in December 2006 that having regard to overall expert evidence it could not be proved that negligence had occurred to a criminal standard and whilst the expert medical evidence was detailed and complex, it did not prove that the drugs which had been administered to the patients had contributed substantially to their deaths. Even if causation could be proved, there was not sufficient evidence to prove that the conduct of doctors was so bad as to be a crime and there was no realistic prospect of convictions.

The decision of the Crown Prosecution Service was then communicated to the families of ten deceased persons and the criminal investigation was then closed. Following this, Hampshire Police forwarded their files on Operation Rochester to me to consider whether I should investigate and conduct Inquests into any of the deaths involved.

Given the fact that the Police investigated 92 deaths, hundreds of witnesses were interviewed and their statements run into many thousands of pages. For obvious reasons, I have not read in detail the totality of the evidence gathered but from my understanding of it and my discussions with police officers involved in the investigations, I take the view that in respect of the ten deaths which were ultimately the subject of full criminal investigation I have reasonable cause to suspect that the ten persons concerned have died in the circumstances described in Section 8(1)(a) and (b) of the Coroners Act 1988 and that I am under a duty to hold Inquests into their deaths.

The ten persons are: -

1. Elsie Devine: died 21.11.99. Recorded cause of death "bronchopneumonia and glomerulonephritis".

2. Elsie Lavender: died 22.2.96. Recorded cause of death "cerebrovascular accident".

3. Sheila Gregory: died 22.11.99. Recorded cause of death "bronchopneumonia".

4. Robert Wilson: died 14.10.98. Recorded cause of death "congestive cardiac failure and renal/liver failure".

5. Enid Spurgin: died 26.3.99. Recorded cause of death "cerebrovascular accident".

6. Ruby Lake: died 21.8.98. Recorded cause of death "bronchopneumonia".

7. Leslie Pittock: died 24.1.96. Recorded cause of death "bronchopneumonia".

8. Helena Service: died 5.6.97. Recorded cause of death "congestive cardiac failure".

9. Geoffrey Packman: died 3.9.99. Recorded cause of death "myocardial infarction".

10. Arthur Cunningham: died 26.9.98. Recorded cause of death "bronchopneumonia".

Needless to say, there has been intense interest and speculation regarding the police investigation not only amongst the families concerned but also in the local media and the general public. Once criminal prosecution was ruled out, this has turned to how the Coroner will react to being presented with the results of Operation Rochester.

As I have stated above, the evidence in relation to the foregoing ten deaths (which runs to 39 experts' reports totalling several thousand pages and 368 witness statements) indicates to me that I should open Inquests into these deaths. However, I have a problem in this regard. Of the ten people, only the bodies of three of them – Sheila Gregory, Elsie Devine and Elsie Lavender – are buried within my district. The rest have been cremated.

Given that all ten families will not now have the circumstances of the deaths explored in criminal proceedings, the only way a public examination of the circumstances of the deaths can be conducted is by Inquest hearings. It seems to me to be most unfair to the families of the seven cremated people that they will miss out on this opportunity simply because there are no remains within my district. Accordingly, I should be grateful if this letter could

be treated as my report to the Secretary of State under Section 15(1) of the Coroners Act 1988 to enable the Secretary of State to consider whether it is desirable for me to hold Inquests into all ten deaths rather than simply the three where bodies remain.

To assist the Secretary of State's deliberations, I enclose a copy of an overview of Operation Rochester prepared for me by the senior investigating officer, Detective Superintendent David Williams of Hampshire Police.

Due to the intense local interest in this matter, and the need to address questions of resources and logistics necessary to conduct what will inevitably be ten long and complex Inquests, early directions from the Secretary of State would be greatly appreciated.

Please contact me if you require any further information to assist the Secretary of State.

Yours sincerely

David C Horsley
Tel: Code A
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Enc

cc Asst. Ch. Constable S Watts) Hampshire Police)
Det. Supt. D Williams)
Andrew Smith, Hampshire County Council) No Enclosures
Karen Murray, Hampshire County Council)