



Coroner
Room T20
The Guildhall
The Guildhall Square
Portsmouth
Hampshire
PO1 2AJ

New Kings Court, Tollgate, Chandler's Ford
Eastleigh, Hampshire SO53 3LG

DX: 155850 Eastleigh 7

DDI:
T:
F:
E:
Code A
www.blaw.co.uk

For the attention of Mr David Horsley

Our Ref: 558203/000001/JCW/RICHARD/S2D

Your Ref:

27 February 2013

Dear Sirs

Mrs Gladys Mabel Richards (Deceased) - Inquest

Thank you for your letter dated 20 February 2013 reiterating the scope of the enquiry. We will forward a copy to Mrs MacKenzie so that she is reminded about this.

Yours faithfully

Blake Laphorn

David C. Horsley LLB
Her Majesty's Coroner
for Portsmouth and
South East Hampshire



Coroner's Office
Room T20
The Guildhall
Guildhall Square
Portsmouth
PO1 2AJ

Fax: 023 9268 8331

Blake Laphorn
FAO: Mr White
New Kings Court
Tollgate
Chandler's Ford
Eastleigh SO53 3LG

20th February 2013

Dear Mr White,

Inquest - Gladys Mabel Richards:

Further to the recent correspondence I have received from you and Mrs Mackenzie regarding the Inquest, please may I remind you and your client that the Inquest will be directed solely towards answering the question of how Mrs Richards died (in other words, by what means she met her death) and will be restricted to the parameters set by Rules 36 and 42 of the Coroners Rules.

As Mrs Richards died in August 1998, the Human Rights Act 1998 does not apply in any way to the Inquest. Hence the evidence I can take into consideration must be geared towards assisting me with the task I have to perform under Rules 36 and 42. The Inquest will not look into wider issues of the kind suggested in some of the correspondence I have received from your client.

With regards to treatment Mrs Richards received during her admissions to Gosport War Memorial Hospital, what I will want to look at is the issue of whether this treatment caused or contributed to her death on 21st August 1998 in anything more than an insignificant way. This I believe to be the core issue for me.

I have repeatedly sought to make this clear but the message appears not to be getting across. Please could you draw your client's attention to this letter?

Yours sincerely,

Code A

David C Horsley

Tel:

Email:

David C. Horsley LLB
Her Majesty's Coroner
for Portsmouth and
South East Hampshire



Coroner's Office
Room T20
The Guildhall
Guildhall Square
Portsmouth
PO1 2AJ

Fax: 023 9268 8331

Blake Laphorn
FAO: Mr White
New Kings Court
Tollgate
Chandler's Ford
Eastleigh SO53 3LG

20th February 2013

Dear Mr White,

Inquest - Gladys Mabel Richards:

Further to the recent correspondence I have received from you and Mrs Mackenzie regarding the Inquest, please may I remind you and your client that the Inquest will be directed solely towards answering the question of how Mrs Richards died (in other words, by what means, met her death) and will be restricted to the parameters set by Rules 36 and 42 of the Coroners Rules.

she
As Mrs Richards died in August 1998, the Human Rights Act 1998 does not apply in any way to the Inquest. Hence the evidence I can take into consideration must be geared towards assisting me with the task I have to perform under Rules 36 and 42. The Inquest will not look into wider issues of the kind suggested in some of the correspondence I have received from your client.

With
~~As~~ regards to treatment Mrs Richards received during her admissions to Gosport War Memorial Hospital, what I will want to look at is the issue of whether this treatment caused or contributed to her death on 21st August 1998 in anything more than an insignificant way. This I believe to be the core issue for me.

I have repeatedly sought to make this clear but the message appears not to be getting across. *Please could you draw your client's attention to this letter?*

Yours sincerely,

David C Horsley

Tel:

Email:

Horsley, David

To: john.white: Code A
Subject: Inquest - Mrs Gladys Richards

Dear Mr White,

Further to the recent correspondence I have received from you and Mrs Mackenzie regarding this Inquest, please may I remind you and your client that the Inquest will be directed solely towards answering the question of how Mrs Richards died (in other words, by what means met her death) and will be restricted to the parameters set by Rules 36 and 42 of the Coroners Rules.

As Mrs Richards died in August 1998, the Human Rights Act 1998 does not apply in any way to the Inquest. Hence the evidence I can take into consideration must be geared towards assisting me with the task I have to perform under Rules 36 and 42. The Inquest will not look into wider issues of the kind suggested in some of the correspondence I have received from you and your client.

As regards the treatment Mrs Richards received during her admissions to Gosport War Memorial Hospital, what I will want to look at is the issue of whether this treatment caused or contributed to her death on 21 August 1998 in anything more than an insignificant way. This I believe to be the core issue for me.

I have repeatedly sought to make this clear but the message appears not to be getting across.

David C Horsley, LL.B, Solicitor
HM Coroner
Portsmouth & South East Hampshire