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Mr David Horsley
Coroner
Room T20
The Guildhall
The Guildhall Square
Portsmouth
Hampshire
PO1 2AJ

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

Your Ref:

RECEIVED
07 JUN 2011
BY H.M CORONER

BY LETTER AND FAX
FAX NUMBER: Code A

6 June 2011

Dear Sirs

Re: Gladys Richards (Deceased) – Inquest

We write further to the Pre-Inquest Review hearing which took place on 12 May 2011.

You may recall that our Counsel wished to make Submissions in respect of provision of Legal Aid funding for Mrs Mackenzie under exceptional circumstances. You kindly agreed to take those Submissions in writing.

Further to this discussion we enclose Submissions by Counsel in respect of public funding. We would be grateful if the Coroner can review the position and indicate his decision.

Please can you acknowledge safe receipt. We look forward to hearing from you.

Kind regards.

Yours faith

Code A

Blake Lapthorn

Enc.

IN HM CORONER'S COURT PORTSMOUTH

RE: GLADYS MABEL RICHARDS (DECEASED)

SUBMISSION ON LEGAL AID

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1. These submissions relate to the application of Mrs Gillian MacKenzie for legal aid so that she may be represented at the inquest into the death of her mother, Gladys Richards. At present an application has been made to the Legal Services Commission (the 'LSC') for legal aid on the grounds that the facts of this case amount to 'exceptional circumstances'. While this application is pending Mrs Mackenzie is represented on a pro bono basis by Blake Lapthorn solicitors.

2. The Coroner has stated that he remains neutral on the question of whether legal aid should be granted to Mrs Mackenzie. It is submitted that given the unusual circumstances, as well as the factual and legal complexity, of this case it is in the interests of justice for the Coroner to reconsider this position and support the granting of legal aid.

Background

3. The Coroner will be well aware of the basic facts of the case and it is not intended to rehearse them here in any detail. Mrs Richards' death was one of a number of deaths which occurred at Gosport War Memorial Hospital in the 1990s. These deaths have led to inter alia, 4 criminal investigations, a report by the Commission for Health Improvement and a finding by the General Medical Council against the doctor in charge, Dr Barton. The Assistant

Coroner for Portsmouth considered 10 of these deaths at a previous inquest in 2009.

4. The present inquest into the death of Mrs Richards is likely to be the final hearing which deals with these matters. The inquest was opened in March 2009 and immediately adjourned. The inquest is not subject to the provisions of the Human Rights Act 1998 (the 'HRA') as Mrs Richards' death took place before the HRA came into force.

5. In oral communications with Mr John White of Blake Lapthorn the Coroner indicated that he was happy to support Mrs Mackenzie's application to the LSC. Since that time the Coroner has informed Mrs Mackenzie's legal representatives that his position on legal aid is that he is neutral.

6. A pre-inquest hearing took place at The Guildhall in Portsmouth on 12 May 2011. At this hearing submissions were made on behalf of Mrs Mackenzie that the Coroner reconsider his position with regard to legal aid. The Coroner stated that he would consider written representations on the topic. These submissions are made to assist the Coroner in understanding why it would be prudent to return to his original position.

7. It is submitted that the Coroner should reconsider his position with regard to legal aid due to the factual and legal complexity of the evidence in the case. It would not be in the interests of justice to force Mrs Mackenzie to represent herself in a case of this length which involves such a large amount of papers, many of which are complicated technical medical documents. Having legal representation would not only assist Mrs Mackenzie to make her submissions fully and clearly, it will also assist the Coroner in his enquiries into Mrs Richards' death.

Factual complexity

8. There can be no doubt that this inquest covers a very complicated set of circumstances which led to the death of Mrs Richards. The medical records of Mrs Richards' care amount on their own to 3 lever arch folders. The Coroner

has also agreed (at the pre-inquest hearing) that the inquest bundle is to include nursing records and the ward controlled-drug book which relate to Mrs Richards. The inquest bundle also includes a report prepared by Professor Black into the standard of care received by Mrs Richards. Further to these voluminous documents the case has generated a huge number of witness statements and reports which would need to be carefully considered by any advocate or litigant in person in order for this case to be presented properly.

9. The Coroner recognised the complexity of this case when he set the inquest down for a 2 week listing. Although an inquest with only 8 witnesses would be expected in normal circumstances to be significantly shorter, this longer listing correctly acknowledges the complexity of the material to be dealt with in Mrs Richards' inquest.

10. When the case was taken on by Blake Lapthorn and Counsel, on a pro bono basis, it was expected that the hearing would take approximately 3 days. The longer listing, while correct in all the circumstances, means that the pro bono commitment of Mrs Mackenzie's representatives is now substantially more than was originally envisaged.

11. The complexity of the case is further demonstrated by the fact that the families of the deceased in the previous inquest had the benefit of legal aid. Notwithstanding the fact that those inquests took place before a jury, it would appear to any reasonable observer that this inquest covers material of the same complex and technical nature. Therefore such a reasonable observer could only conclude that it was unfair and inconsistent not to provide legal aid in the case of Mrs Richards when such support had been provided to other families.

12. It may be tempting to assume that because 10 previous families have managed to make clear representations on a similar set of factual circumstances there is no need to provide representation in this case as the issues have been aired already. However this conclusion is unsatisfactory for a number of reasons.

13. Firstly the Coroner has already stated (at the pre-inquest hearing) that there was no need to go over issues which had been considered by the previous inquest. Therefore it is clear that the submissions made previously on behalf of family members of those who died at Gosport War Memorial Hospital will not be sufficient to cover the case of Mrs Richards.

14. Secondly, this case is taking place before a coroner alone rather than a jury. Therefore any submissions which would be made on behalf of Mrs Mackenzie would need to be presented in an entirely different way than those which have been presented at the previous inquest. The Coroner will be aware of the advantages of both types of inquest and that the way that submissions are made, and witnesses examined, are very different. Although Mrs Mackenzie did attend a large part of the previous inquest, such experience would not automatically mean that she would be able to present the case on her own behalf in front of a coroner alone.

15. Thirdly, it is clear that all the other interested parties do not consider the enquiries which were made and conclusions that were reached at the previous inquest to have drawn a line under the events that took place at Gosport War Memorial Hospital. For this reason at least 4 interested parties (Dr Barton, the Royal College of Nursing, the relevant hospital administrators and the relevant NHS Trust) will be fully represented at the inquest as they were at the pre-inquest hearing.

Legal complexity

16. The HRA has produced substantial jurisprudence in relation to coronial law and in many ways it has given greater protection to family members of those whose deaths are being considered by inquests. However Mrs Richards' death took place prior to the HRA coming into force. Therefore the inquest has to be conducted in light of the law as it stood at the time of her death. Regardless of whether one considers the 'old' law to be more straightforward than the 'new' law, it has to be accepted that is more difficult to make legal arguments under an out of date regime. Accessing appropriate materials for such

arguments takes more time and indeed deciphering 'old' law is often considered to be a very difficult task even by experienced practitioners.

17. The second area of legal complexity in this case relates to the law regarding gross negligence manslaughter. Mrs Mackenzie is certain that the evidence supports a finding of 'unlawful killing'. As the Coroner will be aware the burden and standard of proof for reaching such conclusion are very high. As a result of this, the presentation of any case involving such arguments should be made with the greatest of precision and sensitivity. It cannot be in the interests of justice to have family members of the deceased cross-examining people they considered may have caused the death of their loved one. Detached professional cross-examination will assist a coroner with their enquiries far more efficiently and sensitively than if a family member were to conduct such an examination themselves. Similarly, any closing submissions relating to the appropriate verdict to be reached will benefit from the same efficiency and sensitivity.

Mrs Mackenzie's health

18. Mrs Mackenzie suffers from a number of health conditions which derive from an underactive thyroid which was diagnosed in 1998. Her care is managed by 2 hospitals including King's College Hospital in London. Over the course of the summer she will have to attend both hospitals regularly to speak to her specialists. She finds these trips tiring. The months between now and the inquest is a time when the majority of our hospital visits take place. Although she will be able to attend the entire of the inquest it is likely to be too physically taxing to undertake the intense preparations needed to present her case. If she is legally represented she will not be placed under this strain and her health is not likely to be something which would cause a delay in the proceedings.

19. As the Coroner will remember from the pre-inquest hearing, Mrs Mackenzie is hard of hearing. The Coroner helpfully stated that he would attempt to have the inquest in Portsmouth Crown Court so that Mrs Mackenzie could have the benefit of an induction loop. Even with such a loop Mrs Mackenzie's hearing

will make it very difficult for her to follow all of the proceedings and make all of the appropriate representations on her own.

Conclusion

20. The issues surrounding the death of Gladys Richards raised complex issues of fact and law. Due to these complexities it cannot be in the interests of justice for a family member to have to represent themselves in such a hearing. Notwithstanding Mrs Mackenzie's detailed knowledge of the case, there can be no doubt that any hearing in which an interested party represents themselves will take substantially longer than if that party were legally represented. This is particularly true in cases where a coroner wants to focus on specific issues within a large and technically complicated body of evidence.

21. Further to these considerations of complexity and expediency it is important to consider Mrs Mackenzie's health. Her ongoing care at 2 hospitals in different parts of the country will make it difficult and exhausting for her to properly prepare to present her own case. It is also fair to say that given her difficulties with hearing she may have difficulty following her case closely enough to make the appropriate representations. Therefore it would be in the interest of both the inquest and Mrs Mackenzie for her to be legally represented.

22. For these reasons it is submitted that the Coroner should change his position with regard to legal aid for Mrs Mackenzie from one of neutrality to one that is supportive of legal aid.

JAMES MEHIGAN
Tooks Chambers

1 June 2011

Blake Lapthorn

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To:	Mr David Horsley - Coroner	Fax no:	Code A
Company.		No of pages.	8(including this page)

From: Helen Pattison

Subject.

Please see attached

DAVID

FOR YOUR INFORMATION

THANKS

DAVE.

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