Blake Lapthorn
New Kings Court
Tollgate
Chandlers Ford
Eastleigh
Hampshire SO53 3LG

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

14 September 2010

Dear Sirs

Gladys Richards – Inquest:

I refer to your letter dated 13 September 2010.

In the light of what you say, I must set out my rationale for opening an Inquest last year in relation to Mrs Richards' death and what the parameters of the Inquest will be.

Mrs Richards died in 1998. She had been admitted to hospital having suffered a broken hip sustained in a fall in the nursing home where she lived. This was repaired but she suffered another fall whilst hospitalised. Thereafter, her condition deteriorated and she died on 21 August 1998 whilst still in hospital. Her death was not reported to my predecessor as Coroner. Indeed, it was not the norm for him to open an Inquest when someone died in such circumstances. Consequently no autopsy was carried out on her. However, if someone died now whilst in hospital not having made a recovery from surgery to repair a fractured hip sustained in a fall, I would open an Inquest into the death. Albeit that the death occurred 12 years ago, I believe I have reasonable grounds to suspect that Mrs Richards' death not to have been due to entirely natural causes. Hence I was prepared to open an Inquest in this case.

Your client's allegations that Mrs Richards was unlawfully killed have been repeatedly investigated by the police who have also, at my behest, reviewed their conclusions in the light of evidence heard last year at the multiple Inquests into deaths at Gosport War Memorial Hospital and at the disciplinary

hearings in relation to Dr Barton. The police review has brought to light nothing to suggest that their previous conclusions were wrong.

The issues of administration of morphine to elderly patients at Gosport War Memorial Hospital have already been aired in public in great depth before a Jury at the aforementioned Inquests and at the disciplinary hearings and I do not consider that the public interest will be further served in any way by airing them again to that degree at Mrs Richards' Inquest – particularly as there is no evidence that her death was due to criminal acts. The starting point for the Inquest will be her admission to hospital on 29 July 1998 and it will hear evidence about subsequent events culminating in her death on 21 August 1998. I will prepare a witness list which I consider will provide me with the necessary evidence to enable me to discharge my duty under Rule 36 of the Coroners Rules 1984. I do not consider it necessary to the performance of that duty to call all of the expert witnesses who gave evidence at the 2009 Inquests and disciplinary hearing. Hence their reports will not be Inquest documents in this case. I am instructing my own medical expert to look at the issues which I consider relevant to Mrs Richards' Inquest and I will give thought to disclosure of their report when that report has been provided to me. Similarly, when I have decided upon the other witnesses I intend to call I will identify them to you and consider issues such as disclosure, etc.

As the available evidence appears to bring forward nothing new to now cause me to suspect that Mrs Richards may have been unlawfully killed and as it does not appear to me to serve the public interest by re-airing issues which have already been considered in depth in previous proceedings, my position regarding your client's application for Legal Aid for the Inquest must, I believe, be a neutral one.

I trust the foregoing explanations assist you and your client.

Yours faithfully

David C Horsley
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