Calle
David S.

Blake Lapthorn

Mr John Baker
Legal Services Commission
Special Cases Unit
DX 100170 DOCKLANDS 2

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

DX: 155850 Eastleigh 7

DDI: Code A
T: +44 (0) 2380 908090
F: +44 (0) 844 620 3415
E: Code A
www.bllaw.co.uk

BY LETTER AND FAX
FAX NUMBER: Code A

6 July 2011

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

Your Ref:

Dear Sirs

Our Client: Mrs Gladys Mabel Richards (deceased) – Inquest
"Exceptional Funding"

We write and enclose revised costings. As you will be aware, the previous estimate was based upon a time estimate of three days, in fact the Coroner has listed the Inquest to take place over two weeks on the 25 October 2011. We therefore enclose copies of:-

1. Revised costing (with track changes);
2. Submissions by Counsel made to the Coroner in support of Public Funding; and
3. Letter from Mr Horsley, HM Coroner for Portsmouth, dated 23 June 2011 confirming his view that representation would assist his Inquiry.

Please can you now consider the information and we would be grateful if you can grant Public Funding under exceptional circumstances for this Inquest. Should you require any further information or have any questions concerning this letter, please ask to speak to John White.

Yours f

Code A

Blake L

Enc. Various

ATTACHMENT IN SUPPORT OF APPLICATION
UPDATED 12.04.11 AND FURTHER UPDATED 05.07.11

We are asked by Mrs Gillian MacKenzie (DOB 08.11.33) to represent her at the forthcoming inquest called by the Coroner, Mr David Horsley, at the Coroner's court in Portsmouth. The case concerns the death of her late mother, Mrs Gladys Richards (deceased).

A pre-inquest hearing took place on 12 May 2011 at which Mr John White, from this firm, attended with Mr James Mehigan of Counsel. The Coroner has now listed the inquest hearing to take place on 25 October 2011 with a time estimate of two weeks. Further to the pre-inquest hearing the Coroner asked for submissions in respect of public funding which were duly provided; copy attached. Having considered these, the Coroner is now of the view that public funding for representation of Mrs MacKenzie will assist him with his enquiry and he is now supportive of the need for this.

This application was originally submitted on 22 April 2009 and was re-submitted on 25 June 2009 when it appears that the original application had gone missing.

The costings have been revised again to take in to account the latest assessments as to length and complexity of the inquest and in particular the new time estimate of two weeks.

Background

Although the events in question relate to the late 1990s, they are highly significant because they coincide with the critical time scale for the Gosport War Memorial Hospital ("GWMH") inquest. That hearing started on 18 March 2009 and dealt with the deaths of ten patients who had been treated with morphine and tranquillizing drugs at GWMH. Of the five families represented the jury concluded that in three cases the treatment was inappropriate and contributed to those patients' deaths and in one case that the treatment was inappropriate. Other families have come forward to express their concerns to us about the care their relatives received at GWMH at that time but they were excluded from the inquest hearing in 2009.

On 30 July 1998 Mrs MacKenzie was informed that her late mother had been admitted to Haslar Hospital with a fractured hip. The admission was between 30 July 1998 and 18 August 1998 and she seemed to be doing well, mobilising and eating and drinking.

Towards the end of the admission at Haslar Hospital, Dr Reid was introduced to the late Mrs Richards' care. It was decided that Mrs Richards would be admitted to GWMH for rehabilitation whilst an alternative nursing home could be found for her. The estimated time of the admission was 4 weeks.

Mrs MacKenzie's sister observed shortly after the transfer that Mrs Richards seemed to be sedated. Within two days Mrs MacKenzie heard that Mrs Richards had suffered from a fall. She had been transferred back to Haslar Hospital to have her hip manipulated. She again seemed to make a good recovery.

On 17 August 1998 Mrs Richards was transferred back to GWMH.

Mrs MacKenzie alleges that a Mr Bead, nursing manager, administered two unrecorded diamorphine injections. She opposed giving diamorphine because there was nothing in her view to justify this. Further x-rays were undertaken. Dr Barton then attended. She has been the doctor at the centre of allegations concerning opiate and sedative drug mis-prescribing at GWMH.

After the x-rays Mrs MacKenzie states that her mother was unconscious. Mrs MacKenzie and her sister spoke with Dr Barton who was due to review Mrs Richards the following morning.

On returning the following morning Mrs MacKenzie was advised that Mrs Richards had a massive haematoma and there was nothing further that could be done. We have seen no evidence that there ever was a haematoma. The proposal was to put her on a syringe driver device with diamorphine. The impression given was that Mrs Richards was very close to death and the syringe driver was necessary.

Mrs Richards never regained consciousness and died at GWMH on 21 August 1998. Further to Mrs Richards's death, a number of investigations in to her death and others were undertaken : -

(i) There was a complaint to the police, Hampshire Constabulary. This was partially investigated. There was then a complaint about the police's handling and this led to a further investigation;
(ii) Mr Millet dealt with a complaint to the hospital trust responsible for the late Mrs Richards' care;
(iii) There was a further investigation by the police who referred this matter to the Commission for Health Improvement (CHI) and to the GMC;
(iv) CHI prepared their report in 2002;
(v) There was the GWMH inquest in respect of 10 families in March/ April 2009;
(vi) Dr Barton has been investigated by the General Medical Council (GMC). They concluded early in 2010 that she was guilty of serious professional misconduct; and
(vii) The Crown Prosecution Service (CPS) re-evaluated the evidence but they declined to bring criminal proceedings against any person, confirming their view in 2011.

Submissions in relation to costs

By reference to Part C of the Funding Code: Guidance, 27. Exceptional funding

Please see the attached submissions made in writing to the Coroner. We refer to paragraphs in the Code : -

27.4

- [8(a)] There is a wider public interest and representation is necessary. The allegations are against an NHS hospital and are connected with, multiple and potentially avoidable deaths;
- [8(b)] Whilst there have been other forms of investigations these are not able to reach a conclusion as to the cause of death in this individual case;
- [8(c)] Mrs Mackenzie will not be able to participate effectively. There is complex medical evidence

and she will need assistance from an advocate to participate effectively, particularly bearing mind the complicating issue of the GWMH inquests. We suggest therefore that it is essential that Counsel should be instructed to represent Mrs MacKenzie;

- [8(d)] The view of the Coroner has been sought as to whether he will be assisted by representation and he confirms that it would be of assistance.
- [12] The Commission has discretion to waive financial eligibility limits relating to representation and it would not be reasonable to expect Mrs MacKenzie or her family to bear the costs of representation at the inquest;

27.5

- [1] No other funding is available. In particular a conditional fee agreement is wholly unsuitable since there is no means to recover the costs, it not being expected that there will be any civil action in negligence. Pro-bono representation is not realistic to have any meaningful impact in these circumstances because of the amount of preparation needed and complexity of the issues and specialist expertise required from the advocate in respect of the medical issues;
- [2] There is significant wider public interest. Furthermore, the circumstances at to the death of her late mother is of overwhelming importance to Mrs MacKenzie.

27.6

A. SOLICITORS' COSTS

Assumptions:
Time estimate of hearing = tenthree days

Preparation:
Senior solicitor (SS) @ £53.00 x 90% uplift = £100.00 p.h.
Solicitor (S) @ £45.00 x 90% uplift = £85.00 p.h.

Attendance at Court:
Senior solicitor @ £42.25 x 90% uplift = £80.00 p.h.
Solicitor @ £34.00 x 90% uplift = £65.00 p.h.

Travel and waiting
Senior solicitor @ £24.75 x 90% uplift = £47.00 p.h.
Solicitor @ £24.75 x 50% uplift = £47.00 p.h.

Description	**Time**
1. 22 April 2009 – 12 April 2011: Costs to date incurred	
1.1 Attendances (SS)	6.719.2
1.2 Preparation: (SS)	12.026.0
(S)	8.0
1.3 Correspondence (SS)	7.714.6
1.4 Telephone (SS)	17.121.1
1.5 Travel and waiting (SS)	1.53.2
Total (6.7 19.2x £100 p.h. + 12.0 26.0x £100 p.h. + 8.0 x £65 p.h. + 7.7 14.6x £100 p.h. + 17.121.1 x £100 p.h. + 1.5 3.2x £47 p.h.) =	~~£5,100.50~~
	£8,760.40

From 12 April 2011: Costs to and including inquest hearing

2.1 Preparation of documents - medical records and clients' papers (SS)	~~2.0~~6.0 hours
2.2 Correspondence (SS)	2.0 hours
2.3 Telephone (SS)	~~3~~4.0 hours
2.4 Briefing counsel (SS)	3.0 hours
~~2.5 Attending pre-inquest hearing and conference with counsel (S)~~	~~5.0 hours~~
2.6 Attending inquest for 3 days:	
(SS) ~~1~~2 days =	~~7.0~~ 14.0hours
(S) ~~2~~8 days =	~~14.0~~ 56.0hours
1.7 Travel and waiting:	
(SS)	~~3~~8.0 hours
(S)	~~6~~2.0 hours
~~Total (10.0 x £100 p.h. + 12.0 x £80 p.h. + 14.0 x £65 + 9.0 x £47 p.h.) =~~	~~£3,293.00~~
Total (15.0 x £100 p.h. + 14.0 x £80 p.h. + 56.0 x £65 p.h. + 10.0 x £47.00) =	£6,730.00
Total for solicitors' costs (Ex-VAT)	**~~£8,393.50~~15,490.40**

B. COUNSEL'S FEES

Assumptions (as above)
~~Rate applied to pre-inquest preparation and conference = £125.00 p.h.~~
~~Brief fee = £2,000.00~~
~~Refresher = £1,000.00 per day~~
~~Preparation for closing submissions = £125.00 p.h.~~
~~Travel and waiting = £31.25~~

Description	**Cost**
2.1 Preparation for pre-inquest hearing and conference with client 5.0 hours @ £125 p.h. =	£ 625.00
Attending pre-inquest hearing:	£ 500.00
2.2 Attending meeting with client = 2.0 hours @ £125 p.h.	£ 250.00
2.3 Attending ~~pre-inquest~~ conferences ~~= 2.0 hours~~ (X2) @ £500~~125 p.h.~~	~~£ 250.00~~1,000.00
2.4 Attending inquest for ~~two~~ten days = ~~£2,000.00~~4,500 (brief fee) based on 30 - 40 hours preparation and first day of hearing+ ~~3~~9 days ~~x £1,000~~500 per day (re-fresher) =	~~£5~~9,000.00
2.5 Travel and waiting = 3 x 3.0 hours per day = 9.0 hours	£ 281.25
2.6 Reasonable expenses: £245+ VAT(9 x £25 rail fares and 2 x £10 taxi fares)	£ 245.00
Total for Counsel's fees (Ex-VAT)	**~~£6,406.25~~£11,901.25**

TOTAL FUNDING REQUIRED (EX-VAT) **~~£14,799.75~~27,391.65**

Means

Mrs MacKenzie confirms her financial means to be as follows: Basic state pension as from 7 April 2011 £137.59 per week plus savings credit of £20.43. Guarantee credit has been withdrawn because Mrs MacKenzie's state pension is now 24p over what is the appropriate amount and she is appealing that decision.

Other parties

Of the six witnesses to be called other than Mrs MacKenzie and her sister, all are professionals, one being the medical expert. Please note that the key medical witness Dr Barton will be represented by Counsel and was represented by Leading Counsel at the GMC. Having been through the 6 week inquest hearing and subjected to cross examination and then through the extensive examination by the GMC we do not believe that an unskilled advocate has any realistic chance of successfully cross-examining Dr Barton on this matter. Accordingly without representation Mrs MacKenzie cannot realistically participate in this inquest. This is aside from the complex medical causation evidence which needs to be analysed.

Having had the opportunity to consider this application and in particular in light also of the outcome of the GWMH inquest hearing, we anticipate that it will be granted.

Should you have any questions or require any further information, please ask to speak to John White.

IN HM CORONER'S COURT PORTSMOUTH

RE: GLADYS MABEL RICHARDS (DECEASED)

SUBMISSION ON LEGAL AID

---

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

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

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

Fax: 023 9268 8331

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

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

7 June 2011

Dear Sirs

Inquest – Mrs Gladys Richards:

Thank you for your letter dated 6 June.

In the light of the proceedings at the recent pre-Inquest meeting, Counsel's submissions enclosed with your letter and my further consideration of the matter, I am now of the opinion that legal representation of Mrs Mackenzie at her mother's Inquest will aid the effective conduct of the Inquest. To that extent, I would support Mrs Mackenzie's application for legal aid funding.

Yours faithfully

Code A

David C Horsley
Tel: Code A
Email: Code A