

LONDON - SCU

14 APR 2011

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BY LETTER AND FAX

FAX NUMBER: Code A

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

Your Ref:

13 April 2011

Dear Sirs

**Re: Mrs Gladys Mabel Richards (deceased) – Inquest
 Exceptional Funding**

We write further to our recent email conversation and hereby enclose copies of:-

- (i) Letter from Mr Horsley, HM Coroner for Portsmouth, dated 7 April 2011; and
- (ii) Updated estimated costings for representation. We have included our costs to date since the Application was first notified to you. Also we have applied an uplift to reflect on the factual and medical issues in the case.

We would be grateful now if you can confirm whether or not funding will be granted. We need to make preparations for the hearing.

We look forward to hearing from you as soon as possible. Thank you for your help.

Best wishes.

Yours sincerely

John W

Encs.

Code A

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

Mr J White
Blake Lapthorn
New Kings Court
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Eastleigh SO53 3LG

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8 APR 2011

Blake
Lapthorn

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

7 April 2011

Dear Sir

Gladys Richards: Inquest

I consider that I am now in possession of sufficient evidence to enable me to proceed with an Inquest into the death of Mrs Richards. I enclose a copy of a list of the persons I intend to call to give me evidence at the Inquest. You will note that I intend to call Professor D A Black as an independent expert witness to give me his opinions on the medical care Mrs Richards received prior to her death. I shall forward a copy of his report to you or your legal representative prior to the meeting referred to below.

Before I arrange a hearing date, I propose to hold a meeting for persons properly interested in the Inquest so that I can explain what I consider to be the issues for the Inquest to consider and discuss other matters relevant to the Inquest. This meeting will be held at this office on Wednesday 12 May 2011 at 11.00 am. As a person whom I consider to be properly interested in this Inquest, you or your legal representative are invited to attend this meeting.

It would assist me greatly if you could within the next seven days confirm if you or your legal representative intends to be present at the meeting. If your legal representative will be attending, please confirm their identity to me.

Yours faithfully

Code A

David C Horsley
Tel: 02392 688326
Email: Code A

This is a duplicate of a letter sent to Mrs Mackenzie.

**ATTACHMENT IN SUPPORT OF APPLICATION
UPDATED 12.04.11**

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 Mrs Gladys Richards (deceased).

Pre-inquest hearing is due to take place on 12 May 2011. The Coroner intends to list the inquest hearing to take place by the end of July 2011. He has issued a witness list.

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 to take in to account the latest assessments as to length and complexity of the inquest.

Background

Although the dates 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. At least six other families have come forward to express 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.

INQUEST – GLADYS RICHARDS

Provisional Witness List

- 1) Mrs Gillian M Mackenzie/Mrs Lesley O'Brien
- 2) Professor David A Black – Consultant Physician (Geriatric Medicine)
- 3) Dr Jane Barton
- 4) Philip Beed – Clinical Manager
- 5) Margaret Couchman - Staff Nurse
- 6) Christine Joice – Staff Nurse
- 7) Dr R I Reid – Consultant Geriatrician

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

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. Although initially in favour, his stance is now neutral;

- [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 = three 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)

6.7

1.2 Preparation:

(SS)

12.0

(S)

8.0

1.3 Correspondence (SS)

7.7

1.4 Telephone (SS)

17.1

1.5 Travel and waiting (SS)

1.5

Total (6.7 x £100 p.h. + 12.0 x £100 p.h. + 8.0 x £65 p.h. + 7.7 x £100 p.h. + 17.1 x £100 p.h. + 1.5 x £47 p.h.) =

£5,100.50

From 12 April 2011: Costs to and including inquest hearing

2.1 Preparation of documents - medical records and clients' papers (SS)

2.0 hours

2.2 Correspondence (SS)

2.0 hours

2.3 Telephone (SS)

3.0 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 day =	7.0 hours
(S) 2 days =	14.0 hours
1.7 Travel and waiting:	
(SS)	3.0 hours
(S)	6.0 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 for solicitors' costs	£8,393.50

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
2.2 Attending meeting with client = 2.0 hours @ £125 p.h.	£ 250.00
2.3 Attending pre-inquest conferences = 2.0 hours @ £125 p.h.	£ 250.00
2.4 Attending inquest for two days = £2,000.00 (brief fee) + 3 x £1,000 (re-fresher) =	£5,000.00
2.5 Travel and waiting = 3 x 3.0 hours per day = 9.0 hours	£ 281.25
Total for Counsel's fees	£6,406.25

TOTAL FUNDING REQUIRED	£14,799.75
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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 subject 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.