E-mail Message

From:	Code A EX:/O=MOJ/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN= Code A
To:	Code A [SMTP: Code A
Cc:	
Sent:	25/08/2010 at 17:00
Received:	25/08/2010 at 17:00
Subject:	FOI Request 59436
Attachments:	DCL_Information002.PDF Lakhani 59436 .doc

Dear Ms Lackhani

Please see the attached letter with reference to your FOI request.

Many thanks

Code A
Data Access & Compliance Unit
6th Floor
Post Point 6.25, Zone B
102 Petty France
London
SW1H 9AJ

DX 152380

Westminster 8

Peter C Thorpe LLB
Her Majesty's Coroner
for Portsmouth and
South East Hampshire

Coroners Office
Room 120
The Guildhall
Guildhall Square
Portsmouth
PO1 2AJ

Fax 023 9268 8361

Coroners Unit
5th Floor, Steel House
11 Tothill Street
London SW1H 9LH

15 June 2007

Dear

Hampshire Police Operation Rochester – Deaths at Gosport War Memorial Hospital, Gosport, Hampshire:

I have recently been passed a report by Hampshire Police on Operation Rochester which was an investigation they conducted between 1998 and 2006 into the deaths of some 92 elderly patients at Gosport War Memorial Hospital between 1989 and 2000. The investigation was commenced following allegations made to the Police that the patients had been inappropriately administered Diamorphine or other opiate drugs and that had caused or contributed to their deaths.

The final phase of this lengthy investigation was a review of the 92 cases by a team of medical experts with specialisms in toxicology, general medicine, palliative care, geriatrics and nursing. Of the 92 deaths, the team found that 78 of them failed to meet the threshold of negligence required to conduct a full criminal investigation. Of the remainder, the team reached the conclusion that four of the deaths could be described as being entirely natural. The ten others were then the subject of a full criminal investigation as the team had reached the conclusion on them that they were cases of "negligent care that is today outside the bounds of acceptable clinical practice and the cause of death is unclear".

A common denominator in these ten cases was the involvement of Dr Jane Barton who at relevant times had been the attending clinical assistant at the hospital and responsible for the ten patients' initial and continuing care, including prescribing and administering opiates via syringe drivers. It should also be noted that none of the ten deaths (nor any of the remaining 82) had been reported to the then Portsmouth and South East Hampshire Coroner.

Full files on the ten cases were forwarded to the Crown Prosecution Service for consideration of criminal proceedings in relation to the deaths. Subsequently, the Crown Prosecution Service concluded in December 2006 that having regard to overall expert evidence it could not be proved that negligence had occurred to a criminal standard and whilst the expert medical evidence was detailed and complex, it did not prove that the drugs which had been administered to the patients had contributed substantially to their deaths. Even if causation could be proved, there was not sufficient evidence to prove that the conduct of doctors was so bad as to be a crime and there was no realistic prospect of convictions.

The decision of the Crown Prosecution Service was then communicated to the families of ten deceased persons and the criminal investigation was then closed. Following this, Hampshire Police forwarded their files on Operation Rochester to me to consider whether I should investigate and conduct Inquests into any of the deaths involved.

Given the fact that the Police investigated 92 deaths, hundreds of witnesses were interviewed and their statements run into many thousands of pages. For obvious reasons, I have not read in detail the totality of the evidence gathered but from my understanding of it and my discussions with police officers involved in the investigations, I take the view that in respect of the ten deaths which were ultimately the subject of full criminal investigation I have reasonable cause to suspect that the ten persons concerned have died in the circumstances described in Section 8(1)(a) and (b) of the Coroners Act 1988 and that I am under a duty to hold Inquests into their deaths.

The ten persons are: -

1. Elsie Devine: died 21.11.99. Recorded cause of death 'bronchopneumonia and glomerulonephritis'.

2. Elsie Lavender: died 22.2.00. Recorded cause of death 'cerebrovascular accident'

3. Sheila Gregory: died 22.11.99. Recorded cause of death 'bronchopneumonia'.

4. Robert Wilson: died 14.10.98. Recorded cause of death "congestive cardiac failure and renal/liver failure".

5. Enid Spurgin: died 26.3.99. Recorded cause of death "cerebrovascular accident".

6. Ruby Lake: died 21.8.98. Recorded cause of death "bronchopneumonia".

7. Leslie Pittock: died 24.1.96. Recorded cause of death "bronchopneumonia".

8. Helena Service: died 5.6.97. Recorded cause of death "congestive cardiac failure".

9. Geoffrey Packman: died 3.9.99. Recorded cause of death "myocardial infarction".

10. Arthur Cunningham: died 26.9.98. Recorded cause of death "bronchopneumonia".

Needless to say, there has been intense interest and speculation regarding the police investigation not only amongst the families concerned but also in the local media and the general public. Once criminal prosecution was ruled out, this has turned to how the Coroner will react to being presented with the results of Operation Rochester.

As I have stated above, the evidence in relation to the foregoing ten deaths (which runs to 39 experts' reports totalling several thousand pages and 368 witness statements) indicates to me that I should open Inquests into these deaths. However, I have a problem in this regard. Of the ten people, only the bodies of three of them – Sheila Gregory; Elsie Devine and Elsie Lavender – are buried within my district. The rest have been cremated.

Given that all ten families will not now have the circumstances of the deaths explored in criminal proceedings, the only way public examination of the circumstances of the deaths can be conducted is by Inquest hearings. It seems to me to be most unfair to the families of the seven cremated people that they will miss out on this opportunity simply because there are no graves within my district. Accordingly, I should be grateful if this letter could

be treated as my report to the Secretary of State under Section 15(1) of the Coroners Act 1988 to enable the Secretary of State to consider whether it is desirable for me to hold Inquests into all ten deaths rather than simply the three where bodies remain.

To assist the Secretary of State's deliberations, I enclose a copy of an overview of Operation Rochester prepared for me by the senior investigating officer, Detective Superintendent of Hampshire Police.

Due to the intense local interest in this matter, and the need to address questions of resources and logistics necessary to conduct what will inevitably be ten long and complex Inquests, early directions from the Secretary of State would be greatly appreciated.

Please contact me if you require any further information to assist the Secretary of State.

Yours sincerely

Code A

David C Horsley
Tel:
Email:

Enc

cc) Hampshire Police
)
Hampshire County Council
Hampshire County Council

David C. Horsley LLB
Her Majesty's Coroner
for Portsmouth and
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Fax: 023 9268 8331

Mr
Coroners Unit
Ministry of Justice
3rd Floor
102 Petty France
London
SW1H 9AJ

7 January 2009

Dear

Deaths at Gosport War Memorial Hospital:

. has forwarded to me a copy of his letter dated 6 January 2009.

For my own part, I wholly endorse what he says to you regarding this matter. When I initially made representations to the Ministry of Justice in 2007 about the scale of Inquests in relation to the Gosport deaths, I was concerned principally about the resource implications of holding up to 92 Inquests. Since then, as Andrew has proceeded with the 10 cases in which I opened Inquests it has become apparent that the Inquest process is not going to deliver the sort of investigations and conclusions which are envisaged by the families involved. It is also not clear what the other 82 families are expecting to happen as regards their relatives' deaths.

At the meeting held at the Ministry of Justice in August 2007, you will recall that I raised the possibility that a public inquiry could be held into all 92 deaths rather than a number of Inquests as being a more appropriate way of allaying public concerns regarding the deaths. I was told by the representative from the Department of Health that a public inquiry would not be an option because the Department considered that the Gosport deaths did not raise any issues of national concern. I pointed out that although the two situations were not entirely similar in the public mind what happened at this hospital in Gosport would be linked with the Shipman case and there was a potentially important [illegible] involved, namely the administration of morphine [illegible] [illegible] in an NHS hospital. The representative from the Department of Health [illegible].

As events have panned out, I consider that a public inquiry into all the deaths is needed to allay public concerns about what happened and will do so in a way which the limited scope of the Inquest could never do so.

Hence, I would ask that the question of a public inquiry into what happened at Gosport War Memorial Hospital be reconsidered as a matter of urgency.

Yours sincerely

David C Horsley
Tel:
Email: _____

cc

Ministry of JUSTICE

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2nd floor (2.40)
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Mr
HM Coroner for North East Hampshire
Coroner's Office
Goldings
London Road
Basingstoke
Hampshire
RG21 4AN

8 January 2009

Dear Mr

OPERATION ROCHESTER – DEATHS AT GOSPORT WAR MEMORIAL HOSPITAL

I refer to your letter of 6 January to about concerns you have in connection with the above inquests that you are handling as assistant deputy coroner to

Any decision about a public inquiry into the deaths at Gosport War Memorial Hospital would be a matter for the Department of Health. We have raised your concerns with that Department, but their view remains that given the variety of investigations that have already been undertaken and the powers you have to inquire into all the circumstances leading up to the deaths, the inquests should now proceed – as directed by the Secretary of State under section 15 of the Coroners Act 1988 in seven of the cases.

If on conclusion of the inquests there remain any issues that need further attention, the Department of Health will review the position.

Yours sincerely

From: Horsley, David [
Sent: 28 January 2009 12:31
To:
Subject: RE: s15 -

David C. Horsley
H.M. Coroner
Portsmouth & South East Hampshire

-----Original Message-----
From:
Sent: 28 January 2009 12:28
To: Horsley, David
Cc:
Subject: RE: s15 -

David

Letter and formal direction will be posted this pm.

From: Horsley, David [mailto:
Sent: 08 January 2009 16:21
To:
Cc: / (E-mail)
Subject: RE: s15 -

Thank you for the email.

Thanks very much.

David C. Horsley
H.M. Coroner
Portsmouth & South East Hampshire

-----Original Message-----
From:
Sent: 08 January 2009 16:14

To: Horsley, David
Subject: s15 -

David

Thank you for your letter of 5 January.

I shall, of course, let you know as soon as the decision is made.

Current Coroner Policy Team
Coroners & Burials Division
Ministry of Justice
2nd Floor (2.40)
102 Petty France
London, SW1H 9AJ

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David C Horsley LLB
Her Majesty's Coroner
for Portsmouth and
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Coroner's Office
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PO1 2AJ

Fax: 023 9268 8331

Coroners Unit
Ministry of Justice
8th Floor
102 Petty France
London
SW1H 9AJ

5 January 2009

Dear

Possible Inquest into the death of Mrs Gladys Richards:

I refer to my letter dated 17 November 2008 and your response of 9 December 2008.

As the Gosport War Memorial Hospital Inquests are due to commence on 18 March 2009, time is now very short for relatives – and my deputy who is conducting these Inquests on my behalf – to prepare for an Inquest into death, if such an Inquest is to take place in sequence with the other Inquests. Hence it is vital that I have a decision at the earliest opportunity as to whether I shall be permitted to open an Inquest into death.

Yours sincerely

David C Horsley
Tel
Email

Ministry of JUSTICE

Coroners and Burials Division
2nd Floor (2.40)
102 Petty France
London
SW1H 9AJ

T
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David C Horsley LL.B
HM Coroner for Portsmouth and South East Hampshire
HM Coroner's Office
The Guildhall
Guildhall Square
Portsmouth
PO1 2AJ

28 January 2009

Dear Mr Horsley

Operation Rochester: death at Gosport War Memorial Hospital –

I am sorry for the delay in considering your report to the Secretary of State on the above case, dated 17 November 2008.

The Secretary of State has now considered your report, and he has agreed to the issue of a direction for an inquest to be held in respect of the death of

Please see enclosed the direction under Section 15, together with a copy for your records.

Yours sincerely

Current Coroner Policy Team

To: David Horsley
Her Majesty's Coroner for Portsmouth and South East Hampshire

WHEREAS You, Her Majesty's Coroner for Portsmouth and South East Hampshire, in pursuance of section 15(1) of the Coroners Act 1988, have reported to the Secretary of State that you have reason to believe that the death of

has occurred in or near your district, in such circumstances that an inquest ought to be held, and that the body has been destroyed by fire;

NOW, therefore, in pursuance of the powers conferred by Section 15(2) of the Coroners Act 1988, the Secretary of State hereby directs you, the said Coroner, to hold an inquest into the said death.

Coroners and Burials Division

Ministry of Justice
23 January 2009

Ministry of JUSTICE

Coroners Unit
Steel House
11 Tothill Street
London SW1H 9LH

Code A

www.justice.gov.uk

David C Horsley
H M Coroner
Coroner's Office
Room T20
The Guildhall
Guildhall Square
Portsmouth PO1 2AJ

21 August 2007

Dear David

Operation Rochester - Deaths at Gosport War Memorial Hospital

Thank you for your letter of 15 June to about Operation Rochester. As you know we discussed a number of investigated deaths at Gosport War Memorial Hospital today with the police, the Department of Health and your local authority.

I note that you are seeking up to seven Section 15 orders in respect of persons, whose bodies were cremated and who died at the hospital. I am also aware that the police investigated up to 92 deaths of persons who died at the hospital between 1989 and 2000. I also understand that the Crown Prosecution Service has decided that there are insufficient grounds to prosecute anyone in respect of any of these deaths. None of the cases was referred to your predecessor for investigation. You have not yet made a final decision about holding inquests on three cases where the bodies are buried within your district.

I further understand that the common thread in all these cases is a Dr Jane Barton who was employed at the hospital between and is under investigation by the General Medical Council but any hearing is unlikely to take place before early summer of next year.

Perhaps most importantly, this case has the potential to be highly demanding of resources and your county council representative expressed her concern about this. However, the costs of all inquests should be met by the local authority. The Department of Health made it clear that the advice of their Ministers and the Chief Medical Officer was that a public inquiry was unjustified and that any concerns would be best addressed by the inquest process.

In order to determine whether the Secretary of State should issue directions in respect of any or all of the seven cases I think would be helpful to have more information.

Firstly I would be grateful if you could confirm that in accordance with the terms of section 15 you have reason to believe that, in respect of each case, the death occurred in or near your district in circumstances requiring that an inquest be held and that the body has been destroyed by fire or is lying at a place from which it cannot be recovered.

Secondly, as I mentioned at the meeting, the Secretary of State has to consider whether it is desirable to hold an inquest into these deaths. I would welcome your views on whether you think it is desirable to hold inquests and, if so, why that is the case.

The information on the seven cases where cremations took place would need to be provided in much more detail. The summaries at pages 10-11 of the Overview report need to be augmented with full details of why it was thought there was a case which needed to be referred to the Crown Prosecution Service. Are there summary police reports relating to individual cases? If so it would be helpful to have sight of these.

In the light of all the information you have received from the police it would also be helpful to know whether there are other cases which might also require section 15 orders. I understood from the meeting that concerns from family members extend beyond the ten cases under discussion. It would also be helpful to have sight of any representations from family lawyers about these cases, or indeed directly from family members (even if there has been no recent correspondence).

One possible course of action, as discussed, might be to await the outcome of the GMC proceedings against Dr Barton. The problem with this is that these proceedings are unlikely to be concluded before the middle of next year. Such delay does not appear to be justifiable.

I would be grateful if you could provide me with the information requested. I am happy to discuss the matter with you at any time. I do appreciate how demanding these cases will be of time and resources and it is good that you have already been in discussion with about his capacity to conduct the inquests.

Yours sincerely

Coroners Unit

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

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

Ministry of Justice
Coroners Unit
Steel House
11 Tothill Street
London SW1H 9LH

26 November 2007

Dear

Deaths At Gosport War Memorial Hospital:

Thank you for your letter.

I can confirm that all of the ten people mentioned in my letter of 15 June 2007 died at Gosport War Memorial Hospital which is within the administrative district of the Portsmouth and South East Hampshire Coroner's District. Of those ten, only three have been buried in the District (Sheila Gregory, Elsie Devine and Elsie Lavender), the other seven have been cremated. I interpret this as "destroyed by fire" as stipulated in Section 15 of the Coroners Act 1988.

I had attempted to describe in my earlier letter, and at the meeting we had in August, the reasons why I considered it desirable to hold Inquests into the deaths of the seven cremated people in addition to the three buried ones. In fact, precisely the same reasons would apply and I have enumerated these previously.

To assist you further, I enclose more detailed case summaries relating to each individual death which have been provided to me by the Police for your use. I hope you now have enough information for a Section 15 decision to be made.

As I explained at the meeting, the opening of Inquests into these ten deaths may well give rise to calls to open Inquests from the relatives of the other 12

Hampshire

persons whose deaths were investigated as part of Operation Rochester. None of the 92 deaths investigated by the police were ever reported to the then Coroner at the time of the deaths. All had elements to them suggesting that the circumstances of the deaths might not be entirely natural. It is obviously impossible to estimate how many other Inquests might have to be opened if relatives ask me for Inquests but the police share my concerns in this regard. Up to now, the families concerned have targeted the police with their concerns as they believed that the outcome of the investigations was going to be criminal prosecutions rather than Inquests and I have only had a small amount of contact – so far – with families. I enclose for your information copies of letters I have received so far from family members.

On the point of additional finance being made available by central government to supplement the resources of Hampshire County Council in staging these Inquests, I understand additional funding has been provided to Oxfordshire and Wiltshire County Councils to finance Inquests. Please could you confirm why Hampshire cannot be similarly assisted?

I look forward to hearing from you. Please contact me if you need any further information regarding the Section 15 consent.

Yours sincerely

David C Horsley
Tel:
Email:

Encs

Ministry of JUSTICE

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Code A

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David C Horsley LL.B
HM Coroner for Portsmouth and South East Hampshire
HM Coroner's Office
Room T20
The Guildhall
Guildhall Square
Portsmouth
PO1 2AJ

12 February 2008

Dear Mr Horsley

Operation Rochester: deaths at Gosport War Memorial Hospital

I am very sorry for the delay in considering your report on the above cases to the Secretary of State, dated 26 November 2007, with which you enclosed the additional copy documents that we requested on 21 August 2007.

The Secretary of State has now considered your report, and he has agreed to the issue of a direction for inquests to be held in respect of the deaths of:

Arthur Denis Brian CUNNINGHAM
Ruby Josephine Dorothea LAKE
Geoffrey Michael John PACKMAN
Leslie Charles PITTOCK
Helena Frances SERVICE
Enid Phyllis Dormer SPURGIN
Robert Caldwell WILSON

Please see enclosed the direction under Section 15, together with a copy for your records.

In your letter of 26 November you raised the question of additional, central funding being made available to Hampshire County Council for these inquests, on the basis that such funding had been provided to Oxfordshire and Wiltshire. Funding has been made available, exceptionally, from within central Government to the Oxfordshire coroner and Wiltshire and Swindon coroner solely because of the singular burden created by the decision to repatriate all overseas military fatalities initially via RAF Brize Norton, and since 1 April 2007 at RAF Lyneham.

I am therefore afraid that we cannot consider providing you or your local authority with any additional funds to deal with these cases.

Yours sincerely

To: David Horsley
Her Majesty's Coroner for Portsmouth and South East Hampshire

WHEREAS You, Her Majesty's Coroner for Portsmouth and South East Hampshire, in pursuance of section 15(1) of the Coroners Act 1988, have reported to the Secretary of State that you have reason to believe that the deaths of

Arthur Denis Brian CUNNINGHAM

Ruby Josephine Dorothea LAKE

Geoffrey Michael John PACKMAN

Leslie Charles PITTOCK

Helena Frances SERVICE

Enid Phyllis Dormer SPURGIN

Robert Caldwell WILSON

have occurred in or near your district, in such circumstances that inquests ought to be held, and that the bodies have been destroyed by fire;

NOW, therefore, in pursuance of the powers conferred by Section 15(2) of the Coroners Act 1988, the Secretary of State hereby directs you, the said Coroner, to hold inquests into the said deaths.

Coroners Unit

Ministry of Justice
12 February 2004

Your Ref:

31 October 2008

Dear Sirs

Deceased:

Further to my letter dated 7 October, I have now heard from Hampshire Police and and have discussed the circumstances of death with my Deputy, HM Coroner for North Hampshire) who will be conducting the Inquests into a number of deaths at Gosport War Memorial Hospital on my behalf.

As the circumstances of ' death appear to be from the information available to me, i.e. that sustained a fractured neck of femur following a fall and died from bronchopneumonia due to immobility following surgery to repair the fracture, then if death had been reported to me in the present time, I would have opened an Inquest into death irrespective of any other issues of the sort referred to by in letter to me of 23 October 2008.

Consequently, I am mindful to do so now. However, as body was cremated, I must first obtain the consent of the Secretary of State to do so under the provisions of Section 15 of the Coroners Act 1988. I shall be making the necessary application to the Secretary of State within the next few days.

If consent is forthcoming, it would be my intention to open Inquest at the earliest opportunity and to have it be the first in a series of

Gosport War Memorial Hospital Inquests which are scheduled to be held in March 2009.

I shall let you know the outcome to my application.

Yours faithfully

David C Horsley
Tel:
Email:

cc.

Det Supt D Williams
, Coroners Unit, Ministry of Justice

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

Coroner's Office
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Coroners Unit
Ministry of Justice
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102 Petty France
London
SW1H 9AJ

17 November 2008

Dear

Hampshire Police Operation Rochester – Death at Gosport War Memorial Hospital, Gosport:

I refer to the correspondence some months ago in relation to my being given consent by the Secretary of State pursuant to Section 15 of the Coroners Act 1988, particularly my letters of 15 June 2007 and 26 November 2007.

I have now received a request from a to open an Inquest into the death of was one of the 92 deaths at Gosport War Memorial Hospital looked at by Hampshire Police as part of Operation Rochester. died at the hospital on August 1998. death was not reported to the then-Coroner and was, in fact, registered by body was then cremated. Obviously, no autopsy was carried out.

From the evidence before me, were death to occur now, the circumstances surrounding it (i.e. died before recovering from an operation to repair a hip broken in a fall and may have suffered a subsequent fall post-operatively whilst in hospital) would persuade me to open an Inquest. Therefore, although died in 1998, now being in possession of these facts I do not believe it would be proper for me not to do so.

However, I am granted Law and legal authority to open an Inquest after a time without the consent of the Secretary of State under Section 15

I should be grateful, therefore, if this letter could be treated as my formal report/request to the Secretary of State to open and hold an Inquest into the death of

Although death was not one of those where a file was submitted to the Crown Prosecution Service by the Police under Operation Rochester, many of the considerations referred to in my letter of 15 June 2007 apply equally to

By way of additional information to assist the Secretary of State, I enclose copies of recent correspondence I have received from who has requested me to open an Inquest.

I understand that there is now an accelerated procedure for requests such as mine and I should be obliged if it could be applied in this case to allow ample time for an Inquest on to be included in the programme for the Gosport War Memorial Hospital Inquests scheduled to commence in mid-March 2009.

Yours sincerely

David C Horsley
Tel:
Email:

Encs

cc

Det Supt Hampshire County Council

MEETING ON DEATHS AT GOSPORT WAR MEMORIAL HOSPITAL

Ministry of Justice (MoJ), Steel House, 11 Tothill Street London SW1H 9LH
10.00 21 August 2007

Present:

David Horsley (DCH)	MoJ Coroners Unit (chair)
	HM Coroner, Portsmouth and SE Hampshire
ACC	Hampshire County Council (HCC)
Det Supt	Department of Health (DH)
	Hampshire Constabulary
	~~Hampshire Constabulary~~
	MoJ Coroners Unit
	MoJ Coroners Unit (note taker)

Introductions and background

welcomed those present. The purpose of the meeting was to determine what further action if any should be taken in connection with 10 deaths at the Gosport War Memorial Hospital (GWMH) in DCH's jurisdiction.

- DCH had written to on 15 June, to make a report under Section 15 of the Coroners Act 1988 about seven of the deaths (the decision on the other three lay with him), and to draw attention to the demand these cases would make on the coroner's resources.
- had come to give the Council's view of the resourcing issue and to explore the possibility of any further investigation taking the form of a public inquiry.

•

- attended as DH's Head of Investigations and Inquiries to outline medical investigations into the deaths to date and give a view of the prospects of future action on these lines.

The agenda was agreed as follows:

1. DCH – the background to his letter;
2. and – an update on the police investigation;
3. – the DH view;
4. DCH and coroner's view; council's view on resources; public inquiry issue
5. Agree next steps

1. Background

1. While acting as DCH conducted the Police Operation Rochester Major Crime

92 deaths investigated had been reported to the then Portsmouth coroner (though doctors today were much readier to check with the coroner). While 82 of the 92 did not pass the test for criminal investigation, many more deaths than the remaining 10 might well warrant an inquest, with its lower evidential hurdle. There were extremely serious resource implications for the coroner, and for the normal operation of the service in his district.

2. Update on police investigation

2. outlined the history and scope of Operation Rochester, which had begun when concern following the crimes of Harold Shipman was at its height. Some relatives had expressed concern over deaths in GWMH. One doctor, Dr had taken part in the care of all these patients and had prescribed opiates to them.

3. The first police investigation of the matter was later found to have been superficial and the officers had been disciplined. A second investigation raised considerable publicity and brought forward a second group of relatives who felt doubts but had not expressed them till then. A third group came to the police because their loved ones had died in GWMH and they wanted information to decide whether they should be concerned.

4. The second police investigation concluded, in consultation with the Crown Prosecution Service, that there was no likelihood of a successful prosecution. There were difficulties over the communication of this decision to the families and the Independent Police Complaints Commission investigated. The officer concerned had changed career. The families remained dissatisfied.

5. SW began the third police investigation in September 2002, bringing to it wide experience of homicide and healthcare-related deaths. He gathered all the allegations, covering a total of 92 deaths. He formed a panel of healthcare experts to review all the cases. The investigative process was quality assured by Field, Fisher, Waterhouse.

6. The panel found that in about a fifth of the deaths treatment had been appropriate and the cause of death was natural. In about two-thirds of cases care had been in some respect sub-optimal but this had not contributed to the death. In 14 remaining cases sub-optimal treatment may have led to the death.

7. These 14 cases, later reduced to 10 on further examination, became the subject of a full investigation in which evidence-gathering experts looked in detail for evidence to support charges of criminal culpability or gross negligence outlined the arguments of expert witnesses which are given in more detail in the Operation Rochester overview report. He confirmed that the cremation certificates had been carefully examined in each case.

8. Dr was interviewed under caution in respect of all the deaths and a second doctor, Dr was also interviewed about 2 of the cases. The police reports in respect of 10 cases went to the CPS. The CPS barrister concluded that in no case could criminal culpability or criminal negligence be proven, and there was no realistic prospect of conviction.

9. In December 2006 the police had informed the families of the decision. The papers had now been passed to the General Medical Council for any action it finds appropriate. Other than referral of papers to interested parties, the police investigation had now concluded. Their role was now to support the coroner. There remained a high level of public concern and media interest in the case.

3. The Department of Health view

10. explained that DH had received assurances that action had been taken to ensure patient safety. Dr was subject to appropriate clinical supervision and was not prescribing opiates

11. He explained that the prescribing climate had changed since the time of these deaths. In the late 1980s and the 1990's syringe drivers (which automatically deliver a prescribed dose at pre-set intervals) were much more widely used for pre-terminal patients than they were today. At the time they were seen as a labour-saving device and there would have been no clear-cut case of prescribing inappropriately. Since Dr had not been charged, the DH would await the outcome of a GMC fitness to practise hearing currently expected to take place in early summer 2008. He recognised that expectations had been raised among relatives and, via the media, in the community.

4. Coroner's view; council's view on resources; public inquiry issue

12. DCH explained his deep misgivings about handling these cases as inquests. The conduct of the doctors concerned was an issue, but so too was the management of the hospital. In his view that aspect went beyond the remit of an inquest. He also had concerns, if the inquest route were taken, about the enormous quantity of evidence and the large number of expert witnesses. Article 2 ECHR was clearly engaged, so the inquests would have to be before juries, but the size and complexity of the evidence was likely to go beyond the comprehension of a jury. He would give only one inquest to each jury, so would need to summon ten separate juries.

13.

Yet what could be done at an inquest would fall short of public expectation.

14. There were very large resource issues for the coroner, with each inquest probably some weeks long, venues to organise, attendance and re-attendance of the expert witnesses. The ordinary work of the jurisdiction would be very seriously affected. He could not organise these inquests with his present complement of admin staff and officers. Recently a 3-week inquest had caused problems in keeping the normal service going. A jury might well find unlawful killing, which would raise the issue of reopening the police case. He suggested that the public inquiry route would be a better way to address the public expectations. Its terms of reference could be set so as to achieve everything that inquests could.

15. affirmed HCC's responsibility to support the coroner. They would do so if inquests were ordered, but had serious concerns.

The council would support the best means of exposing the facts, and believed that a public inquiry was the best way to achieve that.

16. Discussion followed on the potential for a public inquiry:

- referred to the inquests into deaths at Kingsway hospital, Derby, when no public inquiry had been ordered. The DH would lead if an inquiry were ordered in the present case, and then, if a judicial public inquiry were ordered, the MoJ would lead. Central government would not consider this a case for a public inquiry. But the coronial system was not suited to this scope of inquiry.

- argued that a public inquiry was unnecessary. DH lawyers felt it would be wasteful of public money. All the doctors, including Dr had moved elsewhere, and Dr was already under GMC investigation. The DH knew of no major flaw in the organisation of the Health Authority. What was in question were the actions of individuals, whether any cause for concern was picked up, and whether procedures were in place to follow it up. The case was old, and at any public inquiry there would be conflicting evidence from clinicians about past and present practice. However, a review of the evidence would be welcome. The DH view was that these ten inquests should take place once the outcome of the GMC investigation was known.

- read Section 15 to the meeting. He said that the criteria of desirability must include such factors as resources and disruption to the coroner's normal service.

17. The meeting discussed what funding for the coroner might be available if the inquests were ordered.

- With regret, confirmed that MoJ had no resources to offer. In the Kingsway cases, Derbyshire County Council had met the expense. suggested I might discuss this with of Derbyshire.
- regretted that there was no avenue of DH funding for the inquests, although some contribution from the NHS might be a possibility. He would investigate whether any potential funding might have come out of the Shipman case.
- It appeared that the financial burden of any inquests would lie with HCC. , was not aware of any sources for a grant for this purpose. DCH, and agreed this would be a crushing expense for the council. If decisions not to hold inquests were to be judicially reviewed, that too would take time and money.

5. Next steps:

18. As a potential fallback DCH had written to the North Hampshire coroner, who might be willing to undertake the inquests if ordered.

19. would look into any post-Shipman sources of additional money. He would look into how the DH could bring coroners into the Memorandum of Understanding on medical criminal investigations which had been developed together with the Association of Chief Police Officers.

20. DCH asked that future consideration should be given to providing a backstop for coroners in circumstances like these. This was not addressed in the draft Bill.

21. would write to DCH setting out the further information required to reach a decision on the seven cases in the Section 15 report. The decision on the other three lay with DCH.

22. thanked those present. It was useful to have heard everyone's views. and were sorry that MoJ and the DH could not be more helpful to DCH and

Coroners Unit

28 September 2007

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-----Original Message-----
From:
Sent: 14 January 2003 11:11
To: Secretary of State (Submissions)
Cc:

Subject: Directions under s15 Coroners Act - Gosport War Memorial Hospital

The attached submission seeks your agreement to the issuing of directions under s15 of the Coroners Act, in respect of 7 deaths at Gosport War Memorial Hospital.

The further advice that you have requested, on the handling of applications under s15, will be submitted shortly.

Current Coroner Policy Team
Coroners Unit
5th Floor, Steel House

-------< CRCM Record Information -------

Record Number :
File : Submission re Directions Gosport War Memorial Hospital [illegible]

-------< CRCM Record Information -------

Please be aware that the Private Office will not be keeping a file copy of this e-mail or any attachment. It is the responsibility of the policy or business unit to ensure that documents are properly filed on EDRM and accessible to all who need them.

-----Original Message-----
From:
Sent: 18 January 2008 11:11
To: Secretary of State (Submissions)
Cc:

Subject: Directions under s15 Coroners Act - Gosport War Memorial Hospital

The attached submission seeks your agreement to the issuing of directions under s15 of the Coroners Act, in respect of 7 deaths at Gosport War Memorial Hospital.

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Current Coroner Policy Team
Coroners Unit
5th Floor, Steel House

-------< TRIM Record Information >-------

Record Number :
Title : Submission re Jurs re s15 orders Gosport War Memorial Hospital 18-01-2008

-------< TRIM Record Information >-------

Record Number :

FW: Op Rochester

From:
Sent: 14 August 2009 12:49
To:
Subject:

Thanks,

From:
Sent: 20 May 2009 15:31
To:
Subject: FW: Op Rochester - meeting confirmed - 21 August 2007 at 1000hrs

From:
Sent: 06 July 2007 10:17
To: 'Horsley, David'
Cc:
Subject: RE: Op Rochester - meeting confirmed - 21 August 2007 at 1000hrs

David

Many thanks for all your help.

From: Horsley, David
Sent: 06 July 2007 09:41
To:
Cc:
Subject: RE: Op Rochester

Thanks,
From the "Hampshire side", the attendees will be yourself, from the County Council (as representative of the Coroner Budget-holder) and myself.
Cheers,
D.

David C. Horsley
HM Coroner

FW: Op Rochester

and/or retained by Portsmouth City Council.

Email monitoring/blocking software may be used.

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