Ministry of JUSTICE

Submission

To: Lord Chancellor and Secretary of State for Justice

Date: .. January 2008

cc: Rod Clark, Kevin Sadler, Mary Pattison, Code A Code A Code A Special Advisers

From: Code A
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Subject: Section 15 Coroners Act 1988 – deaths at Gosport War Memorial Hospital

Issue

1. Applications under section 15 of the Coroners Act 1988 by David Horsley, the Coroner for Portsmouth and South East Hampshire, for directions to hold inquests into the deaths of seven patients at Gosport War Memorial Hospital, in addition to a further three which do not require such directions. The Coroner has written to Coroners Unit (letter of 15 June 2007 at **Annex A),** as these matters are generally dealt with by officials. You have asked for further briefing about the operation of this policy, which will be submitted shortly. In the circumstances of these cases, however, we consider it appropriate for you to deal with these applications.

Timing

2. Pressing. The Coroner needs to press on with holding the inquests, and he awaits a decision on section 15 before he is able to appoint an additional assistant deputy to hear them.

Recommendation

3. That you make the requested directions.

Argument

4. Section 15 of the Coroners Act 1988 enables a Coroner to report to the Secretary of State if he has reason to believe a death has occurred in or near his jurisdiction, in circumstances in which an inquest ought to be held, and owing to the destruction of the body by fire or otherwise, or it lying in a place from which it cannot be recovered, no inquest can be held. If the Secretary of State considers it desirable, he can then direct that an inquest should be held. There are no time limits for this.

5. The Coroner is applying for directions to hold inquests into the deaths at Gosport War Memorial Hospital of seven patients, whose bodies have been cremated. The Coroner has confirmed that the Hospital is in his jurisdiction and he interprets the cremation of the bodies as meeting the section 15 criterion of "the destruction of the body by fire." The bodies of a further three patients are buried in the Coroner's jurisdiction and do not therefore require directions for inquests to be held.

6. Consideration of whether to make directions under section 15 is usually guided to a large extent by the Coroner's views. Mr Horsley has misgivings about the scope of such inquests and the resource implications (see paragraphs 17-20 below). However, in view of the findings of the police investigations, he considers that he is under a duty to hold inquests because the provisions of sections 8(1)(a) and (b) of the Coroners Act - which require him to have reasonable cause to suspect that the deceased has died a violent or an unnatural death or has died a sudden death of which the cause is unknown - are met

7. In most cases directions under section 15 are exercised at official level – there are between 6 to 12 applications each year. However, in view of the high-profile of these cases, and the echoes of the Dr Harold Shipman case, they are being submitted for your consideration

Background

8. On 15 June 2007 Mr Horsley first applied for directions under section 15 of the Coroners Act 1988 to hold inquests into the deaths at Gosport War Memorial Hospital of seven patients, whose bodies have been cremated. The bodies of a further three patients – where inquests will also need to be held - are buried in the Coroner's jurisdiction and do not therefore require

directions for inquests to be held, although there will need to be exhumations.

9. The application followed an operation by Hampshire Constabulary ('Operation Rochester'), in which – during the period 1998 to 2006 - they conducted three separate investigations into the deaths of 92 elderly patients at the Hospital between 1989 and 2001. The investigations took place after concerns were expressed by family members about the standard of care, and allegations were made of unlawful killing. None of the deaths was reported to the Coroner at the time, as they were certified as natural by Hospital doctors and medical staff. The police investigations focused on the actions of one particular doctor, Dr Jane Barton. Dr Barton was a General Practitioner who worked part-time at the Hospital as a Clinical Assistant in Elderly Medicine, and she was responsible for prescribing and administering opiates and other drugs via syringe drivers.

10. The first two investigations were solely into the death of one patient, Gladys Richards, who had been admitted to the Hospital, under Dr Barton's care, for recuperation following a hip replacement operation at another hospital. Following her death, her daughters complained to the police about the treatment she had been given. On conclusion of both investigations the Crown Prosecution Service decided there was insufficient evidence for a prosecution.

11. In September 2002, after the second police investigation had taken place, nursing staff provided to the Hospital's management copies of documents dating back to 1991, which recorded their concerns about the increased mortality rate for elderly patients, the introduction of syringe drivers and their use by untrained staff, the use of Diamorphine, and the conduct of Dr Barton in relation to its prescription and administration. This information was passed on to the police, and prompted the third and wider investigation.

12. The third police investigation considered whether patients admitted to the Hospital for rehabilitative or respite care were inappropriately administered opiate-based drugs, which hastened or caused their deaths. Of the 92 cases investigated, 78 failed to meet the threshold of negligence required for a criminal investigation, and 4 were attributed to natural causes. The remaining 10, in all of which Dr Barton was the attending doctor, were

subject to full investigation. This included the use of medical experts to look for evidence of either criminal culpability or gross negligence. There was little consensus between the two principal medical experts as to whether the deceased were in irreversible, end-stage, terminal decline, or whether negligence more than minimally contributed to their deaths. The Crown Prosecution Service concluded that in none of the cases could either criminal culpability or gross negligence be proven, and there was therefore no realistic prospect of conviction.

13. During the period of the police investigations the General Medical Council (GMC) also considered on three separate occasions whether Dr Barton's registration to continue in practice should be withdrawn. They found no such requirement, and she continues to practice (under voluntary restrictions on the administration of opiate-based drugs). Following the conclusion of Operation Rochester, however, there is to be a further hearing on her fitness to practice, which is expected to be held this summer.

14. The Commission for Health Improvement (CHI) also reported on the Hospital in July 2002, in the light of the concerns expressed by the police and others about the standard of care for the elderly. The CHI made a number of recommendations, which are being taken forward by the local Primary Care Trust.

15. A meeting was held in August 2007 between the Coroner and representatives of the MoJ, the Department of Health (DH), the police and the local authority. A subsequent letter of 21 August to the Coroner asked for the submission of further information about the seven cases which require directions (**Annex B**). That has now been provided (Coroner's letter of 26 November 2007 at **Annex C**). A summary of each case is at **Annex D**.

Parliamentary handling

16. None from this submission.

Financial implications

17. None for the MoJ. Costs of inquests are met by local authorities. The Coroner and the local authority (Hampshire County Council) have expressed concern about the resource implications of these inquests and asked if there might be funding from the MoJ. Each case would need to be heard

separately. They would involve large amounts of evidence and large numbers of witnesses, and would need to be held before juries (Article 2 of the ECHR would be engaged). There would also be disruption to other business, although we understand that the Coroner is considering appointing a recently retired Coroner as an additional assistant deputy, in order to undertake these inquests.

18. It has been explained to the Coroner that central funding is not available from either the MoJ or the DH. He has queried this, on the basis of the additional funds made available centrally to the Oxfordshire and Wiltshire and Swindon Coroners to meet the costs of military inquests. Assuming that you agree to make the directions, when we send him these we will explain that funding has been provided to Oxfordshire and Wiltshire exceptionally, and jointly with the MoD, because of the exceptional, singular burden created by the decision to repatriate all overseas military fatalities initially via RAF Brize Norton and since 1 April last year via RAF Lyneham.

19. The Coroner also feels that if he holds inquests in these 10 cases, he is likely to come under pressure from family members of the other 82 patients whose deaths were investigated in Operation Rochester to hold inquests into their deaths as well. He feels this would be difficult to resist, and that he would be likely to face legal challenge were he to do so.

20. The County Council are concerned that just these 10 inquests could use up the entire annual budget for the coronial service (£800k). They and the Coroner feel a full public inquiry would be a better option, in terms of remit and meeting public expectation. DH, however, have already ruled this out, in view of the passage of time since the events in question, and the pending hearing into Dr Barton's fitness to practice. The DH's view is that inquests should be held after Dr Barton's further GMC hearing. However, the Coroner is under pressure from the families to commence the inquests, and a further delay would be difficult to justify.

Presentation and Media Handling

19. Operation Rochester and the other investigations into the deaths at the hospital and Dr Barton have attracted considerable media attention, both locally and nationally, and questions in Parliament. Parallels with the Shipman case have been drawn. The families of the deceased remain

unhappy about the way in which the investigations were conducted, and that no criminal charges have been brought. During the investigations, they formed an action group, and appointed to represent them Ann Alexander, the solicitor who represented the families of many of Dr Shipman's victims. It appears they are hoping for inquests leading to further action being taken. Should an inquest jury return a verdict of unlawful killing, this could lead to calls for the police investigation to be re-opened.

Code A

ANNEX D

SECTION 15 CORONERS ACT 1988
DEATHS AT GOSPORT WAR MEMORIAL HOSPITAL (GWMH)

CASE SUMMARIES

1. Arthur CUNNINGHAM

Date of birth	Code A
Date of death	26/9/98
Age at date of death	79
Time spent in GWMH	5 days
Cause of death	Bronchopneumonia

- 21/9/98 admitted to GWMH, under Dr Barton's care, because of bed-sores.
- Stepson was told Mr Cuningham would not survive.
- 22/9/98 was given 'something to quieten him down' after he became difficult.
- 23/9/98 stepson found him unconscious and on syringe driver. Nurse said only doctor could authorise removal.
- Stepson told Mr Cunningham was dying from poison from bed-sores, and drugs needed to continue for alleviation of discomfort.
- 26/9/98 Mr Cunningham died without regaining consciousness.

Operation Rochester conclusions

- Dr Barton breached the duty of care.
- Standard of care was sub-optimal (as per GMC guidance).
- Excessive doses of Diamorphine and Midazolam were administered on 25&26/9/98 and may have shortened life.
- Medical notes were inadequate.
- Unclear why syringe driver used.
- Reasons for increased doses of Diamorphine unclear.
- Other strategies could have been considered.

2. Ruby LAKE

Date of birth	Code A
Date of death	21/8/98
Age at date of death	84
Time spent in GWMH	3 days
Cause of death	Bronchopneumonia

- 18/8/98 admitted to GWMH and transferred to Dr Barton's care, as part of recuperation from hip replacement operation.
- Nursing care plan described her as settling quite well.
- 18&19/8/98 morphine administered via syringe driver, prescribed by Dr Barton.
- 19/8/98 Mrs Lake complained of chest pain.
- 20&21/8/98 further administration of morphine via syringe driver.
- 21/8/98 Mrs Lake died.

Operation Rochester conclusions

- Dr Barton breached the duty of care.
- Standard of care was sub-optimal (as per GMC guidance).
- Medical notes inadequate.
- No documentation why morphine prescribed.
- No assessment of Mrs Lake's chest pain.
- No justification for use of syringe driver.
- No justification for increased doses of Diamorphine.
- Lack of documentation made it difficult to establish cause of rapid deterioration, or to confirm Mrs Lake was in terminal stage of life.

3. Geoffrey PACKMAN

Date of birth	Code A
Date of death	3/9/99
Age at date of death	67
Time spent in GWMH	11 days
Cause of death	Myocardial infarction

- 23/8/99 admitted to GWMH for recuperation and rehabilitation after a spell in another hospital, in Portsmouth, because of weeping leg sores.
- Family reported him as happy and settled.
- 25/9/98 recorded as passing blood and vomiting.
- Wife told he was going to die, and later that had had heart attack.
- 26/8/98 Dr Barton diagnosed possible myocardial infarction, and prescribed Diamorphine and Oramorphine.
- 27/8/98 some improvement noted.
- 28/8/98 Mr Packman described as very poorly, with no appetite.
- 29&30/8/98 sleeping for long periods, but some appetite.
- 31/8/98 passed a lot of blood rectally.
- 1/9/98 drugs in syringe driver increased, and again next day.
- 3/9/98 Mr Packman died.

Operation Rochester conclusions

- Dr Barton breached the duty of care.
- Standard of care was sub-optimal (as per GMC guidance).
- Suspected gastro-intestinal haemorrhage in Portsmouth hospital not been followed up.
- Bleed from pressure sores not attended to.
- When identified as seriously ill, examination either not undertaken or not recorded in notes.
- Difficult clinical decision was made without discussion with senior colleagues.
- Prescription, management and use of drugs unacceptably poor.
- No justification for higher than normal starting dose of Diamorphine.
- Prescribed morphine doses excessive for Mr Packman's needs.
- Mr Packman's deterioration was possibly due to potentially reversible cause (gastro-intestinal haemorrhage), which could have been managed by transfer to acute hospital.

4. Leslie PITTOCK

Date of birth	Code A
Date of death	24/1/96
Age at date of death	82
Time spent in GWMH	42 days (19 days under Dr Barton)
Cause of death	Bronchopneumonia

- 13/12/95 admitted to GWMH elderly mental health ward (Mr Pittock had a history of depression and had been cared for in a residential home).
- 5/1/96 transferred to elderly general ward for long-term care, following physical deterioration.
- 9/1/96 increased agitation and anxiety noted.
- 10/1/96 Oramorph commenced.
- 15/1/96 syringe driver commenced.
- 16/1/96 Haloperidol (anti-psychotic medication) added.
- 17/1/98 Dr Barton changed doses of medication and added second syringe driver.
- 18/1/96 Nozinan (anti-psychotic medication) added.
- 20/1/96 Haloperidol discontinued, Nozinan doubled.
- 24/1/96 Mr Pittock died.

Operation Rochester conclusions

- Dr Barton breached the duty of care.
- Drug management and record keeping was sub-optimal (as per GMC guidance).
- Not clear why Dr Barton apparently – and inappropriately - prescribed opiates for anxiety and agitation, or pain in hand.
- Medical notes do not record explanation for opiates or use of syringe driver.
- Doses prescribed were excessive.
- Doses may have contributed to his death.
- No recorded explanation for changes in dosage or discontinuance of drugs.
- Physical pain suffered by Mr Pittock not properly assessed.

5. Helena SERVICE

Date of birth	Code A
Date of death	5/6/97
Age at date of death	99
Time spent in GWMH	2 days
Cause of death	Congestive cardiac failure

- 3/6/97 admitted to GWMH, under Dr Barton's care, on transfer from another hospital (where she had been admitted for back pain, bed sores and a chest infection; she had a history of cardiac problems and diabetes).
- Her discharge notes from the previous hospital recorded her as being well, but in a degree of heart failure.
- Her medication was continued at GWMH, but Diamorphine was added.
- 4/6/97 recorded as having failed to settle during the night, and a syringe driver was commenced.
- Medication doses increased.
- A friend who visited Mrs Service was told by a nurse she had been 'given something to make the journey more comfortable'.
- 5/6/95 Mrs Service died.

Operation Rochester conclusions

- Assessment of Mrs Service's condition on admission to GWMH was inadequate.
- Medical notes fell below acceptable standard.
- Dosages of Diamorphine, Midazolam (sedative drug) and Hyoscine (to dry secretions) not adequately justified.
- May have contributed to her death.
- Blood test confirmed renal impairment and low potassium, which could have been reversed with appropriate treatment.

6. Enid SPURGIN

Date of birth	**Code A**
Date of death	13/4/99
Age at date of death	92
Time spent in GWMH	18 days
Cause of death	Cerebrovascular accident

- 26/3/99 admitted to GWMH for recuperation, following an operation on her hip at another hospital.
- She was post-operatively mobile, with assistance, and her only medication was Paracetamol. She had a small bed-sore on her right leg.
- On admission to GWMH she was recorded as not weight-bearing, and being in constant pain.
- 26 or 27/3/99 Oramorphine commenced.
- Medication changed by Dr Barton.
- 31/3/99 walked with assistance, but in a lot of pain.
- 4/4/99 operation wound infected, antibiotics prescribed by Dr Barton.
- 7/4/99 recorded as being in a lot of pain. Dosage of morphine increased, and medication for schizophrenia commenced.
- 12/4/99 recorded as being very drowsy since commencement of Diamorphine by syringe driver. Diamorphine dosage reduced by another doctor.
- 13/4/99 Mrs Spurgin died.

<u>Operation Rochester conclusions</u>

- Dr Barton (and another doctor) breached the duty of care.
- Standard of care was sub-optimal.
- Lack of clear, accurate records.
- Inadequate assessment of Mrs Spurgin's condition.
- Lack of consultation with colleagues when her condition deteriorated; other diagnoses and treatments not considered.
- Excessive use of medication.

7. Robert WILSON

Date of birth	Code A
Date of death	18/10/98
Age at date of death	75
Time spent in GWMH	4 days
Cause of death	Congestive cardiac failure, renal failure, liver failure

- 14/10/98 transferred to GWMH from another hospital, under Dr Barton's care, for continuing care following a fracture of his left arm.
- Notes record his history of alcohol problems, heart failure and oedema.
- Paracetamol (prescribed at previous hospital for analgesia) discontinued, and Oramorphine prescribed by Dr Barton.
- 15/10/98 recorded as settled.
- 16/10/98 recorded as having deteriorated overnight.
- Syringe driver commenced.
- 17/10/98 suction for chest secretions.
- 18/10/98 further deterioration recorded, Diamorphine dose increased. Regular suction required.
- Mr Wilson died.

Operation Rochester conclusions

- Dr Barton (and another doctor) breached duty of care.
- Standard of care was sub-optimal (as per GMC standards).
- Lack of clear note keeping.
- Inadequate assessment of Mr Wilson; no pain assessment.
- If clinical examinations were undertaken, not recorded.
- Decision to commence opiate analgesia not recorded or justified.
- Treatment provided was excessive to his needs.
- Use of syringe driver and dosage of morphine difficult to justify.
- Causes of death as recorded on Death Certificate probably inaccurate.