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:

Code A	MoJ Coroners Unit (chair)
David Horsley (DCH)	HM Coroner, Portsmouth and SE Hampshire
Karen Murray	Hampshire County Council (HCC)
Code A	Department of Health (DH)
ACC Steve Watts	Hampshire Constabulary
Det Supt Dave Williams	Hampshire Constabulary
Code A	MoJ Coroners Unit
	MoJ Coroners Unit (note taker)

Introductions and background

Code A 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 Code A 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.
- KM 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.
- SW, Assistant Chief Constable of Hampshire Constabulary, attended as he had been the Senior Investigating Officer 2001-2003 on Operation Rochester (the investigation into these 10 deaths and 82 others at the GWMH).
- DW had been Operation Rochester SIO from May 2004 to December 2006 when the third police investigation concluded.
- CP 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. **SW and DW - an update on the police investigation;**
3. **CP - the DH view;**
4. **DCH and KM – coroner's view; council's view on resources; public inquiry issue**
5. **Agree next steps**

1. Background

1. While writing to Code A DCH had realised the scale of Operation Rochester. None of the

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. SW 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 Barton, 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. DW 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 Barton was interviewed under caution in respect of all the deaths and a second doctor, Dr Reid, 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 rôle 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. CP explained that DH had received assurances that action had been taken to ensure patient safety: Dr Barton 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 Barton 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. He thought it dangerous to consider only these 10 cases. Other families would call for inquests and he could not see how to resist. There would be judicial review cases against him. 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. KM affirmed HCC's responsibility to support the coroner. They would do so if inquests were ordered, but had serious concerns. The whole Hampshire budget for the normal coroner service was some £800,000, and these ten inquests would cost at least that. 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:

- JB 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.
- CP argued that a public inquiry was unnecessary. DH lawyers felt it would be wasteful of public money. All the doctors, including Dr Barton, had moved elsewhere, and Dr Barton 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.

- BP 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, JB confirmed that MoJ had no resources to offer. In the Kingsway cases, Derbyshire County Council had met the expense. She suggested KM might discuss this with David Tyso of Derbyshire.
- CP 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. KM was not aware of any sources for a grant for this purpose. KM, DCH, SW and DW 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 Andrew Bradley the North Hampshire coroner, who might be willing to undertake the inquests if ordered.

19. CP 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. BP 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. JB thanked those present. It was useful to have heard everyone's views. She and CP were sorry that MoJ and the DH could not be more helpful to DCH and KM.

Coroners Unit

28 September 2007