In the matter of the Gosport War Memorial Hospital Inquests

INSTRUCTIONS AND BRIEF TO COUNSEL

Counsel is instructed by [redacted] of Mills & Reeve 78-84 Colmore Row, Birmingham B3 2AB. Telephone number: [redacted], mobile number: [redacted] Email [redacted]

1 Counsel is instructed to:

- review the evidence,
- advise in conference (provisionally booked for 26th or 30th January in Portsmouth),
- advise on the telephone (On Thursday / Friday 15/16 January)

Counsel is also briefed to represent Portsmouth Hospitals NHS Trust ("PHT") at the forthcoming Inquest into 10 deaths to be held at the Combined Court Centre in Portsmouth and listed to commence on 18th March at 10:00 hours. The matter is listed for 6 weeks.

2 Counsel is also asked to note that instructions include representation and assistance to the management and medical staff involved in this matter. The nursing staff are advised by the Royal College of Nursing and it is understood that they will be separately represented at the Hearing.

3 Counsel will see as she considers these instructions that Hampshire PCT are also involved in this inquest. We anticipate that counsel will also hear from solicitors representing the PCT and that a joint conference will take place.

4 We have arranged for the following people to be available at the conference:

- [redacted]
- [redacted] (of Mills & Reeve)

- Dr Reid
- Dr Logan
- Peter Mellor (Trust Board Secretary PHT)
- Elaine Williams (Complaints and Litigation Manager Hampshire PCT)
- Kiran Bhogal (from Weightmans representing Hampshire PCT)
- Lesley Humphrey (relevant service manager until December 2008)

Clearly if counsel wishes to see any one else at conference we would ask that we be advised as soon as possible.

5 We believe that much of the preparation has new been completed although we would ask counsel to note that we only received instructions twelve weeks ago and if counsel feels that further investigations or matters need to be put in hand then we would be pleased to discuss this during our telephone discussion.

Documentation

6 With these instructions Counsel will find eight bundles of documents to include the following: -

- Witness statements taken by the Police, pursuant to original investigations. These are separately indexed. The statements are marked either Rule 37 or Evidence to be given orally. [folders 1(a) (b) (c)].
- Indexed folder of summaries of the witness and expert statements produced by your instructing Solicitors. [folder 2]
- A folio of documents marked "documents". This folder is separately indexed and includes additional evidence from the PHT which it is proposed we provide to the Coroner, along with various documents including note of a Pre-Hearing Inquest and investigation into this issue by the Commission of Health Improvement completed in July 2002. [folder 3]
- "Client evidence" held by Hampshire PCT and PHT. This is also separately indexed and contains documents selected by your instructing Solicitors and

provided by the NHS from folders held by the PCT and the PHT. This bundle also contains an index of additional documentation held by the PCT (Section 1). Your instructing Solicitor has not obtained copies of these at this stage but the NHS has agreed to keep these documents safe, in case they are required. [folder 4]

- A folio of documents separately indexed containing details of controlled drug administrations to patients along with relevant extracts from the controlled drugs register and from the medical records. Relevant entries are annotated. [folder 5]

Background

7 This is a high profile Inquest which refers to prescribing practices at the Division for Medicine for Older People (DMOP) in the late 1990's and particularly on Dryad and Daedalus wards at the Gosport War Memorial Hospital ('GWMH') This issue has, over the years, attracted considerable negative media attention and has had, and continues to have, a significant negative impact on staff of all levels employed by Portsmouth Hospitals NHS Trust (PHT). There are significant governance implications.

In May 2008 Jack Straw, Home Secretary, ordered an Inquest into the deaths of 10 elderly people who died at GWMH in the late 1990's. Prior to this the Hampshire Police were involved in a total of 3 investigations following an original complaint in the late 1990's. The final police investigation was significant and covered the deaths of around 90 patients where there were concerns about the prescribing practice of a GP (Dr Barton) who provided medical cover at GWMH. The relations of some of those who died suggested that high doses of Morphine and other drugs led to the deaths of family members and could be seen as some form of "euthanasia". Following the police investigation no criminal proceedings were brought. A General Medical Counsel (GMC) investigation has been undertaken and Dr Barton is to face a GMC Hearing later this year.

It is not entirely clear why the Ministry of Justice (MOJ) has decided to order an Inquest nearly 10 years after many of the deaths. It is thought likely that there has been significant pressure from the families who were originally pressing for a public inquiry. We understand that this avenue has been rejected by the MOJ.

Management of the service

8 DMOP is now managed in its entirety by PHT. At the time in question the clinical services were provided on Dryad and Daedalus wards by 2 different management teams. The nurses were managed by the Gosport and Fareham Division of the Portsmouth Healthcare Trust and the doctors by the Department of Medicine for Elderly People, also part of the Portsmouth Healthcare Trust. There was a significant reorganisation in April 2002 when the Healthcare Trust was dissolved and the management of the medical services for the two wards transferred to East Hampshire PCT, the management of the nursing services to GWMH and the management of the hospital building was with the Fareham and Gosport PCT. It was not until October 2006 that management of the entire DMOP was brought under the one organisation (PHT).

9 The changes in management will prove confusing to those involved at the Inquest and complicates the handling of this matter, and also investigation and explanations to be put before the Coroner and into the public domain. More information on the changes can be found in the statements and documents in binder 3.

Medical cover at GWMH

10 At the time of the deaths in question a Dr Jayne Barton (a local GP) was employed by the Healthcare Trust to work as a Clinical Assistant and provided junior medical cover. Dr Barton worked nominally under the guidance of Consultants (particularly Dr Ian Reid), though it would seem that day to day supervision was minimal.

11 Dr Barton would visit Dryad and Daedalus wards regularly but during the evenings and weekends, cover was provided by an out of hours service. At the time of the deaths Dr Barton performed most of the prescribing undertaken.

12 At the time in question staff used a booklet known as the "Wessex Guidelines" (binder 4) which set out guidelines for prescribing drugs to manage pain. It would seem there was a lack of clarity over prescribing practice and the main issue subject to the investigations so far concerns the fact that Dr Barton often prescribed a range (20 - 200 mgs) of Diamorphine. This was intended to permit nursing staff to drawdown Diamorphine and administer as appropriate when no clinical staff were present.

13 Subject to confirmation, we understand this may have been "accepted" practice and may have been approved "on the nod". Further comments are being sought on this particular point from Dr Ian Reid and can be explored in conference. The Consultants employed as 'experts' by Hampshire Police are critical of this practice regarding it as exposing patients to unnecessary risk of an overdose. However the police indicate that one of the reasons why a prosecution was never commenced reflected the fact that in spite of the prescribing procedures there was, in fact, no real evidence of over administration of the drug.

14 One of the criticisms of Dr Barton was a failure to communicate properly with the families. Issues arose because families had erroneous expectations for their relations admitted to Dryad and Daedalus wards. Often very elderly patients were transferred to these wards for "end of life care". This fact was poorly communicated to families who felt that their relations were admitted for rehabilitation. It would seem therefore that the deaths of relations sometimes came as a surprise.

Initial investigations

15 Matters were initially investigated because of a complaint in August 1998. This initial complaint (which in fact was not one made by relatives of any patient subject to the Inquests) was handled in such a way by the NHS that one of the patients' relations complained to the Police. Following initial police investigations there was subsequent high profile media coverage of "issues" at GWMH which led to a flood of complaints and enquiries. These were investigated on an individual basis as, initially, no common themes to the complaints or more general concerns were identified.

16 Unfortunately one of the families felt that the initial police investigation was not detailed enough and there followed complaints to the Police which led to a second investigation and eventually to a third, full scale investigation involving up to around 90 patients.

CHI Investigation

17 During subsequent police investigations more general themes were identified by the NHS management and issues became clearer. Concerns over the prescribing practice mentioned above and management at GWMH were referred, in 2001, to the Commission for Health Improvement. CHI undertook a complete review of the service provided by DMOP.

18 CHI's review included a vast number of documents and medical records as well interviewing 36 patients, friends and relations and 59 members of staff. External and independent agencies were consulted.

19 CHI reported in July 2002 (binder 3) and concluded that a number of factors led to a failure of systems designed to ensure good quality patient care. A number of detailed recommendations were made which were much more wide ranging than just prescribing practice and, in addition, reflected problems with management, training, prescribing guidelines and service provision.

20 As a result a management group at the then PCT was charged with creating and implementing detailed action plans and changes to the service and these were put in place by the various NHS organisations involved and it appears assurances were given to the Strategic Health Authority in 2004.

21 It does not appear, on the evidence to hand, that either the CHI report or the police investigations demonstrated a "causative link" between the prescribing practice and actual deaths of any patients. The CHI report says:

> *"Though CHI is unable to determine whether these levels of prescribing contributed to the deaths of any patients, it is clear that had adequate checking mechanisms existed in the trust, this level of prescribing would have been questioned"*

Relevant patients

22 The Coroner has identified the following patients to be the subject of the inquest:

- Gladys Richards – Daedalus ward – died August 1998
- Helena Service – Dryad ward – dob **Code A** died June 1997
- Elsie Lavender – Daedalus ward – died 6 March 1996
- **Code A**
- Elise Divine – Dryad ward – died 1999
- Ruby Lake – Dryad – died August 1998
- Arthur Cunningham – Dryad ward – died 26 September 1998
- Robert Wilson – Dryad ward – died 18 October 1999
- Sheila Gregory – Dryad ward – died 22 November 1999
- Enid Surgin – Dryad ward – died 13 March 1999
- Geoffrey Packman – Dryad ward – died September 1999.

23 We are not entirely certain how these patients have been selected and our enquiries have drawn a blank on this question. We do know that there are additional families, some of which have been quite active in the past, whose relations are not on this list. The Coroner has resisted pressure to add to this list.

The Steering group

24 When it became clear to the NHS organisations in Hampshire that inquests were to be held, a 'steering group' was established to include all relevant stakeholders in the NHS in the county. The main stakeholders were Hampshire PCT ["PCT"] and PHT. Initial aims were agreed and noted to be:

> *"to manage the Coroner's inquests effectively in order to maintain the continuity, quality and confidence of local people in health services at Gosport and to support [staff] that have to continue to deliver this care".*

25 PHT did not receive notification of the pre-inquest hearing. One of the doctors was notified and it is unclear why this was not brought to the attention of PHT or the steering group. Unfortunately therefore, it has not been possible to input into the pre-inquest hearings to date. Another hearing has been set for Monday 19th January and your instructing solicitor intends to be present. Counsel is asked to speak with Stuart Knowles on the phone. A time is being arranged with the clerks.

"Liability"

26 Prior to our instruction there was a lack of clarity as to which NHS body was now 'liable' for matters at GWMH in the late 1990's. Problems arose because of the transfer of various parts of the service to various PCTs and finally to PHT as outlined above. We were instructed to advise.

27 Following extensive investigations we located a copy of "The East Hampshire Primary Care Trust (Transfer of Staff, Property, Rights and Liabilities) Order 2006" (binder 3). The transfer schedule drafted and attached to the Order was of no assistance. However interpretation of the document as a whole showed that 'liability' for the service in the 1990s remained with Hampshire PCT. PHT were advised.

28 Having said that the PHT continue to be actively involved as they are the current managers of the service and the employers of the staff called by the Coroner. PHT are taking an active interest in the management of this inquest including legal input, media relations and support for staff.

Representation

29 Your instructing Solicitor has been instructed by Portsmouth Hospitals NHS Trust (PHT) to represent the Trust and the various management staff. We have also been requested by the Medical Protection Society to assist Dr Logan. Dr Logan appeared on the original list of witnesses produced by the Coroner, but has been left off the latest list (folder 3). The Trust has requested that we give assistance to Dr Ian Reid who remains a Consultant in DMOP and was at the time the relevant Medical Director. We anticipate that the nursing staff will be represented by Counsel instructed by the RCN and we anticipate representation for various members of the family; the Medical Defence Union on behalf of Dr Barton, and Field Fisher Waterhouse on behalf of the GMC. It is not entirely clear at the moment how many other interested parties and families are likely to be represented.

Liaison with the Coroner

30 We are in direct contact with the Coroner and the following points and should be noted:

- The Coroner has accepted our view that Human Rights are not engaged. The Inquest is not therefore an Article 2 Inquest. The Inquest is limited to considering who died, where they died, when they died and how they died. Prior to our involvement all parties had been advised and considered it to be an Article 2 inquest. This included the families and their lawyers. The Coroner accepted our submission that it was not, nor could it have ever been the case. The Human Rights Act 2000 was not in force at the time of the deaths and the case of *Commissioner of Police for the Metropolis v Christine Hurst [2007] ILR 29, House of Lords* confirmed this point.

- The Coroner has decided to sit with a jury. Although we were not present when this decision was made we are of the view that this is because of the high profile nature of the case clearly under section 8 (4) of the Coroner's

Act 1988 the Coroner has a residual discretion to summon a jury if he believes there is any reason to do so.

- We have requested the Coroner to make sure all other parties are informed about the Human Rights point to avoid confusion.
- The Coroner agreed to advance disclosure of witness statements and made this available (3 lever arch files of 88 witness statements were disclosed by him – folders 1 (a) – (c)).
- The absence of PM reports was confirmed (in all but one case).
- The Coroner has confirmed that he does not intend to copy medical records to the jury. He is keen to avoid 'information overload' as far as they are concerned. He may make relevant entries available, as necessary, during the hearing.
- He has agreed to schedule the witnesses as soon as possible and notify the running order to us.
- He has agreed to set a second pre-inquest hearing (19 January at 10:00 hours).

31 We would ask counsel to note that, during an informal telephone conversation with the Coroner, he has indicated that, in his view, the Inquest will not be wide-ranging and this will not satisfy the family. Your instructing solicitor has always taken this view. We understand the Coroner has written to the MOJ suggesting a public inquiry. We are hopeful that this will be rejected.

32 In anticipation of the pre-inquest hearing on 19th January 2009, the Coroner has provided us with a new witness list (folder 3). Counsel is asked to consider this carefully and advise and we will discuss with the Coroner at the pre-inquest hearing. Although it is not for us to conduct the Coroner's inquiry, and we would hesitate before suggesting additional staff be called, we are mindful that the 'smooth running' of the main hearing is in everyone's interests.

33 The current witness list is as follows:

WITNESS	ROLE
Code A	
HAMBLIN,Gillian	Ward Sister (separately represented)
BARRETT,Lynne	Staff Nurse (separately represented)
LAVENDER, William	Son of Elsie Lavender
JOINES, Sheelagh	Staff Nurse (separately represented)
TUFFEY,Alexander	Nephew of Helena Service
TUBBRITT, Anita	Staff Nurse (separately represented)
FARTHING, Charles Stuart	Step son of Arthur Cunningham
TURNBULL, Beverley	Night Shift (separately represented)
WILSON,Iain	Son of Robert Wilson
WILSON,Neil	Son of Robert Wilson
JEWELL, Carl	Nephew – Enid Spurgin
PACKMAN,Victoria	Daughter – Geoffrey Packman
Code A	Elsie Devine
REID, Richard	Consultant (to be represented by Trust)
GREGORY,Pauline	Granddaughter of Sheila Gregory
Professor BLACK	Expert
Dr WILCOCK	Expert
BARTON, Jane	GP (separately represented)

In addition we may want to ask the Coroner to consider calling:	
Lesley Humphrey	Divisional General Manager
Dr Logan	Consultant Physician in Geriatrics
	(Both to be represented by PHT if called)

Counsel will see that at the moment only Dr Reid is being called to give evidence and being supported by PHT and your instructing solicitors. His police statements are in the evidence disclosed for the patients Elsie Devine and Sheila Gregory. In addition a statement is being prepared by Lesley Humphrey to put the matter into context for the Coroner and to avoid any possibility of Rule 43 correspondence and reporting. Counsel will find her draft statement in bundle 3. If counsel has a advice on this proposal we would be pleased to discuss.

Expert evidence

34 We have undertaken a provisional review of the expert evidence recently disclosed by the Coroner. The main experts are Professor Black (physician and palliative medicine) and Dr Wilcock (palliative medicine and medical oncology) as listed above. The experts were instructed to comment on criminal matters and to a large extent their reports criticise the standard of care provided as against the criminal or professional standards that apply and concentrates on criminal intent and the conduct of the doctors falling below a reasonable standard (or not) and potentially exposing the patients to risk. That is, of course, entirely different to advising on 'how' someone met their death.

35 We have produced a summary of their evidence for each patient and this is included in folder 1. Upon review of their evidence generally there appear to be recurring critical themes:

- They regard elements of care as a "breach of duty" and "out-with the GMC guidelines of professional standards of care". Interestingly Dr Ian Reid (Consultant) is criticised in at least 2 cases.
- There is inadequate clinical note taking.

- There are inadequate clinical assessments and a lack of evidence of appropriate assessments.

- They are unclear as to how patients are assessed in "terminal decline" rather than having a temporary recoverable condition. (this refers to the point that Dr Barton's communication with patients was poor [see paragraph 7] and that the note taking was inadequate).

- They criticise a lack of basic observations.

- It is suggested that they "cannot exclude" the effect of the drug regime as a cause of death for some patients. The prescriptions of drugs may have "shortened life" in some cases. By how much is unclear. They say it could have contributed to death more than is "minimal or negligible". On the other hand the experts conclude that any negative effect may only be for a few hours or days. They also confirmed that the drugs may have the effect of shortening life although, as is well known and common practice, the intention is to relieve distress and not to shorten life.

- Some prescriptions of drugs are excessive for the patient's needs. There is a lack of explanation or inappropriate explanation for the drugs used.

- There is a failure to follow "the analgesic ladder". Your instructing Solicitor believes that Diamorphine and other opiates should be provided in increasing doses to escalate their effect as the patient's condition deteriorates and as their body gets used to the drug.

- It is suggested in some reports the drugs may have been prescribed "*intending*" to shorten life. We are not sure there is evidence to show that it had this effect. We a not entirely clear what is meant by this statement nor upon what evidence it is based. Considering the other criticisms made we are not sure how its adds to the evidence other than to raise the uncomfortable use of the concept of "intention".

- Inappropriate use of syringe drivers and inappropriate use of boosters causing excessive/erratic delivery.

- Lack of clarity on occasions as to the relevant consultant in charge.

- Poor communications with relations.
- Lack of post mortem examination report being unhelpful.

36 Of course not all these criticisms apply to each and every patient but they are some of the main themes which we have drawn out of various reports. We accept that the experts were originally instructed not for the purpose of advising the Inquest and clearly we need to consider how to draw out of them their view as to how these patients met their death and whether they can say, on balance, whether a particular patient had died from the natural disease process or was their death caused by the drug and if so was it more than the incidental effect of a dose of Diamorphine intended to relieve pain and stress?

37 We expect detailed comments from Dr Ian Reid this week. In the meantime he has told us informally:

- he agrees that note keeping was poor
- he rejects suggestions of gross negligence on his part.
- he questions the relevant experience of the experts and particularly Dr Wilcock. GWMH was dealing with particularly elderly and poorly patients with serious co-morbidities and he wonders whether patients like this might be outside his direct area of expertise.

<u>Liaisons with the police and medical records</u>

38 We have obtained access to the essential medical evidence seized by them from the NHS. The Police provided us with a summary of relevant 'administrations' of diamorphine and other relevant drugs and they provided us with copies of relevant entries from the nursing and medical records. We were also given a list of exhibits setting out the other documents held by the Police. We have considered this list and have requested copies of some documents which might assist

39 The original medical records are being returned to the PCT and so we have easy access.

NHS Documentation

40 We have been made aware of additional documents available within the NHS. Though it was our understanding (which we believe has proved correct) that most of the relevant documents were seized and held by the Police.

41 Some documents have been copied and the remaining documents have been listed (binder 4). We understand that there might be further documents available and we are seeking clarification from the PCT on this point.

42 Your instructing solicitor feels at this stage that we have all the necessary documents. If on discussion with counsel or during the hearing issues arise which require answering, the lists which we have will allow us to determine quickly if further documents might be available to help.

Additional evidence for the Coroner

43 As this is not a Human Rights inquest it is our view that we should limit the evidence to suggest to the Coroner that he considers to three main issues:

- to assist him in determining 'how' these patients met their deaths
- to put the work on DMOP and GWMH into context to aid understanding
- to avoid a Rule 43 letter requesting changes / review of the service and which would be published to the government (and almost certainly be made public straight away).

44 Instructing Solicitors are of the view (one apparently shared by the Coroner) that the evidence should be kept as straight forward as possible. Although we appreciate that staff may feel 'on-trial' and the media coverage might be negative, we should remember that the NHS and its systems are not on trial here.

45 Counsel will find in the papers (bundle 3) the following additional evidence with a view to a discussion on it being released to the Coroner and to the other parties:

- A witness statement of Lesley Humphrey
- CHI report response for PHT. (We anticipate the PCT might have a similar document but we do not have a copy and are unaware of its current status)
- Time line
- Summary of changes to the organisational structure at DMOP/ GWMH
- Comments from the PHT Pharmacist
- Comments from Dr Ian Reid

Liaison with RCN & Defence organisations

46 We have advised Dr Logan in a staff meeting and Dr Reid in person. We have been approached by solicitors for the MPS and asked to help Dr Logan and Dr Lord. We have agreed to assist Dr Logan, though we understand Dr Lord is in New Zealand and will not be attending. It now appears that Dr Logan is no longer being called.

47 There is a potential conflict with some nursing staff as nurses raised concerns in 1991 which were poorly handled at the time. These events were some six years before the issue under consideration. We have spoken with the RCN Solicitor and his department perceives a risk to one of their members. We do not know which one or what that risk might be or whether it would materialise. We have not speculated but have agreed with the RCN that, if that is their view, then they should instruct separate counsel.

48 We have agreed with the RCN that it would be in the interests of the PHT and the staff for the lawyers to liaise during the Inquest and take a 'joint' approach and avoid 'difficult questions'. We are hopeful that will be achieved with proper handling.

Other Issues

49 Counsel needs to be aware of one or two other issues upon which instructing Solicitors are advising and upon which comment maybe sought.

- Media relations. Counsel is referred to folder 3 and documents showing the communications plan. We are involved in producing media briefings for staff and for the media and also fast facts and Q&A documentation. Counsel may be asked by the client to consider the impact that this may have on the Inquest or vice versa.

- Conflict. As counsel will have noted from the above, there has been considerable discussion with the client concerning conflict with the nursing staff. This has arisen because nursing staff in 1991 raised concerns with the then management of the service following what they considered to be an unusual or novel prescribing practice. Counsel is referred to folder 4 for a copy of this file. Although there were meetings it does appear to your instructing Solicitor that this matter was not handled well by management at the time. Of course we should not criticise the management in 1991 by the standards of 2009. Having said that it looked pretty poor. As a result nursing staff have been critical of the NHS and were extremely concerned to find themselves accused by the press of "not doing anything about it". This has caused some upset and discomfort. This is referred to in some of the nursing statements. Your instructing Solicitor advised that the NHS would have to accept that the nursing staff acted appropriately and brought this to the attention of management and that no substantive action was then taken. It was so long ago and significantly pre-dated the events complained of. Whilst technically there may be an element of conflict between the nursing staff and the NHS in fact any criticisms made by the nursing staff would have to be accepted. Having said that your instructing Solicitor is aware that the RCN have been advising staff for many years on the Police investigation and following reference to the then UKCC. As we have indicated, in liaison with the RCN, we understand that they are intending to instruct Counsel to assist nursing staff. We are however anxious to avoid any potential division between the nursing staff and the NHS and medical/management staff. In fact we do not believe any exists and the RCN are happy to liaise over joint approaches to the evidence in due course.

- Internal assurance. Your instructing Solicitor has been involved to some extent in assisting the Trust and advising on internal assurance governance processes. The main document as far as PHT is concerned is the CHI report response which is in binder 3. This is currently awaiting Board approval and is in draft form. A final version will be made available when approval has been sought. The Board of our client PHT as well as the Boards of the other PCTs involved and the SHA need to sign off assurances as to the current status of the service and levels of safety and

risk etc. We understand that the SHA is providing assurance to the Department of Health.

To some extent your instructing Solicitor was initially concerned that this should have been done by the SHA in 2002/2003 following the CHI report. We have been given assurances that the process was undertaken at the time though the documentation has been lost. The process is now being undertaken again. For the purposes of public consumption it has been suggested that further assurances are being done at this time because new management are involved and the NHS needs to assure itself once again since this matter is now likely to become extremely high profile again. It is unlikely that Counsel will be asked to advise on internal assurance processes but Counsel should bear in mind that these are taking place.

Instructions

Counsel is asked to:

1. Advise in conference on the evidence and other issues which she considers relevant for the hearing. We wish to ensure that in respect of each death we have secured all relevant evidence. In addition we want to make to make sure we have 'covered off' the possibility of Rule 43 recommendations and reports.

2. Contact instructing Solicitor for initial discussion on the telephone prior to conference to ensure that everything is in hand and to particularly cover points in anticipation of the pre-inquest hearing on the 19th January.

3. To advise whether Counsel believes if there are any particular issues which he would wish to see addressed at the forthcoming pre-inquest hearing.

4. To represent Portsmouth Hospitals NHS Trust at the forthcoming Inquest.

Should Counsel have any questions or any issues whatsoever then do not hesitate to contact [redacted] on the details above.