Client: Hampshire Primary Care Trust - 4007152-0002

Matter: Gosport Inquests (Joint Instruction)

Date of Attendance: 19 January 2009

Fee Earner: [redacted]

10.00hrs (10 units)
Attending pre-inquest meeting at Portsmouth Guildhall.

Attendees:

Barrister for Dr Barton (Alan Jenkins) (AJ)
John White – Blake Lapthorn (solicitor for 2 families Spurgin (??) and ? Gregory)
[redacted]
Peter Mellor – PHT
Kiran Bhogal (KB) – Weightmans – PCT
Elaine Williams – PCT
Mr Stewart-Farthing's rep
Dominic Lake
Pauline Gregory
Ian Wilson
Mr Lavender
Betty Packman
Vicky Packman
Mr McQueen – police
DS Stephenson - police

Interested parties

The Coroner indicated that the interested persons were as follows:

Families;
Dr Barton
PHT (current managers of the two wards and employers of involved staff)
PCT (employers at the time)

Hearing logistics

The Coroner said that he would be dealing with the inquests as 10 individual inquests and not one collective inquest. He confirmed that there would be generic parts to all the inquests. He said that he had drawn up a time table for each day (see below) Families were only required to attend their family members part of the proceedings but could attend on any day if they so wished. The families would not be excluded from any part of the proceedings. He felt that although certain days may not relate to their relative the facts given on any said day may be related to their family death.

AJ asked if families who were not strictly an interested party in a particular inquest on one death would in fact be deemed an interested party. AJ wondered whether family members would be able to ask questions during evidence into deaths other than members of their families. The Coroner gave a vague reply repeating the above and indicating that he did not want interested parties to be prevented from asking questions.

There would be only 1 jury throughout the proceedings and there would be 10 verdicts at the end. The Coroner indicated that the witness list that he had provided was not chronological.

The inquest was to start on 18 March at 10am at the Combined Court Centre.

The Coroner gave the following time table:

18 – Jury to be sworn in, submissions and housekeeping

19 – Mr Lavender: Personal identification, Sheelagh Jones, Dr Peters, Margaret Couchman

Code A

23 - Service

24/25 – Professor Black

26 – Lake

27 – Cunningham

30/31 – Wilson

31 – Gilliam Hamblin

1 April - Spurgin

2 - Packman

3 – Devine

6/7 - Dr Wilcock

8 – Devine (if needed)

9 – Gregory

14 – Dr Barton (for as long as needed)

The Coroner will now schedule who is needed when and check availabilities. He would take Nurse Hamblin's evidence in one go (she is being called for several different cases)

Documents

The Coroner indicated that the hospital notes were annotated and ready for the family (who could take them today). He also said that the originals are available and will be at the inquest. He also said that in light of these notes, if anyone has any thing to bring up about these to let the office know before the inquest. Mr McQueen said that he should be informed if it was felt that other documents should be included in this bundle.

[redacted] said that he thought it would be helpful to have the prescription charts – the Coroner agreed. The Coroner requested that a bundle would be produced (by whom?).

The jury would have a copy of the papers / jury pro-formas handed out today which shows the deceased, the witnesses relating to cause of death and the witnesses relating to the circumstances. (A set of papers were handed around by the Coroner)

[redacted] said that he thought it would also be help to have the Wessex Guidelines on Palliative Care and PHT/PCT would get together to suggest further papers and provide copies to the Coroner. The Coroner indicated that he would be happy to receive a bundle of appropriate documents and he would disclose the papers to the experts. The Coroner gave no indication as to any additional documents he felt he would want to see and left it to PHT to propose

The Coroner said that he would start each inquest with the families so that they could paint a picture of their family member.

Iain Wilson said that he had not seen the reports of Prof Black/Dr Wilcock.

Experts

[redacted] raised the questions of the experts. He felt that it would be inappropriate for the reports to be given to the jury. The Coroner agreed with that. [redacted] indicated normally there would be an independent expert not one chosen by the family/police. [redacted] suggested an independent expert be properly briefed to advise the inquiry. He accepted time was short and would have made this proposal at the previous PIH if the NHS had been present. The Coroner rejected instructing another expert to assist.

[redacted] felt that Dr Wilcock was not an appropriate expert witness and gave an example of why this was the case to the Coroner (report on Spurgin). [redacted] felt that his report was inaccurate and displayed a lack of understanding of dealing with end of life care. His report was internally inconsistent. In addition [redacted] wondered from his CV whether he was an appropriate expert. [redacted] thought his evidence might not be helpful to the inquiry and the witness might be embarrassed. The Coroner thought he was appropriate and had experience in rehabilitation of the elderly. [redacted] said that was not the issue as we are dealing with end of life care. The Coroner indicated that [redacted] should raise this with the expert witness during the inquests under cross examination.

The Coroner did indicate that he would use just Prof Black *(?? not sure about this but the Coroner did say this in a throw away moment – I am writing to him to confirm he also said that he would write a brief to the experts on the proper questions to consider and I am checking that too).*

Iain Wilson (family) felt that there were two other reports that had been overlooked i.e. that of Gary Ford and Dr Munday. The Coroner indicated that these were specific to his father and he needed to limit the enquiry.

Mr Wilson also brought up the question of why there couldn't be a public enquiry. The Coroner did not have an answer for this.

Mr Wilson also felt that this process was about getting PHT off the hook and that everyone was in it together. He felt that the families were at a disadvantage and were not represented. It was brought to Mr Wilson's attention by PM that at the time PHT were not involved and are only involved now as they have subsequently taken over the wards and employees. Mr Wilson said that it was just a change of name. He also felt that the Coroner did not have all the evidence and he had only been provide certain evidence as were the CPS.

The Coroner said that the inquest was his inquiry into the deaths and not Mr Wilson's. He said that he did have evidence he needed. Under questioning from Mr Wilson the Coroner indicated he could not remember all the experts he had seen and he would check the evidence he had.

Mr Wilson indicated that he had not seen the Ford/Munday reports and when requested them was told he could have them. Mr McQueen said that he could have them if he contacted him.

[redacted] said that he felt that the Coroner should contact the experts and indicate to them what they need to give evidence on and brief them on the questions to address at the inquest.

Article 2 – scope of the inquiry

[redacted] asked the Coroner to make clear his position on Article 2. The Coroner said he thought this had been rejected at the last hearing. [redacted] said he was under the impression the parties were proceeding on the basis of an Article 2 inquiry. The Coroner agreed that the authorities clearly show he can not proceed under Art 2 since the deaths predate the HR Act.

[redacted] asked if he intended the inquiry to be limited to the narrow of issue of how and by what means patients came about their deaths. The Coroner replied that he would allow questions which were more wide ranging even if the verdict was only on the narrower issue.

Rule 43

[redacted] asked about Rule 43. If he was going to permit wider questions (which [redacted] agreed must be right for a full and fair inquiry) would the Coroner consider evidence under Rule 43 which may go someway to helping the families with their issues and would certainly offer reassurance to the wider public. The Coroner replied that he will not hear evidence under Rule 43 as this was 10 years ago and that he can not address history. He will not hear evidence of what is happening now.

Press engagement

[redacted] asked if, following recent discussions from the MOJ, the Coroner attended to engage with the press in this high profile matter to assist them and direct them as to the purpose of the inquest and its limitations. The Coroner indicated that the press will be at the inquest, they will be given a chronology and will not be advised of content until evidence is given.

Other matters

The Coroner reiterated the purpose of an inquest for the families benefit and said that he would stop any inappropriate questioning.

KB suggested it would be helpful if an organisation chart be produced to help the families to see who was responsible for what and when and how it had changed over the last 10 years. The Coroner agreed.

The Coroner said that he would not give the jury the medical records but they will be available.

AJ (Dr Barton's barrister) said he thought a resume of each patient setting out the chronology of admissions, drugs administered etc would be useful. Mr McQueen said that something similar had been produced by the Police and he would arrange for this to be adjusted accordingly.