Client: Hampshire Primary Care Trust - 4007152-0002

Matter: Gosport Inquests (Joint Instruction)

Date of Attendance: 26 January 2009

Fee Earner: [redacted]

Conference with Counsel on 26 January 2009 – 13:05.

In attendance:

Briony Ballard

Dr Logan

Dr Ian Reid

Peter Mellor

Lesley Humphrey

Elaine Williams

Kiran Bhogal

[redacted]

Counsel started by indicating that she wanted to cover the following topics.

1. The approach to the Coroner.
2. The clients' approach to this Inquest.
3. The evidence of Dr Reid.

Additional evidence of Dr Reid

Dr Reid indicated that he had given 2 very detailed witness statements on the matters of Packman and Spurgin. He said he had been interviewed and cautioned by the Police with Will Childs from RLB present. He does have copies of these statements and they run to two and a half folders. He thought he had been interviewed for some 20 hours.

It was clear that these statements had not been made available to anyone at the conference and we only had his short form statements for the patients Gregory and Divine. It was agreed that [redacted] would obtain copies of these statements and make available to Counsel.

Coroner's approach

Counsel was concerned the Coroner had not given this matter due consideration and inadequate thought had been given to the logistics in respect of the evidence and also the approach of the other interested parties had not been thought through properly. It also seemed apparent at this stage that Dr Barton's Barrister had not given this matter proper consideration and appeared to be content to deal with problems as they arise. It was noted that only 2 of the families had representation. only the NHS appears to have given proper thought to this matter.

The solution to our concern here was for the NHS to manage the process and move things into the direction that we want. We would want to avoid an adjournment on 18 March if at all possible. It was noted the Coroner appears only to have the annotated medical records, the

drug register entries and the statements. He indicated he is happy for additional disclosure of documents from the NHS.

Counsel considered what other evidence we may want to put into a bundle for the Coroner.

1. Documents disclosed by the Police. A number of documents have been disclosed by the Police including the prescription charts which should be included in the bundle.

2. The Police produced a summary list of patients. This was considered to be unhelpful and appeared to pre-judge the issues that the Jury may have to consider. Concerns were expressed over it's accuracy and it was agreed to contact the Coroner making it clear that this was not an agreed document to go to the other parties or before the Jury.

3. BNF entries. Counsel asked that the relevant BNF for 1998/1999 be copied and made available. This should be given to the Coroner.

4. Guidance on the syringe driver. This was noted to be in the bundle of documents from the Police though it appeared to be undated.

5. The CHI Report

6. Relevant guidance from the time in question. Counsel referred to binder 4 and to the following documents which should be included in the bundle for Counsel –

   Tab 7 – Administration of medicines programme for updating staff 1997.

   Tab 8b – Administration of medicines policy for nursing staff 1997.

   Tab 10 – Guidelines for the confirmation of death May 1998.

   Tab 12 – Prescription writing policy (July 2000).

Discussion took place in respect of further documentation available on the complaints files and an independent review was undertaken on one of the complaints. It was agreed that KB would review the complaints files held by the PCT and make the impendent review available.

<u>Rule 43 Evidence</u>

A discussion took place in respect of Rule 43 and an explanation of its relevance. It was agreed that it was a problem for the NHS because we want to get certain evidence in, in respect of the changes that have taken place and the position in respect of the service now. This has been taken up in correspondence with the Coroner and [redacted] said that he had written following the PIH. It was considered that the Coroner really did have a statutory requirement to look into issues under Rule 43 though it appears that he is not going to do so.

Counsel pointed out that it is a problem for the NHS in that we have broad facts given by the witnesses and issues of prescribing practice and policies called into question by the 2 experts who will consider that there were failings. If the Coroner goes no further that will be the extent of the evidence and will leave the public with a perception of a service that is failing and we need to consider our angle to get in the current situation and our message today. We need to consider our approach to damage limitation and evidence to support this.

Peter Mellor agreed that the public wanted assurances and he wanted to know whether the Coroner will follow our lead and consider what was going on at Gosport currently.

Counsel pointed out that we would want the Coroner to widen the scope of his investigation slightly to provide this reassurance. There is no restriction on what the NHS can give the families and we can send open correspondence to the Coroner and ask him to put additional evidence in the bundle for general consideration. We could seek to persuade the Coroner additional evidence should be available to all interested parties for consideration.

Peter Mellor's view was that there were 2 main issues. Firstly the public wanted reassurance but secondly the families don't appear to give a "damn" about what is happening now, they simply want "heads on a plate".

Elaine Williams pointed out the PCT have other problems in Hampshire. They are concerned about the media and other issues giving the service a poor public reputation in the County.

Kiran Bhogal wondered whether we could use Rule 43 to get this evidence in.

Counsel pointed out that whilst that maybe possible, as things stand at the moment the only way to get this evidence in is via Dr Reid. Do we have another witness who can deal with this issue for us?

It was noted that Lesley Humphrey had been identified as an appropriate witness. Following a discussion it was agreed that Lesley was able to provide evidence to put the matter into context and her experience and management of the system was such that she could go through the factual changes and explain the current situation within the service. She could not deal with the reasoning behind decisions taken by Directors over the years, but that was not necessary. Leslie could produce the table in response to the CHI report. She could not discuss 1990s management reasoning.

[redacted] indicated that the Coroner was aware that there was potential additional evidence and he said informally that he didn't want it. We are awaiting the outcome of this conference to decide whether or not to proffer up Lesley's statement.

Counsel asked whether the client wanted Lesley's statement in. The PCT indicated that they did and Peter Mellor was in agreement although his concerns were slightly different. As he had already outlined.

Lesley wondered whether or not the information could be shared in another way and not through the Court.

Counsel indicated that she wanted to get the evidence orally into Court if possible or alternatively to give the Coroner and other parties agreed documents indicating the level of service provision currently. However Counsel preferred to give the evidence in a contextual context.

[redacted] pointed out that we had good liaisons with the Coroner currently and [redacted] pointed out that it was necessary to get this evidence into the public domain.

Peter Mellor considered that the SHA was seeking assurance about the level of the service and this had been provided by PHT. It appears that the SHA are reasonably content and he wondered whether the SHA could give a statement. Kiran Bhogal wondered whether Richard Samuels was the right person.

Peter Mellor thought it would be best to get somebody from the SHA, one of the Directors who had been given assurance and this can be put in front of the Coroner and the public. The SHA have examined the evidence and are reassured.

Counsel wondered whether a brief witness statement from the SHA might be more appropriate and could someone be indentified. She will be hopeful to get the Coroner to accept this evidence and simply comment on it and provide public reassurance separately from the investigation into how these patients died.

Peter Mellor was keen the press needed to have the reassurance and Kiran Bhogal indicated that she had made contact with the relevant BBC journo.

Expert Evidence

Counsel noted that there was no interest from the Coroner for any additional expert evidence. Whether or not he was going to write to the experts to brief them on the appropriate questions and evidence the Inquest was not clear. [redacted] indicated he was not confident. The issue had been raised and was being chased in correspondence. It was agreed that if the Coroner did write to the experts with a brief then we should seek copies of those letters.

We needed to consider carefully what was our approach.

It was thought that Dr Reid would not be able to give evidence on the cause of death. Counsel noted the pro-formas which had been produced by the Coroner were designed to assist the Jury to split off the evidence of the various experts for each individual patient. Counsel thought it would be a very difficult process for the jurors to undertake.

Counsel considered the important question was whether or not we could defend the practice of immediately prescribing Diamorphine to be given as required if Dr Barton was not available. Is this anticipatory procedure defensible? Was it accepted practice at the time?

Dr Reid indicated he thought it wasn't defensible in the absence of documented pain. He indicated that he had previously worked in Southampton and there, there had been a Doctor available full time and therefore this problem hadn't arisen. He referred to previous involvement with a GP and he didn't recollect it happening with opiates like Diamorphine. Dr Logan suggested that if the patient is identified as dying then it is good practice to write up opiates and tranquilisers in anticipation. If it is felt the patient was admitted for palliative care the aim is to reduce suffering and not either to prolong or to shorten life. So if a patient arrives with no prospect of improvement it is appropriate to write up drugs. If the purpose of the admission is for rehabilitation then it would not be appropriate.

Counsel pointed out that we don't have an independent view on the admission and condition of these patients and whether or not it is appropriate. Counsel pointed out that a central issue is whether or not we could defend ourselves and the practice and the only way to do that might be to obtain an independent expert to defend our practice. Of course (as Peter Mellor pointed out) and expert may not support our practice. At least then we would know where we stood.

Counsel pointed out it was a question of causation - what caused the deaths, can it be linked to our Prescribing practice? There are 4 possible short form verdicts and a narrative verdict. We need to defend by getting the best possible verdict and neither of the experts called by the Coroner have addressed the relevant causation issue and Counsel was concerned that the Coroner will be progressing on their view only. They were considering issues with regard to negligence and intent and whether or not individuals were blameworthy. The relevant question is - did these prescriptions actually hasten the death? We need to know what their answers **should** be.

Kiran suggested we should be in the position to question Black and Wilcock. Peter pointed out that we had 2 consultants and "experts" around the table but Counsel was concerned to get a definitive view on causation. A discussion took place with regard to the role of the expert evidence. [redacted] indicated whether or not Drs Reid and Logan could set us up with the questions to cross examine Black and Wilcock. Counsel pointed that an expert would be used to review the medical evidence, comment on the prescriptions and appropriateness and consider the issue of causation - on the balance of probabilities - as to whether or not they contributed to the cause of death and how death was caused. It will be important that they consider the situation on the basis of a care of the elderly and end of life care.

[redacted] wondered whether the relevant issue was in reality the administration (from the drug charts and drug register) rather then the prescription. It was considered the drug register was only indicative of the drug being removed from the cabinet. On examination of the register [redacted] was not so sure about that.

Drs Reid and Logan were concerned about being dispassionate in this case and they suggested Professor Tallis in Manchester might be in a good position to give evidence on palliative care. He is recently retired. Dr Reid pointed out that patients today would be looked after by geriatricians and it would not be palliative care. He thought that Dr Wilcock was a problem and he seemed to have an inability to put the deaths into the context of the likely prognosis for the patients when they were admitted. We need to counter this argument.

Counsel pointed out she wanted to put simple questions as to the cause of death and the effect of the prescription on the balance of probability and keep it simple for the Jury.

Peter Mellor was concerned that evidence obtained at this stage should be cost effective though he wants to be supportive of Drs Reid and Logan.

Counsel said the families will look at it from a different angle. They will regard the dosages as being inappropriate and that there was a "policy" of hastening death and therefore their view will be that on the balance of probability the prescription did cause the deaths.

A discussion took place with regard to Dr Barton's evidence and whether or not we could link in with the MDU . No one knew what they were doing or whether or not they had any evidence. [redacted] pointed out that he thought they must have some evidence by now because they were due to face a GMC Hearing shortly.

It was agreed that as far as evidence and assistance is concerned to help Counsel in cross examination of the experts we should:

1. Contact the MDU to see whether or not they were prepared to share any evidence.

2. Contact an independent expert (subject to cost).

3. Ask Dr Reid and Logan to help.

Dr Reid's Evidence

It was further agreed with Counsel that she would want to go through Dr Reid's evidence very carefully. It was agreed a further meeting between Counsel and Dr Reid should take place. It was noted that Dr Logan was no longer being called to give evidence and we have just been made aware of this by the latest list from Counsel. [redacted] had also received a letter from RLB.

Kiran Bhogal explained that there were still issues with regard to unresolved problems with the nursing staff. It was noted that Betty Woodland had good knowledge about this. There was some question as to whether or not this has been followed through by the NHS and the paperwork disclosed to [redacted] seemed to come to an abrupt halt. Dr Logan thought that was probably "about right" and that he was unaware of what the result (if any) of this issue was in the early 1990s. [redacted] pointed out that in his discussions with the RCN legal rep, he said that they were not intending to make an issue out of this. KB thought it needed looking into further because she was of the view that the nurses will bring this matter up. We are not sure of the answer.

Counsel was content to deal with these issues on an "as and when basis".

Dr Reid indicated that he was away on holiday from 13 – 20 February.

[redacted]

TT: 2 hours 15 mins