Paper No. 2888

CONFIDENTIAL

MINUTES of the COMPLAINTS COMMITTEE MEETING
Tuesday 24th January at 10.30am, Gate House

Present

Lord Edward Faulks
Nazir Afzal
Andy Brennan
David Hutton
Alistair Machray
Helyn Mensah
Asmita Naik
Mark Payton
Andrew Pettie
Allan Rennie
Miranda Winram

In attendance:

Jane Debois, Head of Standards
Charlotte Dewar, Chief Executive
Michelle Kuhler, PA minute taker (remotely)
Robert Morrison, Head of Complaints

Also present: Members of the Executive:

Rosemary Douce
Alice Gould (remotely)
Sebastian Harwood
Natalie Johnson(remotely)
Molly Richards
Martha Rowe

Observers:

Jonathan Grun, Editors Code of Practice (remotely)
Sir Bill Jeffrey, External Reviewer (remotely)
Rebecca Keating, External Reviewer assistant (remotely)

1. Apologies for Absence and Welcomes

No apologies were received. The Chairman welcomed, Jonathan Grun, Sir Bill Jeffrey and Rebecca Keating who all attended the meeting remotely.

2. Declarations of Interest

There were no declarations of interest

3. Minutes of the Previous Meeting

The Committee approved the minutes of the meeting held on 29 November 2022.

4. Matters arising

There were no matters arising.

5. Update by the Chairman – oral

The Chairman expressed IPSOs thanks and best wishes to Tristan Davies who had now left the Committee. The Chairman also expressed his thanks to Martha Rowe, a Complaints Officer, who was leaving IPSO to take up a new role.
He gave the Committee an update on the Online Safety Bill process, due for a second reading in the House of Lords next week.
The Chairman also updated the Committee on practical arrangements for future Committee meetings in 2023.

6. Complaints update by the Head of Complaints – Oral

The Head of Complaints updated members on various operational matters including ongoing recruitment and the progress of a large-scale complaint about an article in the Sun.

7. Complaint 09841-22 Gloucestershire Hospital NHS Foundation Trust v Sunday Mirror

The Committee discussed the complaint and ruled that the complaint should be upheld . **A copy of the ruling appears in Appendix A.**

8. Guidance of the reporting of sex and gender identity – dirscussion of draft document

The Head of Standards introduced the draft document, informing the Committee of IPSO's reasoning and contributing factors for the refreshing of the guidance.

9. Complaints not adjudicated at a Complaints Committee meeting

The Committee confirmed its formal approval of the papers listed in **Appendix B.**

10. Any other business

The Head of Standards informed the Committee members that the Samaritans had offered to do training with the Committee in April.

11. Date of next meeting

The date of the next meeting was subsequently confirmed as Tuesday 7th March 2023

APPENDIX A

Decision of the Complaints Committee – 09841-22 Gloucestershire Hospitals NHS Foundation Trust v Sunday Mirror

Summary of Complaint

1. Gloucestershire Hospitals NHS Foundation Trust, acting on its own behalf and on behalf of two nurses employed by the Trust, complained to the Independent Press Standards Organisation that the Sunday Mirror breached Clause 1 (Accuracy), Clause 2 (Privacy) and Clause 3 (Harassment) of the Editors' Code of Practice in an article headlined "PATIENTS LEFT TO DIE IN HOSPITAL STORE ROOM", as well as the accompanying reader comments, published on 29 May 2022.

2. The article - which appeared in print on page 19 - reported on whistleblowers' claims about patient care at Gloucestershire Royal Hospital. It stated that "[o]ld people were left to die on a trolley in a hospital store room – with only a flimsy screen to protect their dignity, whistleblowers say. Witnesses say the miserable fate was endured by at least three brought into A&E at troubled Gloucestershire Royal Hospital last month." It further reported that "[i]nsiders say the pensioners, classed as end-of-life patients because of their condition, were left in so-called cohort rooms when no relatives could be found while waiting for beds. Sources say similar patients with relatives present were dressed and taken to private rooms before they died."

3. The article explained how "[c]onditions in the cohort rooms may be in breach of laws that say patients should be treated equally and with dignity and respect. This includes respecting privacy, such as not keeping patients in mixed wards overnight, but hospital bosses say the rules do not apply to emergency areas". The article went on to report the salaries of two hospital executives: "The hospital's ex-boss Deborah Lee enjoyed a total pay and pension package topping £385,000 in 2020. Current acting boss Mark Pietroni is paid up to £195,000 a year." In addition, the article included a statement from Professor Pietroni: "Waiting times for urgent care can be long. We do use cohort areas to allow us to release ambulances and paramedics back to the community. These are certainly not used as a holding area for 'end of life' patients, whether or not these patients are accompanied by relatives."

4. The article also included an image of a room in the hospital which showed a patient behind a blue privacy screen. The caption said: "'UNDIGNIFIED' Elderly patient in one of the rooms".

5. The article also appeared online in substantially the same format under the headline "EXCLUSIVE: Patients 'left to DIE in hospital storeroom' at troubled A&E, say whistleblowers". The online version included the same image previously described; however, it showed a wider perspective of the location, and the caption said: "Old people were put into a storage room".

6. The complainant said that the article breached Clause 1 as it had reported that "at least" three elderly people with no relatives had died in cohort areas at Gloucestershire Royal Hospital during April 2022. It said this was inaccurate; at the start of IPSO's investigation, it said that there had been one death in such an area in the month preceding the article's publication, and that the patient had staff with them at all times. During the investigation it said that it had since had to further research this issue in order to provide a response to a Freedom of Information (FOI) request, and there had, in fact, been no patient deaths in this area during April 2022. The complainant also said that the article was misleading to suggest that "end of life" patients were routinely put in cohort areas within the hospital's Emergency Department and left to die, and that patients with relatives present were treated differently from those who were unaccompanied by family members. Patients were treated equally, whether or not they had relatives with them and the areas are staffed by a registered nurse who could provide care to patients.

7. The complainant said that the press office of the Trust had spoken to the journalist on 27 and 28 May on the phone and had also been contacted by the publication for comment via email. During the telephone conversations, the journalist had relayed the whistleblowers' claims about the three deaths in cohort areas and was told by the complainant twice that there had been just one death in the cohort area in April 2022. The complainant said it did not wish to put this information in writing as it was unverified and given that it related to a single patient, it had concerns about patient confidentiality. The Trust also supplied IPSO with a copy of a press statement issued on 27 May from Professor Pietroni – the then interim CEO - which the complainant said refuted the whistleblowers' claims by way of a paragraph which stated: "Although we do use cohort areas to allow us to release ambulances and paramedics back to the community, these are certainly not used as a holding area for 'end of life' patients, whether or not these patients are accompanied by relatives."

8. The complainant also said the description of the cohort areas in the text of the article and in the caption to the photographs was inaccurate; it said that these areas are not store cupboards. The complainant explained that a cohort area is a clinical treatment room which had been repurposed to support timely ambulance handovers and who wait in that space. The complainant reiterated that an attending nurse could provide care to patients in these areas.

9. The complainant also said that the article had inaccurately reported the salaries of Deborah Lee and Mark Pietroni. It provided a copy of the Trust's annual report 2020 – 2021 which included both Ms Lee and Professor Pietroni's salaries. The annual report said that Ms Lee's salary in 2020-21 was between £265,000 and £270,000 per year, with additional pension benefits totalling between £247,500 and £250,000. The report stated that Professor Pietroni was paid between £195,000 and £200,000 per year, with pensions of £52,500-£55,000.

10. In addition, the complainant said that the article was inaccurate to report that Deborah Lee was the Trust's "ex boss". Rather, she was temporarily off work prior to the article's publication and Professor Pietroni, the Deputy CEO, was acting as Interim CEO. The complainant said Ms Lee had returned to her role as CEO after the article's publication.

11. Furthermore, the complainant said that the article was inaccurate as it suggested the Trust had breached NHS Guidance on same-sex accommodation, despite a clear explanation having been provided to the journalist that – due to the nature of incidents presented in A&E and Emergency Departments – these departments were outside the scope of the national same-sex guidance. The complainant said that this inaccuracy implied the staff did not respect the dignity of patients.

12. The complainant also said that the user comments posted in response to the online article by members of the public had breached Clause 2 and Clause 3, as two nurses who worked at the Trust were identified by their first names and targeted online with abusive comments and threats – therefore, breaching the nurses' privacy and harassing them. It provided a screenshot of a critical comment about the named nurses' care, and a further user comment which was of a threatening nature. The first reader's comment said:

> *I can name the horrible nurses as I had a recent experience with a couple of them. My elderly relative was on the same horrible stretcher for 18 hours without food or water or any pain killers and when I tried to speak to them I was literally told "there are other patients who are worse off but their relatives don't moan as much I am and if I want my relative to eat and drink I should have get them a meal from Uber eats" what a disgrace. [Name] and [name] remember you reap what you sow!!!! When you have your loved ones treated like you treat others you will know the pain!!!!*

Another reader responded to this and commented:

> *[Name] and [name] sound like they would benefit from a spell in hospital, recovering from a multitude of broken bones and assorted injuries*

13. The publication did not accept a breach of Clause 1, firstly noting that the claims in the article were clearly attributed to whistleblowers and therefore distinguished as comment – in line with the terms of Clause 1 (iv) of the Editors' Code. It further said the reporter had notes from his conversation with one of the whistleblowers, who had said they had 'witnessed three deaths' in the cohort areas. It said that, after receipt of the complaint from the Trust via IPSO on 14 June, the publication approached the whistleblower to advise that the number of deaths was in dispute. However, it said that the whistleblower confirmed their original position that there had been three deaths in the cohort area.

14. The publication said that the description of the cohort areas contained in the article had come from a whistleblower who said that – when they began to work at the hospital – the cohort area was used for storage and had boxes full of equipment, and was also used as a staff tea break area before the A&E came under greater pressure later that year. The whistleblower had provided images of the hallway outside the cohort area and said the boxes in the hall area were previously stored in the room, though these images were not provided to IPSO.

15. The publication did not accept that it had been relayed twice to the journalist that there was only one death in the cohort area in April. It said that, at the time they had approached the Trust for comment on the number of deaths that had occurred in these areas, the journalist had stressed the need for a formal reply. It said that the reporter had referred to a claim that there had been 'multiple' deaths in their email requesting comment before publication– a copy of which was provided to IPSO by the complainant. The publication said, despite that, the Trust's subsequent statement did not specifically deny that there had been deaths in the cohort area, nor did it say that only one death had occurred there. It said the article had also included the Trust's response to the claims made in the article about the use of cohort areas: "These are certainly not used as a holding area for 'end of life' patients, whether or not these patients are accompanied by relatives."

16. While the publication did not accept that the article was in breach of Clause 1, during the investigation it offered several iterations of clarifications which it offered to publish in print in the Corrections & Clarifications column on page 2, and online. However, it said it would not be appropriate to publish a correction on the homepage of the website – as it could not say with any certainty whether the original online headline appeared on the website's homepage. On 26 July it offered the following print and online footnote correction:

> *Clarification: Our article [HEADLINE;DATE] reported as fact that end of life patients were left to die in a hospital store cupboards. In fact, this was based on the whistle-blower's claim that the room was previously used to store hospital equipment. We have since been advised that this disputed room is not a store room, but is a cohort area. We are happy to clarify this.*

The publication then offered to update the online correction on 15 August with the following wording:

> *A previous version of this article reported as fact that end of life patients were left to die in a hospital store cupboards and included a photograph of patient behind a blue screen which was captioned to have been in a 'store room'. This was based on the whistle-blower's claim that the room was previously used to store hospital equipment. We have since been advised that this disputed room is not a store room, but is a cohort/clinical area. We are happy to clarify this.*

17. On 23 August it further offered to amend its print correction and online correction to:

> *A previous version of this article reported as fact that end of life patients were left to die in a hospital store cupboards and included a photograph of patient behind a blue screen which was captioned to have been in a 'store room'. This was based on the whistle-blower's claim that the room was previously used to store hospital equipment. We have since been advised that this disputed room is not a store room, but is a cohort/clinical area. The Trust advised in May that there has been a single death in the time these cohort areas have been in use. We are happy to clarify this.*

Having been presented with the FOI information that there had been no deaths in the cohort areas in the time period referenced in the article , it said it would be content to publish the following wording at the top of the online version of the article on 16 September:

> *UPDATE: As a result of an FOI request, the Trust have since advised that there have been no patient deaths during the time these cohort areas have been in use. We are happy to clarify this*

18. The publication nevertheless noted that the figure provided in the FOI response contradicted the information provided by the complainant at the start of the IPSO process. It also added that putting the claim about the number of deaths to the complainant for comment prior to publication – which it did – was reasonable and that it could not be expected to wait up to 20 days for a response to an FOI request to ascertain the correct position.

19. In response to the alleged inaccuracy in reporting the salaries of senior staff members at the trust, the publication said that these figures were publicly available and provided the complainant's annual report for 2019 – 2020. The annual report recorded Ms Lee's salary as £225,000 - £230,000 and her total renumeration as £360,000 - £365,000. Professor Pietroni's salary was recorded as £130,000-£135,000, and his total renumeration as £175,000- £180,000. The publication said that the article made clear the salary figures were from 2020 and that – given that the correct salaries were even higher than what was published – it was not significantly inaccurate; it did not affect the crux and meaning of the story.

20. The publication also said that the article made clear that Professor Pietroni was 'acting boss' at the time the article was published, and the complainant had confirmed that – at the time the article was published – Ms Lee was not fulfilling the role of CEO. While the publication did not consider this to be significantly inaccurate, it said it would be happy to add a further update on 29 September to the top of the online article to confirm that Ms Lee had been back in the role of CEO since August:

Furthermore, we have since been advised that Deborah Lee was reinstated as CEO in August 2022.

21. Responding to the complainant's point that the article inaccurately suggested that the Trust had breached NHS Guidance on same-sex accommodation, the publication said the article had set out the Trust's position on this allegation: "[H]ospital bosses say the rules do not apply to emergency areas" and therefore did not consider the article's claims to be inaccurate.

22. The publication made clear it does not pre-moderate reader comments, such as those which appeared underneath the article and formed part of the complaint. It said that for reader comments to fall within IPSO's remit, such comments must be pre-moderated or remain online once reported to the publication with an alleged breach and the publication has had a chance to review them. In light of the complainant's concerns, as a gesture of goodwill the publication removed the comments and readers' ability to make comments on 8 July, 24 days after it was made aware of the complaint. It did not accept a breach of Clause 2 or Clause 3 as it did not consider the user comments to be within IPSO's remit – they had been removed once it had been made aware of the alleged breach.

Relevant Clause Provisions

Clause 1 (Accuracy)

i) The Press must take care not to publish inaccurate, misleading or distorted information or images, including headlines not supported by the text.

ii) A significant inaccuracy, misleading statement or distortion must be corrected, promptly and with due prominence, and — where appropriate — an apology published. In cases involving IPSO, due prominence should be as required by the regulator.

iii) A fair opportunity to reply to significant inaccuracies should be given, when reasonably called for.

iv) The Press, while free to editorialise and campaign, must distinguish clearly between comment, conjecture and fact.

Clause 2 (Privacy)*

i) Everyone is entitled to respect for their private and family life, home, physical and mental health, and correspondence, including digital communications.

ii) Editors will be expected to justify intrusions into any individual's private life without consent. In considering an individual's reasonable expectation of privacy, account will be taken of the complainant's own public disclosures of information

and the extent to which the material complained about is already in the public domain or will become so.

iii) It is unacceptable to photograph individuals, without their consent, in public or private places where there is a reasonable expectation of privacy.

Clause 3 (Harassment)*

i) Journalists must not engage in intimidation, harassment or persistent pursuit.

ii) They must not persist in questioning, telephoning, pursuing or photographing individuals once asked to desist; nor remain on property when asked to leave and must not follow them. If requested, they must identify themselves and whom they represent.

iii) Editors must ensure these principles are observed by those working for them and take care not to use non-compliant material from other sources.

Findings of the Committee

23. The headline to the article effectively made two claims: that a hospital "store room" was being used for patient care (a reference to the "cohort areas"), and that patients had been "left to die" there.

24. The publication argued that both claims were clearly attributed in the article to a whistleblower, and therefore were distinguished as comment in accordance with Clause 1 (iv). The publication emphasised that it had also sought comment from the complainant on the claim about the number of deaths before publication. At that point the complainant had told the publication that there had been one death in these areas in the month of April, although not on a formal basis. During the IPSO investigation, the complainant had confirmed that, in fact, no patient had died in this area.

25. The Committee acknowledged that the claims had been attributed in the article to "whistleblowers", which it took into account in its consideration of the care taken by the publication. However, given the seriousness and significance of the claims, this attribution alone was not sufficient to satisfy the publication's obligation to take care over the accuracy of the information. The Committee noted that the claims that the cohort area was a "store room" and how many patients were "left to die" in this location appeared to have come from a single source and the publication had not put the "store room" allegation to the complainant prior to publication.

26. The Committee understood that, although the cohort areas may previously have been used for storage, the areas had been converted to a designated space for patients who were attended to by medical staff; at the time it was being used for patient care it was not a storage room, a point that the publication now appeared to accept. The Committee noted that the article featured a picture of a

cohort area which showed some characteristics of a clinical area and that the article stated that the areas were "intended as holding areas for single, non-serious patients arriving in A&E in order to free up ambulances". However, this was not sufficient to offset the significantly misleading impression given by the headline and the introductory text of the article. The publication had not taken care over the accuracy of the claim that patients had been "left to die" in a "store room", and there was a breach of Clause 1(i).

27. The claim that the cohort rooms were "storage rooms" was serious and significant in the context of the complainant's public role. The publication was required to correct the claim under the terms of Clause 1(ii).

28. The Committee accepted that, by putting the claim about the number of deaths in cohort areas to the complainant before publication, it had taken sufficient care in reporting the information provided by the whistleblower, which was clearly attributed as such in the article. The number of deaths which had occurred in the cohort areas was significant and upon becoming aware of the true position, the publication was required to publish a correction in accordance with the requirements of Clause 1(ii).

29. The Committee then turned to the question of whether the actions proposed by the publication were sufficient to avoid a breach of Clause 1(ii). The publication had proposed the same print and online correction to address the article's claims that the cohort rooms were "storage rooms". The Committee noted that the first iteration of the correction had identified the original inaccuracy and made clear the correct position that the areas referred to in the article were not store rooms but in fact cohort areas, and that this had been based on a whistleblower's claim. The Committee was satisfied that both the print and online correction on this point was sufficient for the purposes of Clause 1(ii).

30. Turning to the promptness and prominence of the online correction, where the publication had been made aware on 14 June that the cohort areas were not storage rooms, the publication's offer some six weeks later on 26 July to publish a correction on this point was not sufficiently prompt. The Committee also did not consider that publication of the correction at the top of the online article to be sufficiently prominent where the claim that patients had been left to die in storerooms had appeared in the headline. There was, therefore, a breach of Clause 1(ii) in relation to the proposed correction to the online article.

31. The Committee was satisfied that publication of this correction in print in the established Corrections & Clarifications column on page 2 was sufficiently prominent. However, where the print correction had been offered six weeks after the publication had been made aware of the alleged inaccuracy pertaining to the location patients had died, the Committee did not consider this to be sufficiently prompt, which represented a breach of Clause 1(ii).

32. The Committee considered that the proposed correction in relation to the number of deaths in cohort areas was sufficiently prompt, where the publication had been made aware of the true position on 25 August and the correction had been offered five days later on 30 August. Where the inaccuracy had appeared in the text of the article, rather than the headline, publication at the top of the online article satisfied the requirement for due prominence. However, the clarification offered on this point did not make clear the inaccuracy being corrected and there was a breach of Clause 1(ii). The publication had not offered to publish a correction in print in relation to the correct number of patient deaths and this represented a further breach of Clause 1(ii).

33. Turning to the concerns about the reported salaries of the Trust's executives and their status within the organisation, the Committee noted that there were two annual reports from 2019-2020 and 2020-2021 which contained different salary information. The Committee also noted that the article made clear Ms Lee's salary package was from 2020 with her total pay and pension package reported as "topping £385,000 in 2020". Where the total renumeration stated on the 2019 - 2020 annual report for Ms Lee was £360,000 - £365,000, the Committee did not consider the reported figure to be significantly inaccurate in the context of the article which reported on whistleblowers' claims in regard to patient care.

34. The article also said "Current acting boss Mark Pietroni is paid up to £195,000 a year". Where his salary on the 2020 – 2021 annual report was recorded as £195,000 – £200,000, and where it appeared that the article was referring to his current salary, the Committee did not consider the reported figure to be significantly inaccurate. Further, the article's references to the "[c]urrent acting boss Mark Pietroni" and "ex-boss Deborah Lee" were not inaccurate where Ms Lee was not the CEO at the time of the article's publication and where Professor Pietroni was acting as interim CEO. There was no breach of Clause 1 on these points.

35. In regard to the complainant's concern that the article suggested the Trust had breached NHS Guidance on same-sex accommodation, the article did not present this claim as fact but said "the cohort rooms may be in breach of laws that say patients should be treated equally and with dignity and respect". Therefore, the claim was clearly presented as speculation on the part of the publication. The article also included the Trust's position on this issue, reporting that "hospital bosses say the rules do not apply to emergency areas." For these reasons, there was no breach of Clause 1 on this point.

36. The Committee next considered complaint made about the online reader comments. The complaint had been brought to the publication's attention on 14 June and the publication confirmed on 8 July they had been removed from the comments section. As the comments had remained available for 24 days after the publication had first been made aware of the complainant's concerns, the Committee considered that they were within IPSO's remit. While the Committee acknowledged that the complainant found the comments to be unpleasant and

expressed sympathy for the named nurses, the comments were made in relation to the professional lives of the nurses and did not amount to an intrusion into their private lives. The Committee did not consider that publication of the comments breached Clause 2.

37. The Committee then considered whether the comments had represented a breach of Clause 3. The clause provides that journalists must not engage in intimidation or harassment and generally relates to the way journalists behave when gathering news, including the nature and extent of their contacts with the subject of the story. As they had been added by readers after the article had been published, publication of the comments did not amount to a breach of Clause 3.

Conclusions

38. The complaint was upheld in part under Clause 1(i) and Clause 1(ii).

Remedial action required

39. Having upheld the complaint, the Committee considered what remedial action should be required. In circumstances where the Committee establishes a breach of the Editors' Code, it can require the publication of a correction and/or an adjudication, the nature, extent, and placement of which is determined by IPSO.

40. The Committee considered that there was a serious breach of Clause 1. The publication had published inaccuracies on matters of significance and in particular not sought to verify the claim regarding "store rooms" with the Trust. It had not taken adequate steps to correct these inaccuracies when they had been brought to its attention by the complainant. In light of the newspaper's failure to take care over the article's accuracy, and its failure to correct the inaccuracies in line with its obligations under Clause 1(ii), the Committee concluded that an adjudication was the appropriate remedy.

41. The Committee considered the placement of this adjudication. The print article had featured on page 19. The Committee therefore required that the adjudication should be published on page 19 or further forward in the newspaper. The headline to the adjudication should make clear that IPSO has upheld the complaint, reference the title of the newspaper and refer to the complaint's subject matter. The headline must be agreed with IPSO in advance.

42. The adjudication should also be published online, with a link to this adjudication (including the headline) being published on the top 50% of the publication's homepage for 24 hours; it should then be archived in the usual way.

43. If the newspaper intends to continue to publish the online article without amendment to remove the breach identified by the Committee, a link to

the adjudication should also be published on the article, beneath the headline. If amended to remove the breach, a link to the adjudication should be published as a footnote correction with an explanation that the article had been amended following the IPSO ruling. The publication should contact IPSO to confirm the amendments it now intends to make to the online material to avoid the continued publication of material in breach of the Editors' Code of Practice. The headline to the adjudication should make clear that IPSO has upheld the complaint, give the title of the publication and refer to the complaint's subject matter. The headline must be agreed with IPSO in advance.

44. The terms of the adjudication for publication are as follows:

Following an article published on 29 May 2022 headlined "PATIENTS LEFT TO DIE IN HOSPITAL STORE ROOM", Gloucestershire Hospitals NHS Foundation Trust, acting on its own behalf and on behalf of two nurses employed by the Trust, complained to the Independent Press Standards Organisation that the newspaper had breached Clause 1 (Accuracy) of the Editors' Code of Practice. IPSO partially upheld this complaint under Clause 1 and has required the Sunday Mirror to publish this adjudication as a remedy to the breach.

The article reported on "whistleblowers'" claims about patient care at Gloucestershire Royal Hospital. It stated that "[o]ld people were left to die on a trolley in a hospital store room – with only a flimsy screen to protect their dignity, whistleblowers say. Witnesses say the miserable fate was endured by at least three brought into A&E at troubled Gloucestershire Royal Hospital last month." It further reported that "at least" three elderly people with no relatives had died in cohort areas at Gloucestershire Royal Hospital during April 2022.

The complainant said the article was inaccurate as there had been one death in the allocated area in April 2022 and that the patient had staff with them at all times. It later said a Freedom of Information request had found that there had actually been no patient deaths in this area during April 2022. The complainant also said the article was inaccurate as it had described the cohort areas as "store cupboards" in the text and as a caption to an image.

IPSO noted that the article effectively made two claims: that a hospital "store room" was being used for patient care (a reference to the "cohort areas"), and that patients had been "left to die" there.

IPSO acknowledged that the claims had been attributed to the "whistleblowers" but given the seriousness and significance of the claims, this attribution was not sufficient. IPSO found that claims that the cohort area was a "store room" and the number of patients "left to die" there appeared to have come from a single source, and the "store room" allegation had not been put to the complainant prior to publication.

IPSO found that the “store room” was, in fact, a “cohort area” - a designated space for patients attended by medical staff, and that no patients had died in these areas in April 2022.

The claim that the cohort areas were “storage rooms” was highly significant in the context of the claim that they had been used for end-of-life care and that patients had died there. The publication had not taken care over the accuracy of the claim that patients had been “left to die” in the “store room”. The publication had breached Clause 1.

Date complaint received: 29/05/2022

Date complaint concluded by IPSO: 28/03/2023

APPENDIX B

Paper no.	File number	Name v publication
2561	02441-22	Dimond v Sittingbourne News Extra
2611	10348-22	Malster v Mail Online
2619	11103-22	A woman v The Daily Telegraph
2558	02264-22, 02388-22, 02389-22, 02390-22	Williams v dailypost.co.uk, dailyrecord.co.uk, dailystar.co.uk
2614	11061-22	Maclennan v dailyrecord.co.uk
2597	10780-22	Raeburn v southwalesguardian.co.uk
2609	11622-22	Duncan v The Sun on Sunday
2622	11590-22	Lynch v kentonline.co.uk
2827	11288-22	Baillie v The Mail on Sunday
2616	11100-22	Banks v boltonnews.co.uk
2620	10769-22	Edwards v gazette-news.co.uk
2621	11417-22	Dollimore v Daily Mail
2612	10205-22	British Pakistani Christians Ltd v The Sun
2829	11996-22, 11997-22, 11998-22	Higginson v liverpoolecho.co.uk, manchestereveningnews.co.uk, cheshire-live.co.uk
2831	11525-22	Mitchison v express.co.uk