



GUIDE TO OBTAINING RECORDS IN HISTORIC CLAIMS

Tracing GP records for someone who died more than 10 years ago can be challenging, as they may have reached the end of their standard retention period and been destroyed. However, for historical claims like **DES exposure**, there are several alternative routes to explore.

1. Contact Primary Care Support England (PCSE)

Even if 10 years have passed, the records may still be in deep storage if they weren't flagged for destruction.

- **Action:** Submit a request to [Primary Care Support England \(PCSE\)](#) using their online "Access to Health Record" form.
- **Detail:** They manage records for people who are deceased and whose practice has closed or whose records have been archived.

2. Local County Archives

If the GP surgery was very old or has since closed, some historical patient records (particularly those over 20–30 years old) are sometimes transferred to local government archives rather than being destroyed.

- **Action:** Search the National Archives Discovery tool or contact the **County Record Office** for the area where the deceased lived.
- **Context:** These archives often hold the records of old "fringe" or closed municipal hospitals and clinics that acted as primary care providers in the mid-20th century.

1. Check for "Permanent Preservation"

Under the [NHS Records Management Code of Practice](#), some records are selected for permanent preservation because of their historical or research value.

- **Action:** Ask PCSE or the relevant **Integrated Care Board (ICB)** if the records were part of a "Permanent Preservation" set.

3. Cross-Reference Hospital Records

Hospital records are often held longer than GP records for certain conditions—specifically for **maternity (25 years)** and **oncology (30 years after diagnosis)**.

- **Action:** If you cannot find GP records, apply to the **Hospital Trust** where the child was born or where the deceased received specialist care. These often contain summaries of the patient's GP history.

4. Private Medical Records

If any part of the care was private, the retention periods can differ, and records may be held in the archives of private medical groups or specific consultants' offices.

Important Tip: When records are missing, you can request a **"reconstituted record"** from the last known data controller, which combines any surviving fragments, audit trails, and secondary summaries into a new file.

In the UK, hospital records are generally retained for **8 years** after the death of a patient, though certain types of records are kept significantly longer depending on the nature of the treatment.

The NHS Records Management Code of Practice dictates these specific timeframes:

- **Standard Hospital Records: 8 years** after death.
- **Maternity Records: 25 years** after the birth of the last child. These are critical for DES claims as they document the pregnancy and any medications prescribed.
- **Cancer/Oncology Records: 30 years** from the date of diagnosis or **8 years** after death (whichever is longer).
- **Mental Health Records: 20 years** after the last contact or **8 years** after death.
- **Neurology/Brain Injury Records:** Often kept for **10 years** after death or **30 years** in total.
- **Genetic/Clinical Forensic Records:** These are often retained **permanently** or for **30 years** due to their long-term clinical relevance.

Why this matters for DES cases

Because DES exposure typically occurred in the 1950s–1970s, many "standard" files may have been destroyed. However, because DES claims often involve **maternity** or **oncology** (e.g., clear cell adenocarcinoma), you have a much higher chance of finding records that fall under the **25-to-30-year retention rules**.

If the hospital claims the records were destroyed, you can ask for the **"Destruction Certificate"** or a log entry confirming exactly when and why the records were purged.

Summary:

When dealing with historical claims like **DES exposure**, the paperwork can feel like a maze. Here is a straightforward breakdown of who can get these records and where to find them.

Who has the legal right to apply?

Not just anyone can request a deceased person's medical files. Under the **Access to Health Records Act 1990**, the right belongs to the **Personal Representative** (the Executor of the Will or the Administrator of the Estate). If you aren't the representative, you can still apply if you have a **"legal claim"** arising from the death—such as a medical negligence case or an insurance claim—but you will only be allowed to see information relevant to that specific claim.

How long are records kept?

Timing is the biggest hurdle. Most **GP records** are destroyed **10 years** after a patient passes away. Standard **Hospital records** are usually kept for **8 years**. Because DES claims involve often long-term conditions like cancer, some files may be kept for **30 years** or more.

Where to send your application

- **GP Records:** Write to the **Practice Manager** at the last surgery the deceased attended. If that surgery has closed, you must apply to [Primary Care Support England \(PCSE\)](#).
- **Hospital Records:** Contact the "**Access to Health Records**" department or the **Data Protection Officer** at the specific hospital where the treatment took place.

What if the records are older than 10–30 years?

If the records have been removed from the hospital or GP surgery, they aren't always gone forever. Older files are often transferred to **Local County Archives** or the National Archives. When you write to them, be sure to ask specifically for notes that are most likely to contain the prescription details needed for a DES case.

What you will need to provide

The hospital or GP surgery must verify that you are who you say you are before releasing sensitive data.

- **Photo ID:** A high-quality scan or photocopy of your **Passport** or **Driving Licence**.
- **Proof of Residency:** A **utility bill** or **bank statement** dated within the last three months.

To ensure your request is processed quickly and to avoid "back-and-forth" with NHS administrators, gather the following documents before sending your application:

- copy of the **Death Certificate** and proof of your status (like a **copy of the Will** or a **Grant of Probate**).
- If you are applying because of a legal claim, you may need to provide a brief explanation or a letter from a solicitor to prove why the records are necessary.

Evidence of Relationship (For DES Claims)

Because DES claims focus on the "DES-Daughter" or "DES-Son," you may need to prove the link between the mother's medication and your own health.

- **Your Birth Certificate:** To link you to the mother's maternity records.

- **Medical Evidence of Impact:** If you have been diagnosed with a condition linked to DES (like Clear Cell Adenocarcinoma), including a copy of your own **specialist diagnosis** can help justify why historical maternity notes are being requested.

Information to Speed Up the Search

NHS archives are vast; the more detail you provide, the less likely they are to say the records "cannot be found."

- **Historical Details:** The deceased's **full name at the time of treatment** (including maiden names).
- **NHS Number:** If you have any old paperwork or medical cards showing their 10-digit NHS number.
- **Specific Dates:** The approximate dates of the pregnancy or the specific year the medication was likely prescribed.

5. Completed Application Form

While a letter is often sufficient, most NHS Trusts prefer you to use their specific **Subject Access Request (SAR) Form**. Check the "Privacy" or "Access to Records" section of the hospital's website to download this.

RECORDS SPECIFIC TO DES - this is a non-exhaustive list but should provide a guide as to the health records specific to DES administration .

1. Proof of Direct Exposure (Maternal & Birth Records)

Since exposure usually occurred decades ago, finding the "smoking gun" often requires digging into historical pregnancy and neonatal files:

- **Maternity Notes & Handheld Records:** Often the most reliable source for specific drug names, dosages, and the reason for prescription (e.g., "threatened miscarriage").
- **Antenatal Clinic Letters:** Correspondence between a GP and the hospital consultant regarding the management of the pregnancy.
- **Pharmacy & Prescription Cards:** Historical logs of medications dispensed, which may identify the specific manufacturer—a key requirement in many product liability claims.

2. Evidence of Long-term Health Impact

Records from specialists are needed to link present-day conditions to in utero exposure:

- **Colposcopy & Gynaecology Records:** Crucial for documenting "stigmata" of DES exposure, such as structural abnormalities (e.g., T-shaped uterus) or cellular changes.
- **Histology & Oncology Reports:** Essential if the claim involves clear cell adenocarcinoma (CCA) or other cancers.
- **Fertility & Obstetric History:** Records of miscarriages, ectopic pregnancies, or infertility treatments, which are documented DES-related disorders.

3. Institutional & Regulatory Records

These records help establish what the medical community and state knew at the time of prescription:

- **Internal Hospital Policies:** Guidelines or "circulars" from the 1950s–1980s regarding the use of synthetic oestrogens.
- **Safety Alerts & Duty of Candour:** Any official correspondence from the NHS or government acknowledging historical failures or providing specific "DES-daughter" screening advice.
- **Official Parliamentary Statements:** Acknowledgments from the Health Secretary or MPs regarding state failures, which can be used to support "breach of duty" arguments.

4. Financial & Practical Impact

- **Employment & Care Records:** Documentation of lost earnings, time off work for treatment, or costs of private fertility care.
- **Personal Diaries:** Historical logs kept by the mother or daughter describing symptoms or the specific brand/shape of the pills taken.