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Your ref:

Our ref: IR/DCC/hjs

23rd July, 2002.

Mr. R. Daw
Chief Crown Prosecutor
Crown Prosecution Service
3rd Floor
Blak Horse House
8-10 Leigh Road
EASTLEIGH
SO50 9FH

Dear Roger,

Report by Chief Superintendent D. Clacher into Complaints against Detective Superintendent John James following an enquiry into events at Gosport War Memorial Hospital

Following our discussions you are aware of this high profile case and the fact that historically the Crown Prosecution Service sought Treasury Counsel's advice regarding the death of Mrs. Richards at the above hospital. The key issue was whether the use of a syringe driver to deliver Diamorphine to Mrs. Richards was carried out in such a way as to cause her unlawful death.

A critical meeting took place on 19th June, 2001 between Detective Superintendent John James, Detective Chief Inspector Paul Clarke, the Crown Prosecution Case Worker, Mr. Paul Close, Treasury Counsel, and Professor Livesley. It would appear that during that meeting Treasury Counsel came to the view that Professor Livesley's report on the medical aspects of this case and his assertions that Mrs. Richards had been unlawfully killed, were flawed in respect of his analysis of the law. The best summary of the meeting is contained in a letter from Mr. Close which is dated 7th August, 2001. In it, he asserts, "The decision that there is no reliable evidence that Mrs. Richards was unlawfully killed, was the only conclusion that could be reached following the further conference with Counsel on 19th June." The letter goes on to list the reasons behind the CPS and Counsel thinking, as follows:

1. Although Professor Livesley had concluded in his initial medical report that Mrs. Richards had been unlawfully killed, he was not entirely clear of the legal ingredients of gross negligence/manslaughter.

2. That Dr. Barton's decisions were entitled to be afforded some respect as she was involved in Mrs. Richards' care as the frontline clinician.

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3. Dr. Barton's decision could find support among a responsible body of medical opinion.

4. Bronchopneumonia as a cause of death could not be contradicted.

It is not possible in the absence of any post mortem finding to exclude a heart attack as a possible cause of death. Nonetheless, it was decided by the police to examine four similar cases to discover if there were any other evidence which would indicate criminal activity at this hospital. Investigations were carried out but it would appear that the results of those enquires were never formally given to the Crown Prosecution Service. The rationale behind the decision was that they were all of a similar nature to the Richards' case and would therefore attract a similar comment from your office.

I am currently reviewing how senior officers and regulatory bodies were given the impression that this referral had taken place.

Nevertheless, I now take the view, having looked at the report from Chief Superintendent Dan Clacher, that these cases should have been submitted to you for appropriate review. I have now directed that Superintendent Paul Stickler, the Divisional Commander at Havant who has previous CID experience, should be given the task of collating all of this additional evidence and delivering it to your office, if appropriate, along with a copy of the report from Chief Superintendent Clacher. You indicated that you would have to undertake a review of this case to see if it would be a local matter or one that had to be conducted from the outset with the Director of Public Prosecutions.

I go on annual leave this evening but think it may be prudent for us to meet on my return so that we can discuss the matter further when you have obtained a more formal position on behalf of the CPS.

Code A

I.R. Readhead
Deputy Chief Constable