G.31

HAMPSHIRE CONSTABULARY

CONFIDENTIAL

Station : **Fratton** Division : **Portsmouth**

Department : **KQ** Date : **21 July 2002**

Subject : **Formal Complaint against Detective Superintendent John JAMES into conduct of the enquiry at Gosport War Memorial Hospital**

Addressee :
ACC P JACOBS
DCC I READHEAD

1. Introduction:

1.1 In April 2002 I was tasked into calling upon Mrs Marilyn JACKSON of Code A Code A to ascertain the nature of her full grievance against the Constabulary. On 9th May 2002 I reported into that case and made certain recommendations.

Following receipt of Mrs JACKSON's complaint a number of other broadly similar grievances were received from:

1. Mrs Marjorie BULBECK of Code A
2. Mrs Gillian MacKENZIE of Code A
3. Mr Bernard PAGE of Code A
4. Code A
5. Mr Iain WILSON of Code A
6. Mr Michael E WILSON of Code A

1.2 The Jackson file was returned to me with the following instruction from the DCC dated 13 May 2002, "Can I suggest that Chief Superintendent CLACHER is best placed to oversee the rest of the investigation concerning the issues involving Detective Superintendent JAMES."

I therefore saw all of the complainants and obtained witness statements from them, which detail their specific grievances with the constabulary. Appendix 'a' provides a brief resume of each of their specific issues. The key points common to all appears to be that:

a) The enquiry into the death of their elderly relatives was not conducted diligently or professionally and failed to take into account all of the evidence available.

b) That the police failed to keep the complainants appraised of the conduct and progress of the enquiry.

c) That no witness statements, material to the circumstances surrounding the deaths of their relatives, were ever sought or taken.

d) That having made the decision to discontinue enquiries, John JAMES indicated by letter that he would be releasing expert witness reports about the case and treatment of the deceased parties, only to withdraw that offer following two meetings at Fratton Police Station in February 2002.

1.3 Following the recommendations in my report of 9 May 2002, I received Regulation 9 notice to serve on Detective Superintendent John JAMES. The wording and construction of these notices were drafted by PSD. I served them on 22 May 2002.

2. Policy and Procedure of this Investigation

2.1 Following receipt of the file and instructions dated 13 May 2002, I had a meeting with the DCC on Monday 27 May 2002 where we discussed the broad outline of my role and handling of the complaints. I outlined my intended policy as follows:

a) That I would not make any enquiries into the conduct of the original investigation until I had seen ALL of the complainants individually.
b) That I would record their complaints in the normal way and have them registered at PSD.
c) That I would provide a preliminary report before any formal interviews were carried out, should they be deemed necessary. The preliminary report was submitted on 27 June 2002, and following a meeting with DCC READHEAD, ACC JACOBS and C/Superintendent STEVENS on Friday 19 July 2002, it was agreed that this final report should be submitted. In essence, this file is similar in most respects to that dated 27 June 2002, but includes

direct notation and references to key documents which can be found at appendix 'C'. It also contains some additional observations and documents to support them.

2.2 My initial report into the Jackson complaint attempted to separate the issue of allegations against John JAMES from the conduct of the original investigation into allegations made by Mrs Gillian MacKENZIE, about the death of her mother Gladys RICHARDS. I am no longer able to separate these matters as it has become clear that they are inextricably linked.

What is clear, however, is that I was not appointed to re-investigate the original enquiry surrounding deaths at the Gosport War Memorial Hospital. I informed each of the complainants about my role and function as the initial Investigating Officer into the specific allegations made. It quickly became evident that it was impossible to understand and record the detail of their complaints without listening to substantial background information. Although their principal grievance was that a witness statement had not been taken from them about material facts concerning the deaths of their relatives, with the exception of Mrs MacKENZIE (statements already taken) and Mrs JACKSON, I did not take detailed witness statements about the case.

3. BACKGROUND

3.1 The chronology of events chart (appendix B) outlines the sequence of actions up to the present time.

DCI Ray BURT was appointed SIO on 18 August 1999 into the RICHARDS case, following a complaint by Mrs G MacKENZIE, that her original allegations to Gosport CID had not been adequately investigated. Two Gosport CID officers received operational advice for aspects of their handling of the original investigation. It is important to note that one of the main grievances of Mrs MacKENZIE was that no witness statements concerning the death of her mother had been taken from herself or her sister, Mrs LACK.

4. EARLY POLICY IN THE RICHARDS' CASE

4.1 DCI BURT's Policy

DCI BURT's policy file is comprehensive and detailed. It outlines his approach to the enquiry and records his progress and reasons for actions taken.

Policy decision 19 (Document 1), dated 12 April 2000, lays out policy at that time as follows;

'DCS has authorised the commencement of a Major Enquiry – Operation 'Rochester'. It will focus, primarily, on the circumstances of the death of Gladys Mabel RICHARDS, but other lines of enquiry have been identified and will be pursued in consultation with DCS.'

Reason: Appropriate focus for investigation.

4.2 DCI BURT had conducted the bulk of the enquiries into the death of Mrs Gladys RICHARDS at the Gosport War Memorial Hospital and utilising the services of Prof Brian LIVESLEY MD FRCT (as recommended by the national crime faculty), he sent an advice file to the CPS on 11 December 2000.

4.3 On Tuesday 3 April 2001, before the CPS had reached any decision about the RICHARDS case, an article appeared in the *Portsmouth Evening News* about Mrs MacKENZIE's complaint and general thrust of the allegations against the Gosport War Memorial Hospital. This prompted a response from ten members of the public with broadly similar complaints to Mrs MacKENZIE. All of the complainants in this case made contact with the police and left their details with the MIR at Fratton. Each was told that someone from the incident room would get back to them regarding their specific cases.

4.4 At this time, a former employee at Gosport War Memorial Hospital, an auxiliary Nurse, Pauline SPILKA, had also seen the press story and come forward to make a witness statement (Document 2). In this statement she alleges:

'The indiscriminate use of syringe drivers on patients in the Daedalus Ward at Gosport War Memorial Hospital is my main concern. It appeared to me then and more so now, that euthanasia was practiced by the nursing staff.'

Her statement had no useful prosecution evidence to offer the RICHARDS' case. She makes specific allegations about the death of another patient, Code A and the use of morphine through a syringe driver.

4.5 'The SPILKA statement was sent to CPS on 17 April 2001 with a covering letter from DCI BURT dated 14 April 2001 (Document 3). DCI BURT concludes this letter with the following:

'Our current policy is to await the outcome of the decision concerning Mrs RICHARDS deceased, before considering our position regarding the scrutiny of other cases. I'm sure you will appreciate that this development and the problem caused by the unwelcome media disclosure, is placing us under considerable pressure.'

4.6 John JAMES was appointed as SIO on 21 May 2001, taking over from DCI Ray BURT. Superintendent JAMES makes all of his policy intentions clear in his Policy book dated from 21 May 2001. The last entry is policy decision no 48, dated 15 April 2002.

At the point of handover the general thrust of the enquiry appears to concur with the previous policy as set by DCI BURT

5. POLICY DECISIONS – Detective Superintendent JAMES.

5.1 It is evident from all of the documents reviewed so far that John JAMES had taken into account the need to obtain evidence surrounding the deaths of other similar patients to Mrs RICHARDS, that statistical analysis is crucial and that comparative mortality rates were extremely relevant. In addition to Professor LIVESLEY's report, John JAMES seeks the assistance of a practicing geriatric consultant from outside the Portsmouth area. (Dr MUNDY is contacted later and subsequently provides a report.)

5.2 It is also evident that John JAMES and the enquiry team are intent on widening the investigation and looking into a number of other cases from the Gosport War Memorial Hospital connected to Dr BARTON and Philip BEED. The draft reports of, and numerous previous discussions with Prof LIVESLEY, appear to strongly influence the conduct of the enquiry. His firm opinions as to the cause of Mrs RICHARDS death keep the focus very much on the notion that Dr BARTON and Philip BEED are likely to be criminally liable.

This view changes considerably, following a meeting on 19 June 2001 between John JAMES, Paul CLARK, CPS, Treasury Counsel and Prof LIVESLEY.

Superintendent JAMES in Policy Decision 15, dated 19 June 2001 (Document 4) states that

'At the earliest opportunity convene meeting of Enquiry Management Team to consider issues arising from conference of the 19/6 with Senior Treasury Counsel, CPS Senior Caseworker and Professor LIVESLEY.'

Reason: 'Outcome of conference the key issues:

1. *Prof Livesley's report appears to be flawed in respect of his analysis of the law and individual liability.*

2. *Elements of Prof Livesley's report appear misleading in their conclusions i.e. causes of death, possibility of alternative scenario. Urgent need to evaluate impact on the investigation.*

5.3 Up until this time the enquiry team had been heavily reliant upon Prof LIVESLEY's opinions, since his appointment in October 1999. It is not known precisely why the meeting with Treasury Counsel appears to have been so catastrophic in its outcome. No documentation of the precise nature and detail of the discussion has been found. However, a letter from Paul CLOSE of the CPS, casework directive in London, dated 7 August 2001 (Document 5) to John JAMES, does shed some light on the subject. 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 19 June last, which was attended by Prof LIVESLEY, Detective Superintendent John JAMES and DCI CLARKE.'

5.4 The letter goes on to detail the reasons behind the thinking of CPS and Counsel and are laid out 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 'front line' clinician.*

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

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

5. *It is not possible, in the absence of any post-mortem finding, to exclude a heart attack as a possible cause of death.*

It was quite clear from this conference Professor LIVESLEY's conclusion that Mrs Richards was unlawfully killed is untenable.

The following views on the evidence obtained by the police and which we have discussed in detail may assist you.

1. *According to Dr. Barton it was clear by 18th August 1998 that Mrs Richards was near to death. She is supported on this point by Phillip BEED and by the other nursing staff.*

2. *The decision not to transfer a frail, unwell, elderly lady to another hospital was reasonable and one not open to criticism*

3. *The decision to administer drugs by way of a syringe driver was taken in order to keep Mrs Richards pain free.*

4. *By 19th August 1998 Mrs Richards had developed a 'rattly chest'*

5. *The drugs administered, the dose used and the method of administration are not criticised by Dr. Lord or by Jean Dalton*
6. *Thus, but for Professor LIVESLEY's report, there would appear to be no basis for concluding that Mrs Richards had been unlawfully killed.*

7. *For the above reasons Professor LIVESLEY's conclusions cannot now be supported*

I hope it is fair to say that the police were in total agreement with these findings and further, were in no doubt it was fortunate no criminal proceedings had been commenced.

I note the further request by the police, last Friday, for a copy of Counsel's advice. As I have mentioned to officers on previous occasions it is not the policy of this office to supply copies of Counsel's advice to the police.'

5.5 It will be noted that the CPS understanding is that the police were in total agreement with the findings. This raises a number of critical questions, which are outlined in detail at the end of this section.

It is crucial to register at this juncture, that this decision, and judgements connected to it, were made with reference only to the RICHARDS' case. No other matters were documented at that time and therefore counsel would have only given consideration to the possibility of a criminal

conviction on the basis of 'one' apparently isolated death. It is not known whether the SPILKA statement was discussed at this meeting or whether it was rejected as having little relevance to the facts surrounding the death of Mrs RICHARDS.

5.6 As Professor Livesley had been advising the enquiry for nearly two years, this development is likely to have had a significant impact on the morale of the whole enquiry team. It is possible that some officers may have considered that their considerable efforts into the case had been a waste of police time. The views of Detective Superintendent John JAMES should be sought about the effect this meeting had on the enquiry and his subsequent decision-making.

From this point onwards the entries in John JAMES' Policy book appear to lean towards co-operating closely with the other statutory medical authorities. An inference can be drawn that the RICHARDS et al cases seem to be more suited to the internal discipline enquiry mechanisms of the medical profession rather than the police.

6. SELECTION OF CASES

6.1 By 3rd July 2001, John JAMES has had four cases similar to the RICHARDS case submitted to him by Code A

- Eva PAGE
- Brian CUNNINGHAM
- Robert WILSON
- Alice WILKIE.

John JAMES wants further medical opinions about these cases and he directs Code A to contact the families of the four chosen cases. PD 22 (Document 6) In his reasons for this he records:

'To ensure that any expert or other professional view is provided with all relevant information to inform any written report / advice.'

6.2 By 9 August 2001, John JAMES withdraws his instruction to Code A to contact the families of those people that had made contact in April 2001. He expresses concerns about raising the expectations of the families about police involvement in a case where the outcome is not certain. PD 30 (Document 7)

He issues a clear instruction:

'At this stage only respond to queries from relatives and not initiate contact for reasons shown.' He also remarks: 'Need to consider issues of public reassurance and devastating potential impact on Gosport War Memorial Hospital of reporting of widened police investigation.'

6.3 There is no mention at this point about the need to provide some reassurance to the families that had reported their concerns to the police. This decision not to contact them needs further examination. No evidence has been found to show that this decision was conveyed to any of the families that had contacted the constabulary.

A letter dated 14 August 2001 was sent to Mrs LACK (sister of Mrs MacKENZIE) which referred to a meeting John JAMES had with her on 8th August (Document 8). In the penultimate paragraph he says:

'I wanted to further formally offer you my sincere apologies that we failed to inform you personally at the earliest opportunity of the CPS decision. I cannot offer you any adequate explanation for this failing, which I deeply regret. We normally work very hard to ensure families are treated with every respect and for us to have failed is not acceptable. Whilst it may be of little consolation to you we will learn from our mistake on this occasion.'

6.4 It is important to note at this point that at the time of handover, DCI BURT makes reference to FLOs (Family Liaison Officers) in an e-mail to John JAMES dated 19 May 2001 and attached to PD 50 of his policy book (Document 9). It is not known whether they were considered and rejected and if so, by who. It appears that at this stage it was thought even more families of alleged victims may be forthcoming. No FLOs were appointed.

6.5 The next critical point in the decision making process would appear to be when the first contact to the complainants from the Operation ROCHESTER office is made. On 15th November 2001 a letter is sent to them informing them of the Commission for Health Improvement's enquiry

(Document 10). Arguably, this is likely to give a distinct impression that the police have already come to a decision to hand matters over to the Health Authorities.

The reasons for discontinuing the enquiry are recorded on the 28th January 2002 and are outlined below (Document 11) :

PD 42 – SIO's decision re wider police investigation into deaths at Gosport War Memorial Hospital is that further investigation would not be appropriate. Reasons for recording this decision are:

i) Lapse of time since initial report – October 1998 – 3 ½ years – SIO's judges further widened investigation may take 1-2 years – present serious difficulties – particularly in terms of above process concerning those persons already in jeopardy – inc Dr Barton.

ii) Threshold of medical evidence concerning liability of those concerned and death contributors. i.e. FORD refers to the likelihood of patient management contributing to death. This falls short of any lawfulness issues.

iii) Some conflict between practitioners and medical evidence – i.e. see case WILSON – FORD/MUNDY fundamentally disagree – their language is different in terms of conclusive judgements re adequacy of care.

iv) To proceed on basis of arrest information would re-concentrate investigation up to 600 deaths. Considerable numbers raising . ?. . public concerns with no certainty of outcome in respect of current investigations.

v) No certainty of outcome raises or potentially raises expectations for police investigations that it may not be positive to meet and in respect of which support systems are not adequate.

vi) Legal issue present difficulties – particularly in respect of causation and negligence. Negligence specifically and the high threshold required by law.

vii) Other agencies have a role – GMC, UKCC and Trust.

Conclusive analysis of all issues to be included . . ? report.

6.6 Further examination of whether Supt JAMES merely briefed or was being directed by DCS WATTS and ACC SMITH is needed before any assessment as to precisely who was responsible for ceasing the police enquiry.

Whilst the decision making process appears to be well documented and recorded, it still leaves a number of critical issues unclear:

1. Why were no FLOs appointed to liaise with the families that had contacted the police? The 'Murder Manual' Chapter 8 (Family Liaison) states (Document 12):

'The family liaison strategy is one of the most important considerations that the SIO will have to address throughout the investigation. The early appointment of an FLO is essential. Section 8.1.4 Strategic Tactical Management – in formulating the Family Liaison Strategy, the SIO must aim to achieve a partnership approach with the family within the investigation. The strategy will be defined and developed taking into consideration the needs of the family, the lines of enquiry and the available intelligence. This is a dynamic process which must be reviewed at regular intervals and in consultation with the FLO.'

2. What justification was there for not following up the comparative control sample that had previously been regarded as *'crucial in relation to the integrity of the investigation?'*

3. Why weren't the views of the CPS and Treasury Counsel challenged? Was it ever considered or discussed that they could be 'wrong' or that some of their observations required rebutting by obtaining better evidence.

4. Why wasn't a further opinion sought on the basis of similar fact evidence?

5. Why weren't Dr BARTON and Philip BEED re-interviewed about the serious issues raised in the reports of FORD and MUNDY?

6. Why weren't ***all*** cases reported to the police provided for analysis by the expert witnesses?

7. Why wasn't an analyst called in as soon as the SPILKA statement was received? What was the rationale for not employing one before the decision to close the case was made?

8. Why weren't the reports of FORD and MUNDY, in conjunction with Professor LIVESLEY's revised reports ever submitted to the CPS/Counsel for further advice or guidance?

7. MEDICAL EVIDENCE REPORTS

7.1 There are three reports which have been commissioned by the ROCHESTER enquiry team into the events of Gosport War Memorial Hospital. In general terms each of them is highly critical of the care and treatment of patients passing through the hands of Dr BARTON and Philip BEED.

As already stated, this report is not intended to re-investigate the original enquiry, but some understanding of the key factors in these reports is essential when making an assessment as to whether there has been a neglect of duty on the part of the SIO.

7.2 It is apparent that the original report submitted by Professor LIVESLEY and discussed at the meeting with Treasury Counsel on 19 June 2001 was unacceptable and held little credence with the CPS and Counsel. He re-submitted a 'final' report on 10th July 2001 in which he is less strident in the language he uses (Document 13). He is commenting only upon the care and treatment of Gladys RICHARDS.

7.3 It should be noted here that Professor LIVESLEY's final report (referred to above) with his revised but nevertheless damning observations and opinions is likely to be examined in close detail by the complainants following an application for access to it.

Some of the key points he makes are outlined below:

> *No other event occurred to break the chain of causation and in my opinion Mrs RICHARDS' death was directly attributable to the administration of the drugs she continuously received by syringe driver from 18th August 1998 until her death on 21st August 1998.*
>
> *It is my opinion that Mrs Gladys RICHARDS' death occurred earlier than it would have done from natural causes and was the result of the continuous administration of diamorphine, haloperidol, midazolam and hyoscine which had been prescribed to be administered continuously by a syringe driver for an undetermined number of days.*

7.4 Without having seen Professor LIVESLEY's report, the complainants have arrived at very similar conclusions. Professor LIVESLEY remains adamant that the application of a concoction of drugs, including diamorphine through a syringe driver was the cause of death for Mrs RICHARDS. **If his report reaches the public domain, the Constabulary will have to detail precisely why it has not continued with criminal proceedings.**

7.5 Professor LIVESLEY does not appear to be in agreement with Treasury Counsel's views and on 10 October 2001 he faxed a message to John JAMES about a recent similar case (Document 14):

'.....it may be helpful if you direct your attention, that of the Crown Prosecution Service, and also Mr David Perry QC to the indictment in the case of R v Postill to which the defendant recently

pleaded guilty at the Chelmsford Crown Court and for which she appears for sentencing on 19th October 2001. This indictment was drawn to the attention of Counsel by Judge LEVENSON (who as you know appeared in the Rosemary West case) and apparently as an alternative to the charge of manslaughter. It is an offence of' endangering human life, or health by negligence' contrary to common law. I understand that the sentence imposed under these circumstances is at the discretion of the Judge – but Mr Perry may be able to advise us on this matter. Certainly it does not appear to require the exactitude of evidence that a charge of manslaughter requires.'

It is not know what response this fax elicited from the ROCHESTER team. No documents have been found to expand on this point.

8. Report of Professor G A FORD (Document 15)

8.1 Professor FORD had been asked to comment on 5 cases, including Gladys RICHARDS. The other 4 are as follows:

- A) Arthur Brian CUNNINGHAM (No complainant)
- B) Alice WILKIE (Mrs JACKSON's complaint)
- C) Robert WILSON (Mr Iain WILSON's complaint)
- D) Eva PAGE (Mr B PAGE's complaint)

8.2 This report was sent to the ROCHESTER enquiry team. No evidence has been discovered that it has been submitted to the CPS or other counsel for assessment or review. It should be noted that Professor FORD had sight of Professor LIVESLEY's report and Dr BARTON's prepared statement, before compiling his own.

Whilst Professor FORD is less certain regarding 'causation,' i.e. the link between the application of diamorphine and death, he is nonetheless in broad agreement with Professor LIVESLEY over many critical factors.

8.3 The significant difference between Professor LIVESLEY and Professor FORD appears to be in the last line of Professor FORD's summary regarding the death of Mrs RICHARDS. His conclusion that it is possible she would have died from pneumonia, appears on the surface, to introduce a sufficient element of doubt to move the case from the criminal into the civil arena. Arguably, this 'doubt' would be sufficient for the CPS and Counsel to be reluctant to continue. The counter argument, however, is that the possible/probable cause of death is less important than the 'time' of death. The central point in all of these cases is not whether there was a strong

likelihood that these patients might die, but more precisely, when. The principal allegation is that Dr BARTON and Philip BEED were knowingly applying diamorphine to 'hasten or accelerate death.'

The summaries from the four dip-sampled cases are also worthy of note:

A). Arthur 'Brian' CUNNINGHAM

In summary, although Mr Cunningham was admitted for medical and nursing care to attempt to heal and control pain from his sacral ulcer, ~Dr Barton and the ward staff appear to have considered Mr Cunningham was dying and had been admitted for terminal care. The medical and nursing records are inadequate in documenting his clinical state at this time. The initial prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton, was in my view, reckless. The dose increases undertaken by nursing staff were inappropriate if not undertaken after medical assessment and review of Mr Cunningham. I consider it highly likely that Mr Cunningham experienced respiratory depression and profound depression of conscious level due to the infusion of diamorphine and midazolam. ***I consider the doses of these drugs prescribed and administered were inappropriate and that these drugs most likely contributed to his death through pneumonia and/or respiratory depression.***

B). Alice WILKIE (JACKSON Complaint)

'I consider the undated prescription by Dr Barton of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be poor practice and potentially very hazardous. I consider it poor and hazardous management to initially commence both diamorphine and midazolam in a frail elderly underweight patient with dementia such as Mrs Wilkie. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam, had it been appropriate to commence subcutaneous analgesia, which as I have stated before, was not the case.'

'In my opinion, the prescription of subcutaneous diamorphine and midazolam was inappropriate and probably resulted in depressed conscious level and respiratory depression, which may have hastened her death. *However, Mrs Wilkie was a frail very dependent lady, with dementia, who was at high risk of developing pneumonia. It is possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative and opiate drugs.*

In this case Professor FORD is only prepared to say that the application of the drugs 'may' have hastened death and that it is possible she would have died from pneumonia in any case.

C). Robert WILSON (Iain WILSON COMPLAINT)

'The recorded cause of death was congestive cardiac failure. The limited clinical information recorded in the absence of a chest Xray result or post-mortem findings, suggest this may have been the cause of Mr Wilson's death. However, in my opinion, it is highly likely that the

diamorphine, hyoscine and midazolam infusion led to respiratory depression and/or bronchopneumonia and it is possible that Mr Wilson died from drug induced respiratory depression.

Summary

'Mr Wilson was a frail elderly man with early dementia who was physically dependent. Following his admission to Dryad ward he was, in my opinion, inappropriately treated with high doses of opiate and sedative drugs. These drugs are likely to have produced respiratory depression and/or the development of bronchopneumonia and may have contributed to his death.'

D). Eva PAGE (Mr B PAGE COMPLAINANT)

'I do not understand why subcutaneous diamorphine and midazolam infusions were commenced on 3rd march when Mrs page had deteriorated whilst on the fentanyl patch. There is no indication in the notes that Mrs Page was in pain or distressed. the notes describe her as having undergone a rapid deterioration, which could have been due to a number of different causes, including a stroke or an adverse effect of the fentanyl patch. In my opinion, the prescription by Dr Barton of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr was poor practice and potentially very hazardous. I would judge it poor management to initially commence both diamorphine and midazolam in a frail elderly underweight patient such as Mrs Page, who was already receiving transdermal fentanyl. I would expect very clear reasons to support the use of the drugs to be recorded in the medical notes. The combination could result in profound respiratory depression and there are no symptoms recorded which suggest the administration of either drug was appropriate.'

In my view, this was an inappropriate, potentially hazardous prescription. I would consider it highly likely that Mrs Page experienced respiratory depression and profound depression of conscious level from the combination of these two drugs and fentanyl, but I cannot exclude other causes for her deterioration and death at this time, such as stroke or pneumonia.'

8.1 In this case Professor FORD considers the prescription 'inappropriate (and) potentially hazardous,' but concludes: 'I cannot exclude other causes for her deterioration and death at this time, such as stroke or pneumonia.'

He Concludes:

'Having reviewed the five cases presented to me by Hampshire Police, I consider they raise serious concerns about nursing and medical practice on Daedalus and Dryad wards at Gosport War Memorial Hospital. In my opinion, a review of practice at the institution is necessary, if this has not already taken place. I would recommend that if criminal proceedings do not take place, that these cases are brought to the attention of the General Medical Council and United Kingdom Central Council for Nursery, Midwifery and health Visiting, in relation to the professional competence of the medical and nursing staff and the Commission for health Improvement, in relation to the quality of service provided to older people in the Trust.'

Whilst their conclusions speak for themselves, it is important to note that Professor FORD's is concerned enough to recommend further enquiries and he suggests ***police*** interviews.

9. REPORT OF DR K I MUNDY (Document 16)

9.1 Dr MUNDY only reports on the four dip sampled cases and makes no comment regarding Gladys RICHARDS. He provides a useful introduction to the rules and policy regarding the prescriptions and administration of opiates. The British National Formulary, is the standard reference manual and is quite clear on the 'incremental use and application of drugs to regulate pain.'

Dr MUNDY does not cover as much detail as Professors LIVESLEY and FORD, but he does comment on the use of opiates in each case.

A). Arthur 'Brian' CUNNINGHAM

'All the prescriptions for opiod analgesia are written in the same hand and assume they are Dr Barton's prescriptions although the signature is not decipherable. Morphine was started without any attempts to control the pain with less potent drugs. There was no clear reason why the syringe driver needed to be started as the patient had only received two doses of oral morphine, the 24 hour dose requirement of Diamorphine could not therefore be established. The dose of Diamorphine prescribed gave a tenfold range from 20 mg to 200 mg in 24 hours which is an unusually large dose range in my experience. The patient was reviewed by Dr Barton on at least one occasion and the patient was noted to be in some discomfort when moved. The dose was therefore appropriately increased to 40 mg per 24 hours, but there are no further comments as to why the dose needed to be progressively increased thereafter. In my view Morphine was started prematurely, the switch to a syringe driver was made without any clear reason and the dose was increased without any clear indication.'

Dr MUNDY does not come to any clear conclusions as to the cause of death, but is critical in the use of diamorphine. It is also important to note his reference to the unusually large dose range. He could fine no clear reason for the switch to a syringe driver.

B). Alice WILKIE

'There was no clear indication for an opiod analgesic to be prescribed and no simple analgesics were given and there was no documented attempt to establish the nature of her pain. In my view, the dose of Diamorphine that was prescribed at 30 mg initially was excessive and there is no evidence that the dose was reviewed prior to her death. Again the diamorphine prescription gave a tenfold range from 20 mg to 200 mg in 24 hours.'

The point of note here is that the dose of diamorphine was 'excessive.'

C). Robert WILSON

'Mr WILSON was clearly in pain from his fractured arm at the time of transfer to Dryad ward. Simple analgesia was prescribed, but never given (there was an entry earlier in the episode of care that Mr Wilson had refused Paracetamol). No other analgesia was tried prior to starting morphine. Mr Wilson had difficulty in swallowing medication. The Oramorphine was converted to subcutaneous diamorphine in appropriate dose as judged by the BNF guidelines. The patient was reviewed by a doctor prior to the final increase in Diamorphine. Once again the Diamorphine prescription had a tenfold dose range as prescribed.

It is clear that Mr Wilson's condition suddenly deteriorated, probably due to a combination of worsening heart failure and terminal bronchopneumonia and I consider that the palliative care given was appropriate. A Do Not Resuscitate decision had been made by Dr LORD on 29.09.1998.'

Dr MUNDY considers the palliative care given was appropriate. this is the first indication of a significant difference of opinion between Professor FORD and Dr MUNDY.

D). Eva PAGE

'Mrs PAGE had a clinical diagnosis of lung cancer. There was no documentation of any symptoms relevant to this and no evidence of metastatic disease. There was no documentation of any pain experienced by the patient. when she was transferred to Dryad Ward, most medication was stopped, but she required sedative medication because of her distress and anxiety. No psychogeriatric advice was taken regarding her symptom control and she was started on opiod analgesia, in my view, inappropriately. Following her spitting out of medication, she was given a topical form of an opiod analgesic (Fentanyl). A decision was taken to start a syringe driver because of her distress. This included Midazolam, which would have helped her agitation and anxiety.

The prescription for subcutaneous Diamorphine infusion again showed a tenfold range from 20 mg to 200 mg. It was clear that her physical condition deteriorated rapidly and I suspect she may have had a stroke from the description of the nursing staff shortly prior to death.'

9.1 It is important to note here that Dr MUNDY observes that there was no documentation of any pain experienced by the patient and although he is not specific regarding causation he regards the prescription of an opiod analgesic as inappropriate.

Dr MUNDY's conclusions are detailed below, the key points being that in each of the four cases 'standard practice' was not complied with and that the use of Diamorphine 'as required' is in his view, unacceptable.

'Diamorphine on the as required section of the drug chart is, in my view, unacceptable.

There was little indication why the dose of diamorphine increased in several of the cases and the dose appears to have been increased without the input of medical staff on several occasions.

I believe that the use of diamorphine as described in these four cases suggests that the prescriber did not comply with standard practice. There was no involvement, as far as I could tell, from a palliative care team or specialist nurse advising on pain control. I believe these two issues require further consideration by the hospital trust.'

10. GENERAL CONDUCT OF OPERATION ROCHESTER

10.1 Despite the fact that Professor LIVESLEY's evidence was found to be flawed at the meeting on 19th June 2001, there appears to have been no attempt to challenge any of the observations made by the CPS in their letter of 7th August 2001. What is particularly noticeable are the references to Philip BEED and Dr LORD supporting the views of Dr BARTON. This is hardly surprising as both are arguably, to varying degrees, as liable for the care of most of the patients referred to here (although not Dr LORD *directly* in the case of RICHARDS). Some unease as to the direct and forthright language used by Professor LIVESLEY would appear to have been expressed before the 19th June 2001 meeting. On 13 May 2001 Code A submitted a report to Superintendent JAMES in which he refers to other cases involving Professor LIVESLEY. (Document 17). The last two paragraphs are of particular note. It would seem that although the professor's opinions have been challenged openly in court, he has successfully argued and won his case;

'I have spoken to WDS Sally BURKE who was the case officer and sought her opinion. Like us their enquiry was surprised at the unequivocal nature of prof LIVESEYS [SIC] *report. They also considered a range of cases and when LIVESY was not convinced that criminal acts had taken place he said so. However he was clear that some of REEDS actions were criminal and clearly evidenced his findings.*

His evidence was presented in laymans terms to the jury and when challenged by the defence team expert (whose name escapes Sally) clearly won the argument. WDS BURKE is obviously impressed by his performance and recommends contact with Det Supt McKIAN. You may wish to speak with him directly.'

10.2 Taken in isolation, it is perhaps understandable that the CPS and Treasury Counsel would wish to give 'the benefit of the doubt' to Dr BARTON for her 'clinical judgement' in the case of Mrs RICHARDS. Taking the other four dip-sampled cases into consideration ***collectively***

changes matters significantly. Her 'clinical judgement' is seriously undermined by the comments of FORD and MUNDY. Evidence of similar fact is admissible in cases such as these and it should be remembered that only *four* from possibly far more cases were even considered.

10.3 Had the evidence of the relatives been taken into account first, the reports from Professor FORD and Dr MUNDY may well have taken on a very different complexion. Moreover, had a qualified and dedicated analyst been employed and made the selection of cases on the basis of the best possible criteria available, rather than on the calculated assessment of Code A alone, the outcome in terms of criminal liability, would probably have been somewhat different.

10.4 If all of this background information had been researched rigorously, in particular, the basis of statistical comparisons of mortality rates, it would have been possible to demonstrate empirically whether the deaths at Gosport War Memorial Hospital were significantly higher or lower. This evidence alone would have gone a considerable way to rebut allegations of collusion between the Constabulary and Health Authority. ***(See addendum)***

10.5 It is possible to argue that the analyst should have been employed as soon as the SPILKA statement had been received at the MIR. Even if there was an early 'indication' in the investigation that the matter *may* be more suited to a Health Service investigation than a criminal enquiry, an allegation of a 'culture of euthanasia' by an ex member of staff is an extremely serious one. Combine this with the very real and genuine concerns of individuals who have contacted the police with information surrounding such alleged deaths and the issue grows into one of *considerable* public concern. Whilst it is our primary function to present evidence to the criminal courts to *prove* criminal offences, in cases where open public concern has been voiced in the media, we should have cognisance of the requirement to 'disprove' criminal liability beyond reasonable doubt, if necessary.

10.6 In the SHIPMAN case, statistical analysis played an extremely important part. Detective Inspector HEAP from the SHIPMAN enquiry team has stated that this evidence was overwhelming, but prosecuting counsel had decided on a purely tactical basis *not* to introduce it as prosecution evidence as they had more than enough to convict without it. Any suggestion that such evidence is 'inadmissible' or 'unusable' therefore appears to be misplaced.

10.7 It is noted that Superintendent JAMES regarded 'public reassurance' as a major part of his responsibility. It is not clear, however, how that was to be established by the police when such serious and damning observations had been made by Professors FORD and LIVESLEY and Dr MUNDY. The police enquiry team were aware that there were many more cases which they had 'suspicions' about, but had not eliminated them to a sufficient degree to categorically be concerned about 'public reassurance'.

Indeed, it could be regarded as at best careless, or at worst, reckless, to engage on a process of public reassurance before the enquiry had fully satisfied itself as to the facts of the case.

11. MOTIVE

11.1 The professional medical reports of Dr MUNDY and Professors LIVESLEY and FORD, give a strong indication that the application and use of diamorphine within Daedalus and Dryad wards at the Gosport War Memorial Hospital fell outside what should reasonably be expected from medical staff. The allegation of the families and SPILKA is that their deaths have been 'hastened' by an orchestrated, repeated and deliberate campaign by Dr BARTON and Philip BEED in particular. The suggestion is not that the actions of the staff were 'reckless', but deliberate. If, and this is at the heart of the issue, there has been a deliberate and intentional practice of euthanasia by these two members of staff, then the question of motive needs to be explored further. It should also be noted at this juncture that DR LORD is the Consultant with overall responsibility for the care and management of patients on both wards. She too may be quite properly regarded as having significant liabilities in respect of malpractice at the hospital.

It is not clear whether there is any financial gain, either for the doctor, the ward, the hospital or the Health Trust for the 'throughput' of patients such as in these cases.

The question of how funds are allocated to patients or doctors needs to be examined.

11.2 The drugs referred to in this report include powerful sedatives as well as painkillers. The issue of whether the nursing staff have deliberately misled the doctor, in order to make the

handling and administration of the patients easier, warrants further enquiry. It is noted that no 'Nursing Consultant' has been approached to provide a professional opinion upon the standards of nursing care, or upon the standards of record keeping in each of these cases. It is not know if this was considered and rejected, or never considered by John JAMES and the enquiry team.

11.3 Insufficient information has been found within these case papers to make a judgement as to whether the issue of 'motive' has been explored to the depth expected in cases such as these. It is not possible to make a judgement at this stage as to whether they should fall in the realms of civil or criminal liability.

11.4 It is crucial to note the critical dates in this case. On **9th November 2000**, Professor LIVESLEY wrote to DCI BURT with a number of requests. In this letter (Document 18) he states:

'Following our recent conversation the report is headed 'initial medical report for discussion only.' As you know, this is because I regard it as essential for me to discuss the matters arising with the CPS and, preferably also with experienced counsel, before I produce a formal statement as an expert witness.....

I recommend that further enquiries be made to determine if other patients at the Gosport War Memorial Hospital have been affected in a manner similar to that of Mrs RICHARDS and particularly those who have been under the care of Dr BARTON.'

11.5 His final paragraph is particularly telling. Despite his recommendations and the contact by ten families in April 2001, Professor LIVESLEY does not appear to have been provided with the same or similar details as those provided to Professor FORD and Dr MUNDY.

It is conceivable that if statements had been taken from the complaining families in April 2001, and their medical notes been made available to Professor LIVESLEY, before his meeting with Counsel in June 2001, the testing of his evidence would have elicited a more positive outcome.

In Superintendent JAMES' letter to Professor LIVESLEY, dated 5 June 2001 (Document 19), only the broad outline of what 'should' be examined was indicated. No statistical, analytical or even medical, (by way of patient notes) information had yet been obtained.

11.6 This report raises far more questions than answers. It is fully accepted that these observations are made with the benefit of considerable hindsight. In addition, it is acknowledged that this small enquiry team have only touched the surface of the many and complex issues involved. The team (Chief Superintendent CLACHER, Inspector Mark WISE, Roger HOPGOOD) accept that work on the original case file only commenced in earnest on Thursday 20th June 2002, and that a good deal more needs to be done before any firm conclusions can be made. In particular, officers engaged on the Operation ROCHESTER enquiry need to be fully interviewed about their involvement and decision making and those interviewed may be able to shed much light on the matters alluded to here.

11.7 At this stage, the early indications are that there appears to have been a considerable shift in the focus of the enquiry following the meeting between CPS / Treasury Counsel, John JAMES and Professor LIVESLEY on 19 June 2001. Following this meeting and the subsequent advice letter dated 7th August 2001 from CPS, it seems the emphasis shifted from the police to conduct enquiries, to co-operating with the Health Authorities for them to conduct their own investigation. Moreover, there would appear to be a close working relationship formed between Superintendent JAMES and Julie MILLER from the CHI enquiry team. This is evidenced by the friendly and open style of language used in an email dated, 4th April 2002 from Julie MILLER to Superintendent JAMES. (Document 20)

11.8 It would all seem to hinge on whether or not a prosecution for any criminal offence stood any chance of success once Professor LIVESLEY's testimony had been found wanting. There is some logic in senior police leaders not wishing to engage limited and precious resources on lengthy and detailed enquiries into a matter which, on the surface, gave the distinct impression that it was more suited to examination by the civil courts or G.M.C.

11.9 Ultimately, it is a question of judgement as to whether these cases should have been pursued more rigorously in terms of proving or disproving criminal liability. It should be acknowledged that after 7th August 2001, Detective Superintendent John JAMES certainly appeared to have a genuinely held belief that these cases were more suited to examination by the various medical

bodies he was liaising with. This is supported by his clear intention to initially supply the families of the complainants with full copies of the expert witness reports.

11.10 What now needs to be tested is whether, despite genuine and honestly held beliefs, the correct judgement was applied in deciding not to continue with the police investigation. The complainants have significant concerns that the *police* investigation was discontinued or scaled down, not because of a lack of evidence, but because a major enquiry such as this would prove too costly and be too time consuming for the Constabulary.

11.12 It is noted that Superintendent JAMES gave consideration to the points raised here, but apparently rejected them later. It is important to establish whether this was a decision he took alone, collectively or was directed to take from a higher authority.

12. COMMENTS & OBSERVATIONS

12.1 As already stated, the enquiries made so far into the allegations made against Superintendent John JAMES are self evidently incomplete. No police officers, including Superintendent JAMES have been interviewed regarding their actions, decisions or policies in respect of the documentation reviewed in this report. It would therefore be premature to arrive at any firm conclusions as to whether any discipline breaches have occurred. The only reasonable assumption to come to at this stage is that there is a ***'case to answer'***.

12.2 The Case to Answer

12.3 Complaint (a) *The enquiry into the death of their elderly relatives was not conducted diligently or professionally and failed to take into account all of the evidence available:*

Observation: Case to answer for the following reasons:

- None of the expert witness reports produced after 19th June 2001 appear to have been submitted to CPS/Treasury Counsel for advice or direction

- None of the contents of the expert witness reports have been put to Dr BARTON or Phillip BEED in a formal police interview under caution, even though Dr BARTON's solicitor has had full access to the reports since February 2002.

- No statistical research appears to have been conducted into mortality rates at the hospital

- No analyst, or analytical report has been utilised

- Whilst on the surface it may appear that the complainants would have little to offer in the way of evidence, it should be noted that many of them have very close links to medical and the caring professions.

12.4 Complaint (b): *That the police failed to keep the complainants appraised of the conduct and progress of the enquiry.*

Observation: Case to answer for the following reasons:

- Although the majority of the complainants contacted the police in April 2001 the first significant contact they had from the enquiry team was by letter in October 2001 informing them of the CHI investigation. This letter also makes it clear ***that enquires are not complete***. This statement indicated to the complainants that their individual cases were being investigated, but in the case of four of them this was not the case – as they later discovered.

- The next contact was, again by letter in February 2002 to inform them that no further police action was to be taken. They were invited to a meeting to have the decision explained to them. It appears that with the exception of Mrs MacKENZIE none of the complainants had anyone call upon them at home throughout the whole investigation.

- No FLOs were appointed despite reference to them at handover by DCI BURT in May 2001.

- Superintendent JAMES acknowledges poor communication in a letter to Mrs LACK dated 14 August 2001. Yet he records in PD 30 (Document 7) dated 9th August 2001 that Code A Code A should not contact the complainants families as he is concerned that to do so *'raises significant expectations about outcomes of police involvement'*

12.5 Complaint (c) *That no witness statements , material to the circumstances surrounding the death of their relatives, were ever sought or taken.*

Observation: Case to answer for the following reasons:

- It is a material fact that no statements were ever taken (Excepting MacKENZIE)

- Superintendent JAMES records his reasons for not contacting or obtaining the statements, but the decision making process behind this needs to be explored in more detail.

12.5 Complaint (d): *That having made the decision to discontinue the enquiries, Superintendent JAMES indicated by letter that he would be releasing expert witness reports about the case and treatment of the deceased parties, only to withdraw that offer following two meetings at Fratton Police Station in February 2002.*

Observation: Case to answer for the following reasons:

- It is a material fact that the expert medical reports have not been supplied to the families

- At a meeting in February 2002 Superintendent JAMES indicated that he would release the medical reports to the families on request.

- He *subsequently* consulted with the force solicitor Mike WOODFORD and appears to have been advised that the reports should not be released by the Constabulary without a court order. (Woolgar Vs Sussex Police) Mike WOODFORD has since indicated to this enquiry that the Constabulary would not oppose the application for the order.

12.6 This last complaint is potentially the most difficult to countenance as the three expert medical reports of LIVESLEY, FORD and MUNDAY have now been released in their entirety to the defence solicitor for Dr. BARTON (February 2002), despite the fact that they have still not been made available to any of the complainants.

Dr BARTON and Mr BEED were interviewed under caution by police in **July 2000** and this only referred to the RICHARDS complaint. Dr BARTON read out a prepared statement and then made no comment to all other questions put to her.

13. RECOMMENDATIONS

13.1 The recommendations in this report have not changed substantially from those of my earlier report dated 9 May 2002.

- That the additional matters raised in this report be re-considered by the head of PSD and the Deputy Chief Constable to ascertain whether additional and more detailed Regulation 9 forms need to be drafted and served on Superintendent JAMES

- That an early assessment is made as to whether the Police Authority should be informed if it appears that Superintendent JAMES' supervising officers were responsible for directing the conduct of the enquiry, particularly after 19th June 2001.

- That a Senior Investigating Officer is appointed from an outside force to ***fully*** investigate the professional standards issues raised on the **'case to answer'** sheet.

- That an outside force be invited to review the handling and decision making processes in the RICHARDS case as well as the subsequent matters reported to the Constabulary in April 2001.

- That the PCA be informed and consulted about the nature of the complaints.

13.2 My reasoning for the above recommendations is the significant rank of the officers involved, the very serious nature of the alleged offences and the substantial public interest in the case.

Addendum

At a meeting on the afternoon of Friday 19 July 2002 Chief Superintendent STEVENS handed me a copy of an email which outlined a telephone conversation alleging corruption on the part of the police. (Document 21). It is important to note that this is not the only time that the allegation of collusion between the police and health authorities has been raised. Some of the complainants have formed a firm opinion that this was the case, although they could not provide any 'evidence' to support their view. It seems possible, therefore , that Professor LIVESLEY has heard such rumours, or may even have been contacted by one of them. I would therefore suggest that should any further enquiries be conducted Professor LIVESLEY be seen at the earliest opportunity to assess the provenance of the allegations.

Dan Clacher
Chief Superintendent
Portsmouth

APPENDIX 'A'

Brief Details of Complaints.

Mrs Marjorie Bulbeck.

- No statements were taken surrounding the death of her mother and therefore unhappy with the police decision to discontinue the investigation
- Severity of the cases not taken into account when making this decision.
- **Conditional informal resolution possible on completion of C/Supt Clacher's investigation.**

Mrs Marilyn Jackson.

- No witness statement taken which would have highlighted her grave concerns surrounding her mother's death.
- Lack of contact and level of communication – which fell well below the standards expected in such a case.
- The justification for not pursuing the case is flawed and insensitive – in particular the reference made to a lack of police resources to undertake a full investigation.
- The suggestion that medical reports would be available and then to merely withdrew the offer shortly afterwards was unprofessional and inadequate.

Mrs Gillian MacKenzie.

- The officer failed to investigate other similar cases reported to the police following media articles, which could have possibly strengthened her own case and may have led to it being reconsidered by the CPS.
- That she was excluded from a meeting held by the officer with other relatives for no apparent reason.

Mr Bernard Page.

- No witness statements taken or contact made to confirm relevant facts.
- The investigation process was not explained until after a decision had been made not to take any further action.
- His mothers medical notes (dated 27.02.98) indicated an intent to kill by the staff which has not been investigated.
- The officer promised to release two medical reports to the relatives which were never forthcoming – aggravated by the fact that other agencies have been sent copies.
- Suspicion that police had released documents relating to his mother to other agencies prior to a letter he received on the 15th November 2001 which would indicate the police had already decided not to investigate the matter.

Code A

- No witness statement taken and therefore no one listened to her concerns.
- Unhappy with police decision not to proceed with investigation and consider that the whole case has been inadequately examined in detail.
- Severe lack of communication throughout – led complainant to believe case was being investigated when in fact this was not the case.
- Unhappy with comments justifying decision not to proceed -" time involved in bringing the cases to court", " resources would be costly" and "wanted to avoid unnecessary distress to other families coming forward".
- Promised to supply independent medical reports obtained by police only to discover the force solicitor would not allow this to happen without a court order.

Mr Iain Wilson.

- Failed to fully investigate the circumstances of his father's death, who he believes was unlawfully killed.
- Was told that medical reports would be available to the relatives – It transpired this was not the case.
- Lied to other members of the group by telling them that the complainant and another member were only seeking an apology from the hospital which was not the case.

- How were medical reports obtained by the police without due reference to either the complainant or other members of the family.

Mr Michael Wilson.

- Unhappy with the decision not to pursue an investigation into his mothers death – **although has now formally withdrawn complaint against police.**