HAMPSHIRE CONSTABULARY

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17th August 2005

Mrs L Richards

Code A

Dear Mrs Richards

I write further to my letter of the 24th November 2004 regarding the police investigation into the circumstances surrounding the death of your mother, Gladys Richards. In that letter I indicated that your mother's case had been recorded as falling within our category 2. I informed you at that time that further work needed to be conducted to establish whether or not there was any evidence of unlawful criminal activity within the treatment your mother received.

I am now able to inform you that the process of analysis has now been completed and that we are unable to show that there was any evidence of unlawful criminal activity within your mother's treatment.

In order to reach this conclusion, considerable work has been undertaken by a number of clinical experts commissioned by the investigation team. I thought it might be useful to outline this work to allow you to understand the extent of our investigation.

In September 2002 Operation Rochester was commenced to investigate a number of deaths at the Gosport War Memorial Hospital (GWMH). Prior to that time the Hampshire Constabulary had investigated the circumstances of your mother's death. What follows is a brief chronology in respect of the initial police investigations prior to the commencement of Operation Rochester in September 2002.

In September 1998 your sister contacted Gosport CID and made an allegation of unlawful killing. As a result of this initial investigation, a file of evidence was submitted to The Crown Prosecution Service (CPS) in the autumn 1998. After due consideration, in March of 1999 the CPS advised the police that there was insufficient evidence to commence proceedings.

The investigation continued in 1999 and the investigating officers commissioned additional expert opinion. A file of evidence was submitted to the CPS in January 2001. Again, after due consideration, the CPS advised the police in August 2001 that there was insufficient evidence to prosecute any individual or body.

In the event, further expert opinion was commissioned in respect of your mothers treatment. A further file of evidence was submitted to the CPS in September 2002. In November 2002 the CPS advised the police again that there was insufficient evidence on which to base a prosecution against any individual or body.

As mentioned above, the current operation began in September 2002 and was independent from the previous investigations. Because of the publicity generated by the events of that time, a significant number of other people had come forward expressing concerns about the treatment received by their relatives at the GWMH.

You will be aware, that we set about our investigations by commissioning a clinical team of experts headed by Professor Robert Forrest. The team consisted of 5 disciplines; toxicology, palliative, geriatric, general medicine and nursing. Their task was to provide an analysis of the medical records of each of the patients and to categorise each case into 3 separate groups.

The category 1 group contained cases where the treatment provided was considered to be optimal, the category 2 group contained cases where the treatment was considered to be sub optimal. The category 3 group contained cases where the treatment was considered to raise particular concerns that warranted further analysis.

Having been analysed and categorised, the cases were then reviewed together with the specific concerns raised by patient relatives, by a specialist medico legal advisor. This allowed for the work of the clinical team to be quality assured and for any additional work needed to be identified. The independent medico legal advisor agreed with the categorisation of the clinical team in respect of your mother's categorisation.

All of the category 1 and 2 cases were duly submitted, after due liaison with the families involved, to the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) for their attention.

As you are aware from my letter to you of the 24th November 2004, your mother's treatment was categorised as being a case that fell within category 2 but mentioned that work was, at that point, continuing. The additional work alluded to within my letter has now been fully completed.

This included commissioning additional work to be done by an expert in respect of examining again all the medical records in respect of your mother's treatment at the GWMH including, as before, all relevant 'feeder' notes. In addition, the same expert was tasked with reviewing the statements made previously by you and your sister and all other related documents. Lastly, the same expert was tasked with reviewing all of the material submitted subsequently by your sister.

The analysis by this expert confirmed the previous findings that your mother's treatment was sub optimal but with no evidence of unlawful criminal activity.

The concerns with your mother's treatment relate to the lack of detail, in general, within the medical notes. With the lack of specific detail relating to decision making or as to the extent the patient was examined, all of which fall short of the standards set by the GMC. In particular, the expert was concerned over the prescription of opioid analgesia and the high dosages of diamorphine administered. However, the expert concludes that your mother's death was from natural causes.

We now propose to submit your mother's case both to the GMC and NMC for their attention. Clearly the concerns raised need to be given their fullest consideration.

The Operation Rochester investigations continue with a focus on the cases that fell within category 3. At the present time we are liaising with the CPS who, as you know, are responsible for deciding whether proceedings are appropriate or otherwise.

I would like to thank you for the patience and support demonstrated during our investigation. If you have any questions regarding the content of this letter, please do not hesitate to contact me at the above address.

Yours sincerely,

Code A

Nigel Niven
Deputy SIO