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Ms M Bulbeck

Code A

IPCC Contact Rebecca Fuhr
Casework Manager
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Our Reference COM 2003 002112

Date 28 June 2005

Dear Ms Bulbeck

I am writing about the complaint you made against the police.

Your complaint has been investigated by the Hampshire Constabulary. The investigation was then reviewed by a chief officer and has now been submitted to the Independent Police Complaints Commission, which replaced the Police Complaints Authority on 1 April 2004. The role of the IPCC, which is totally independent of the police service, is to satisfy itself that the complaint has been properly investigated and to decide if there is sufficient evidence to justify misconduct proceedings against any officer.

As explained in the enclosed note, the IPCC is required to review the investigation under the rules that applied to the Police Complaints Authority, as your complaint was recorded prior to 1 April 2004.

The investigation into your complaint

In your original letter of complaint dated 7 May 2002, you express your concerns about the investigation into deaths at Gosport War Memorial Hospital by Detective Superintendent (now Chief Superintendent) John James. You say specifically that you were dismayed at the lack of any endeavours by the officer to arrange for you to give a statement. You also express great concern over the closure of the enquiry when it seemed to you that an adequate investigation had not been carried out.

Chief Superintendent James has provided a comprehensive written report in response to your complaints. This is a lengthy document containing a highly detailed account of the police investigation into the allegations made by you and others against Gosport War Memorial Hospital. As part of this report, Chief Superintendent James addresses each of your specific complaints about the manner in which the

investigation was conducted.

Chief Superintendent James acknowledges his decision not to take statements from members of the families of the deceased in the course of the police investigation. He states that this was subject to careful consideration and calls his decision "a professional judgment at the time".

The investigation into the death of Gladys Richards immediately preceded the enquiry into the further deaths at Gosport War Memorial Hospital and Chief Superintendent James states that he recognised the importance of learning all the lessons he could from this earlier case. The Richards enquiry impressed on Chief Superintendent James the fact that the most pivotal element of an investigation such as this was bound to be the expert evidence. He is very clear in his written report that Operation Rochester did indeed hinge almost entirely on the reports of the experts reviewing the case and he appreciated from the outset that it was their evidence that would dictate the running of the investigation as a whole and its future. In his professional judgment, therefore, gaining expert evidence was the clear priority and he did not believe that details collected from the bereaved families would add to the knowledge of the experts compiling their reports. Evidence collected in the form of statements from relatives of the deceased would not feature in the experts' reviews and Chief Superintendent James judged that it would therefore not be appropriate to include them as this stage. He says that statements were not taken from family members not as an oversight, but as a considered course of action based on the limited role that evidence of this type could and would have in the process of the enquiry.

As I have explained, it was clear from an early stage of Chief Superintendent James' investigation that the critical element in determining whether criminal proceedings would be taken forward was the view of expert witnesses. This is because they key issue that would need to be determined was the appropriateness of the frequency and quantity of the administration of diomorphine, in light of the medical condition of the persons whose deaths whilst patients at the hospital were being investigated.

Allied to this was the question of whether the administration of diomorphine could be said to have caused the deaths, as the concept of causation is embodied in criminal law. It became clear to Chief Superintendent James as the investigation progressed that, on the basis of the expert evidence that had been commissioned, he would be required to show:

1. That there was unequivocal evidence that indicated the quantities, combination and delivery of drugs to patients at the hospital were a direct cause of death and that no other cause could be considered.
2. That if the action taken in the hospital was determined to fall short of an appropriate professional standard, it fell so far short of any recognisable standard to be characterised as criminally negligent.
3. The specific liability of all persons involved in giving care, not just those most directly involved in giving care. This would include, for example, consultants acting as supervisor to other clinicians and so on.

Chief Superintendent James engaged the services of a person widely recognised as an expert in this area. The views that person expressed led Chief Superintendent James to put forward material to the Crown Prosecution Service (CPS) for

consideration of initiation of criminal proceedings against the relevant employee, or employees, of Gosport War Memorial Hospital. However, the CPS took the view that the expert's opinion did not provide sufficient support for a prosecution.

Having received that decision, Chief Superintendent James did not abandon his investigation. Rather he consulted two other experts, whose reports and opinions he then considered. The evidence presented in their two reports led him to conclude that, in his professional judgment, although it showed a possible or even probable link between the regime of care given to patients and their deaths, "this fell short of the unequivocal cause or connection that was necessary and which had been very clearly articulated by Senior Treasury Counsel". This issue was compounded by a certain degree of variation in the conclusions reached by the two experts. Due simply to differences in professional opinion, the two reports did not present a thoroughly consistent and unified response to the question of possible negligence. This made the required "unequivocal" link between the regime of care and deaths in the hospital all the more difficult to demonstrate.

Therefore, Chief Superintendent James can be said to have utilised the expertise in existence at that time to the full. The difficulties involved are clearly illustrated by the CPS decision that the initial expert's view was insufficient to sustain criminal proceedings, and by the divergence of opinion between the second pair of experts. His decision of 28 January 2002 to discontinue the investigation was therefore taken after a thorough consideration of all relevant material, and was proportionate in terms of what further investigation might reasonably have been expected to produce. In no sense can that decision be regarded as constituting neglect of duty.

There have been concerns that Chief Superintendent James's decision was based upon, or was heavily influenced by, considerations of cost. There is no evidence to support this view. The material available to the IPCC suggests that decisions by Chief Superintendent James concerning the investigation were based solely on professional judgments of the kind discussed earlier in this letter.

It may well be that the sense of dissatisfaction that has led to complaints about this investigation was unnecessarily heightened by poor communication between the investigation team and yourself. The investigation, it is accepted, did not have a proper strategy for the appointment and use of Family Liaison Officers. It may well be that had Family Liaison Officers been appointed at the outset and established good working relations with yourself and other complainants, the difficulties encountered in the course of the investigation could have been explained in a manner that might have prevented the loss of confidence which undoubtedly occurred. Chief Superintendent James will receive operational advice on this point.

It is well known that, after both the discontinuation of this investigation and your complaint, further complaints were received in relation to the circumstances surrounding the deaths of certain patients at Gosport War Memorial Hospital. It is equally well known that a new criminal investigation was begun, and indeed is still underway. The question has been asked whether the opening of the new investigation suggests that the earlier investigation headed by Chief Superintendent James was deficient, or that it should not have been discontinued.

It is important to assess the standard of competence of this or any other investigation by the good practice of the time, and not by reference to subsequent developments

or in the light of hindsight. Chief Superintendent James made use of the techniques regarded in 2001 as the most appropriate. There is no basis for suggesting that he ignored or failed to be aware of other methods of investigation.

However, the new investigation, which is still ongoing, has pioneered the development of new techniques. These new techniques were set out in a document entitled 'Investigations of Deaths in Healthcare Settings' and they have been regarded as so innovative and valuable that the Association of Chief Police Officers (ACPO) Homicide Working Committee has recommended that this methodology be used in all future investigations of this kind. The development of this new methodology has in part been made possible by the ability to draw upon the lessons learned from the earlier investigation. Whatever the result of the application of this methodology in the current investigation, it would be wrong to use it as a yardstick to assess the investigation conducted by Chief Superintendent James. That must be judged only by the standards of practice as they existed several years earlier.

It has been noted that a number of those who made allegations against Gosport War Memorial Hospital did not feel that they were not kept adequately updated on the progress of the investigation. It has been suggested that it is because of this lack of communication that the news that the investigation was to be discontinued was met with considerable shock and distress. It has also been suggested that the appointment of Family Liaison Officers may have eased this situation somewhat and may well have avoided the escalation of a number of concerns in the minds of the families involved in the investigation.

Chief Superintendent James has acknowledged that a more comprehensive strategy for communicating with those relatives would in all likelihood have been beneficial. He points out that extensive direct communication between himself and the families involved would not necessarily have been the most appropriate means of achieving this. However, he does state that he views it as "a matter of considerable personal regret" that he did not develop a model, along with all the other interested parties, in order to have a mullti-agency forum that would have answered queries and addressed concerns raised by the families. He comments that he feels this would have encouraged an 'opening up' of lines of communication generally, in a way that would have been beneficial to the relatives without compromising the position of the Police Force. Chief Superintendent James wishes for it to be noted, though, that there was no such model in place at the time for him to follow. There is, he points out, a recognition that such a model needs to be developed nationally. Chief Superintendent James concludes, though, that the anguish caused and eventual complaints made by the families concerned on this point, were understandable.

The Commission's provisional decision

For the reasons set out above, there are aspects of your complaint against Hampshire Constabulary that can not be substantiated. With regard to these specific allegations, on the evidence available, the IPCC is not satisfied that there is a realistic prospect that a tribunal would find that the conduct of the officer fell below the required standard. We are therefore minded to conclude that misconduct proceedings cannot be justified in relation to these issues.

However, Chief Superintendent James failed to implicate a communication strategy between the Force and the affected families which, it has been widely agreed and

acknowledged by the officer himself, would no doubt have been beneficial to all concerned. With this in mind and having taken into account all of the circumstances, the IPCC is minded to agree with the police recommendation that the officer should receive Operational Advice about the matter.

Advice is a form of police discipline similar to an oral warning, and is neither given nor received lightly.

Your right to comment

As explained above, your complaint was investigated by the police and the summary in this letter is based on the police investigation that I have reviewed. Before the IPCC makes a final decision we wish to give you the opportunity to comment, and to send any further information or evidence you may have. If you wish to do so, your reply in writing must reach me within 28 days of the date of this letter. If I do not hear from you within that time, the IPCC will make a final decision.

I enclose a reply form which sets out the choices open to you. Please use this form if you wish to comment. You can also telephone the number at the top of this letter if you want more information.

I understand that you may feel more comfortable discussing some of the issues relating to this matter in person. I would be happy to arrange a meeting with all of the complainants involved, in the Gosport area, at a mutually convenient time, if you feel this would be helpful. Please contact me if you would like to participate in such a meeting.

Yours sincerely

Code A

Laurence Lustgarten
Commissioner

Standard of proof

Before the IPCC can recommend or direct formal misconduct proceedings, we must be satisfied that there is a realistic prospect of showing that the officer's behaviour has fallen below the standards set out in the Police Code of Conduct. This has to be proved on a balance of probabilities, which means that the tribunal must decide that it is more likely than not that an allegation is true.

Other disciplinary action

Many complaints, even if supported by the evidence to the required standard of proof, do not justify, in the public interest, an officer facing a formal hearing and in these cases the IPCC can propose that an officer be given a Formal Written Warning or "Advice" (a police term equivalent to an oral warning) by a senior officer. A Formal Written Warning will be recorded for 12 months on the officer's personnel record. Even if the evidence does not reach the required standard, we may propose that an officer should receive guidance or further training to prevent a recurrence of the incident or behaviour giving rise to your complaint.

EXPLANATORY NOTES

The accompanying letter informs you of the provisional decision on the investigation into your complaint against the police. A copy of the letter has been sent to your solicitor, if you have one. Although the investigation was undertaken by the police, the final decision on your complaint is taken by the Independent Police Complaints Commission (IPCC), not the police. We are responsible for writing to you to summarise the findings and conclusions of the investigation. We will also tell you about the disciplinary action, if any, which is proposed, to be taken against the officer(s) you complained about. You have an opportunity to comment on the provisional decision, or send further evidence or information and the enclosed letter tells you how to go about doing this and the time limit for doing so.

The Independent Police Complaints Commission replaced the Police Complaints Authority (PCA) on 1 April 2004 and is totally independent of the police service. Its Commissioners come from different backgrounds, but none have been employed by the police either as a police officer or in a civilian capacity. Our purpose is to see that a complaint made about the conduct of a serving police officer is dealt with fairly, thoroughly and objectively. When reviewing investigations, the IPCC must have regard to the evidence gathered, to law and to the provisions of the Police Code of Conduct. If it considers that more information is reasonably required before it is able to finalise its decision then it has the power to seek this from the police. With complaints recorded before 1 April 2004 the IPCC can only review the investigation under the rules that applied to the PCA (i.e. under the powers of the Police Act 1996).

Allegation of criminal conduct by a police officer

In some cases (such as where the complaint is of an assault or a theft) the Crown Prosecution Service (CPS) will have considered whether the evidence gathered during the investigation of the complaint justifies the officer facing criminal proceedings. If this applied in the case of your complaint you may already have been told of the CPS decision. Any disciplinary outcome resulting from a complaint is only considered after the question of criminal prosecution has been decided and any trial has taken place.

The Investigation Review

When reviewing an investigation and the recommendations made to it by the police, the Commission is not bound to adopt the conclusions of the investigating officer nor does it have to agree with those recommendations. If the police force has not already proposed this and there is evidence to support what you allege, the IPCC has the legal power to recommend to the force that an officer's conduct should be referred to a disciplinary hearing (called a "misconduct tribunal"). It can direct this to happen if the police force refuses to accept a recommendation.