Alexander
Harris
solicitors

FIRST CLASS
Mrs Marjorie Bulbeck

Code A

Our ref: AA/PR/31840/1/9919
Your ref:
Please ask for: ANN ALEXANDER
Direct dial:

24 April 2003

Dear Mrs Bulbeck

Gosport War Memorial Hospital

I write to update you on the meeting I had with Detective Chief Superintendent Steve Watts and Detective Inspector Nigel Niven from the Hampshire Police on 14 April 2003.

I began the meeting by updating DCS Watts and DI Niven on the meeting I had with you and the other families in the GWH Action Group. I informed them that it had been decided that a Steering Group would be set up, as a means of support and also to share information. I explained that I had asked you all to update me on the contact that you had had with the police since the public meeting, whether a statement had been taken from you and your understanding of both the general position and your own position.

I updated the police on your experiences in general terms and gave them some specific examples. I pointed out that the experiences within the group were all very different, particularly in relation to the information that had been given. As I am sure you will appreciate, there will be some information that cannot be shared with you and I agreed that this would be the case with the police. However, I explained that I was concerned that those people who did not receive the information felt they were at a disadvantage. I also pointed out that it only seemed to be those people who were asking for information who were receiving it and it was not being given to the whole group. However, I expressed my concern that any information, which the team were able to give to you, was not being given in a routine and consistent manner.

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DCS Watts and DI Niven both agreed that there was a need for consistency as far as the information provided to the families was concerned.

DI Niven expressed his concern that some people may have the impression that some of the cases had been prejudged and this was not the case. He explained that the whole idea of going to the experts was to try and find out whether there were concerns with the deaths. At this stage there was no indication of where cases would fall and a clinical assessment was being carried out by the clinical team that was on board.

I discussed with the police the mechanism through which the information was being conveyed to you. I suggested that the information should perhaps be given in writing and the police confirmed that they would consider doing so. There would be no prejudice to the investigation if this were to be done and it would ensure that the information was provided in a clear and consistent manner.

DI Niven confirmed that if there were any issues with the families regarding contact with the police he would deal with these directly.

The issue of statements was also discussed. DI Niven appreciated the fact that there may be problems with people forgetting things, and that this existed in all investigations. However, as far as this investigation was concerned they had decided to front load it with the medical team and have them consider all the medical records before statements were taken so that the resources that the police had were used in the best manner possible. Once the medical team had reviewed the medical records and a decision had been reached regarding the treatment that the patient concerned had received, the police would then provide feedback on an individual basis to the families. Statements would be taken at that stage, if appropriate. The experts had been asked to consider the condition that patients had arrived at the GWMH as well as the treatment that they had actually received at the GWMH. At the current time the medical experts were reviewing the medical records of 62 cases.

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DSC Watts updated me on the experts meeting which had taken place. In this meeting, the experts had been asked to consider some questions when they were reviewing the medical records as to whether the patient:

- had died from natural causes
- had died as a result of a clinical action which was proper and properly administered
- had died as a result of a negligent mistake which should be referred to the GMC
- had died as a result of gross negligence which might amount to manslaughter
- had died as a result of a deliberate act which might amount to murder

At the current time the experts were considering the first 20 cases before they came back to the police to discuss the method of reviewing the records to decide whether the process needed refining in any way. The 20 cases which were being reviewed were the first alphabetically as this was one way of reviewing them and was as random as any other way.

No feedback would be provided to the families about any decisions which the experts had come to until all 62 cases had been reviewed. DCS Watts pointed out that the circumstances of the different cases may affect the experts views once they had considered them all and therefore this was why they would wait until after all had been reviewed.

The expert team is being lead by Professor Forrest and also had within it a geriatrician, a palliative care expert, a GP expert and a nurse. All had impressive credentials. Each would review the records within their own sphere of expertise and this would provide the best complete review. Once the experts had considered the cases that had been referred to them, the police would then have to consider whether they needed to consider other deaths which had occurred in the hospital.

DSC Watts, DI Niven and myself were all very happy with the meeting and agreed that it had been helpful. DSC Watts confirmed that they appreciated Alexander Harris' support and were happy to continue the interaction with them.

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If you have any queries regarding the above, please do not hesitate to contact me or my trainee, Patricia Roe on Code A

Yours sincerely

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ANN ALEXANDER
ALEXANDER HARRIS

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