Field Fisher Waterhouse

GENERAL MEDICAL COUNCIL

-and-

DR BARTON

FFW/78/01

'D' DOCUMENTS PROVIDED BY THE POLICE TO THE DEFENCE (MAY 2009)

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GENERAL MEDICAL COUNCIL

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1

Other Document Form

Number **Code A**

Title LETTER FROM MATTHEW LOHN WITH EXPERT REVIEW SUMMARY REPORTS

(Include source and any document number if relevant)

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Code A

O/M	SIO

Indexer

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Our ref: Code A

Strictly Private & Confidential

Detective Sergeant Owen Kenny
Operation Rochester
Fareham Police Station
Quay Street
Fareham
Hampshire PO16 0NA

20 July 2004

Dear Owen

Category 2 Cases

I have now completed my review of the Category 2 cases and enclose, under cover of this letter, my summary reports.

I have concerns about seven cases currently listed as Category 2 namely:-

1. Edith Aubrey.
2. Henry Aubrey.
3. Doreen Cox.
4. Geoffrey Packman.
5. Gladys Richards.
6. Elizabeth Rogers
7. Sylvia Tiller.

As you know, I am away on vacation tomorrow until 2 August 2004. On my return I would welcome the opportunity to discuss my findings with you. Until I have had an opportunity to explain the basis for my views, I do not think that we should communicate any of this information to the families.

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I also write to confirm that I have not reviewed any of the "Bakers Dozen" notes since I have been awaiting the expert reports. Perhaps we can discuss how best to take these cases forward when we meet.

With kind regards.

Yours sincerely

Code A
Matthew Lohn
Partner
Direct Line: Code A
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Expert Review

Victor Abbatt

No. BJC/01A

Date of Birth: Code A

Date of Death: 30 May 1990

Mr Abbatt was admitted to the Gosport War Memorial Hospital on 29 May 1990 as an emergency. Dr Barton requested this as his wife could no longer cope with him at home.

On admission he was diagnosed as having a chest infection with mild heart failure. He was noted to be cyanosed by the nursing staff when they put him to bed at 21.20 on the day of admission. He was then administered 10mgs Temazepam apparently which had been written up for him.[VA1]

The experts criticised the use of a small dose of Temazepam in a patient who is cyanosed. They note, though, that Mr Abbatt was already very unwell.

[VA1] No drug chart exists within the Notes.

Expert Review

Dennis Amey

Code A

Date of Birth: Code A

Date of Death: 20 December 1990

Mr Amey was admitted to Gosport War Memorial Hospital on 14 November 1990 following a request from Mrs Amey. Mr Amey at that time had problems with his catheter, he was incontinent and was having spasms. Code A had very severe Parkinson's disease. He was admitted for terminal care.[DA1]

Mr Amey was started on Morphine elixir on 11 December 1990 and by the time of his death on 19 December 1990 he was on 120mgs of Diamorphine subcutaneously per twenty-four hours. Dr Lawson notes that Mr Amey was very unwell and in pain.

The experts have determined that this dose of Morphine was high and possibly sub optimal but without additional documentary evidence cannot be clear as to whether the doses of Diamorphine was escalated only in response to uncontrolled pain.[DA2]

D1099 has
2 admit
dates
7d 14/11/90

[DA1] There are no drug cards or relevant nursing notes within the medical records.
[DA2] The officer's report refers to a "Report 8C" which has not been provided to me.

Expert Review

Charles Batty

No. BJC/06A

Date of Birth: Code A

Date of Death: 2 January 1994

Mr Batty was admitted to Gosport War Memorial Hospital in September 1990 for long stay care. He had a previous history of Parkinson's disease, epilepsy and Ménières.

He was treated with Coproxamol regularly for a period of years for pain although its origin was not clear.

In December 1993 he was complaining of generalised pain and started on Oramorph. Dr Lawson notes that Mr Batty went from little analgesia to Oramorph 60mgs in twenty-four hours. The dose was gradually increased and when he had difficulty swallowing it was changed to a syringe driver. It was difficult to assess his pain because of his dementia but it is not clear on the face of the notes whether his condition was deteriorating prior to starting opiate treatment.

The experts review has determined that the treatment was sub optimal due to the high doses, especially Midazolam. Cause of death was felt to be unclear by the expert team.[CB1]

[CB1] There is no officer's report in respect of this case.

Expert Review

Dennis Brickwood

No. BJC/06B

Date of Birth: Code A

Date of Death: 12 June 1998

Mr Brickwood was admitted to hospital on 15 January 1998 after a fall where he sustained a fracture to his neck and femur.

On 3 February 1998 he was transferred to Gosport War Memorial Hospital for rehabilitation. His medical history included carcinoma of the prostate, osteoporosis and myoma.

He was assessed in March 1998 with a view to being discharged home but, following a trial visit on 6 April 1998, this was not considered a possibility.

In May 1998 he developed musculoskeletal chest pain together with a chest infection.

The infection did not respond to antibiotics despite a change in treatment.[DB1]

Opioids were started when Mr Brickwood's condition was failing on the second antibiotic tried.

The experts note that the Morphine/Diamorphine was escalated and a large amount of Hyoscine and Midazolam added to the syringe driver although it was not felt death was accelerated as a result of this treatment.

[DB1] The family would seem, from the officer's report, to be unaware of the severity of their father's condition. They have requested that a number of questions are answered about their father's treatment.

Expert Review

Sydney Chivers

No. BJC/09

Date of Birth: Code A

Date of Death: 20 June 1999

Mr Chivers was admitted in May 1999 to the Gosport War Memorial Hospital from the Queen Alexander Hospital for rehabilitation after suffering a cerebrovascular accident as well as being treated for congestive cardiac failure and a chest infection.

In early June 1999, Mr Chivers' condition deteriorated and he complained of a pain in his hands and also abdominal pain. Soon after this he was commenced on Fentanyl together with Oramorph and on 19 June, having been seen by Dr Brooks, a syringe driver was commenced.

The experts felt that cause of death was probably unclear and noted the opioids were escalated without trying other ways of stopping the pain but did not feel the treatment was negligent.

Expert Review

Cyril Dicks

No. BJC/17

Date of Birth: Code A

Date of Birth: 22 March 1999

Mr Dicks was admitted to the Gosport War Memorial Hospital on 28 December 1998. On admission he was doubly incontinent with a urinary tract infection and had a indwelling catheter.

It is recorded in the Medical Notes that he had a number of falls where he only sustained minor cuts and bruising whilst at Gosport War Memorial Hospital.

The Notes recall on 4 January 1999 that he remained poorly and was not eating or drinking well.

The expert review notes that Mr Dicks was deteriorating gradually following admission and then rapidly over the weekend of 20/21 March 1999.

Although there is no record available in the medication cards or in the medical notes one nursing record states that subcutaneous analgesia and Midazolam was started on 20 March 1999.

The experts conclude the care on the ward was reasonable and that it was likely that Mr Dicks would have died no matter how well he was cared for.

Expert Review

Charles Hall

No. BJC/23

Date of Birth: Code A

Date of Death: 6 August 1993

Mr Hall was admitted to Gosport War Memorial Hospital on 5 July 1993 after he had undergone a sigmoid colectomy and colostomy following diverticulitis and a gangrenous gall bladder.

On admission, in addition to the rehabilitation issues following his abdominal surgery, he was suffering pain in his left foot which was associated with vascular disease.

He was started in August on oral Morphine which was converted to Diamorphine via a syringe driver on 5 August 1993.

The experts note that although he undoubtedly had severe underlying disease the acceleration from one dose of Oramorph to 40mgs of Diamorphine was sub optimal treatment.

Expert Review

Catherine Lee

No. BJC/31

Date of Birth: Code A

Date of Death: 27 May 1998

Catherine Lee was admitted to Gosport War Memorial Hospital on 14 April 1998 from the Royal Haslar Hospital where she had been admitted for surgery to repair a fractured neck and femur.

On admission, it was noted that Mrs Lee had poor mobility, was confused at times and needed full assistance with eating and drinking due to poor eyesight and that she had a poor appetite. She needed care for hygiene and dressing.

On admission she was settled on the ward and given oral Morphine.

This was gradually increased during her stay on 5mgs four times a day to 10 mgs by 18 May.

She was transferred to subcutaneous analgesia on 21 May when she was started on Diamorphine and Midazolam.

The experts have raised a question as to whether the indication for Opiates was clear but note that the medical problems were probably enough to account for the final cause of death.[CL1]

[CL1] I have not seen an officer's report in respect of this case.

Expert Review

Stanley Carby

No. BJC/07

Date of Birth: Code A

Date of Death: 27 April 1999

Mr Carby was admitted to Gosport War Memorial Hospital on 26 April 1999 for rehabilitation. He was transferred from the Royal Haslar Hospital where he had been admitted in April 1999 suffering a stroke. The stroke affected the left hand side of his body, this required Mr Carby to have assistance with eating and drinking.

On 27 April 1999 Mr Carby suddenly deteriorated becoming cyanosed dyspnoeic. This clinically appeared to be an extension of his previous stroke.

A syringe driver was set up with a high dose of Diamorphine and Midazolam. Mr Carby died forty-five minutes later. All the experts agree that he would not have received enough of either drug to have influenced his survival. Dr Naismith noted that he may well have received less than normal since he had low blood pressure and was peripherally cyanosed.

The cause of death was shown as cerebral vascular accident and was certified by Dr Barton. Mr Carby was cremated.

The large dose of Diamorphine makes the care sub optimal but it had no effect on Mr Carby's prognosis.

Expert Review

Walter Clissold

No. BJC/12

Date of Birth: Code A

Date of Death: 8 September 1999

Mr Clissold was admitted to Gosport War Memorial on 3 August 1999 following a resection of his prostate and a bladder biopsy at the Royal Haslar Hospital.

Although the original intention was that Mr Clissold would be transferred home with support, his condition deteriorated.

This case is made more difficult to analyse in the absence of a drug chart but it would appear that Mr Clissold's analgesia was advanced from Paracetamol to Fentanyl.

By 6 September 1999 Mr Clissold was deteriorating. In the absence of a drug chart it is not possible to draw any conclusions as to whether this was related to his medication. On the day of Mr Clissold's death, on 8 September 1999, a syringe driver was set up containing 50mgs of Diamorphine and 20mgs of Midazolam. The Midazolam was doubled later that day.

Mr Clissold deteriorated rapidly and died and Dr Naismith raised concerns that the drugs administered via the syringe driver accelerated Mr Clissold's albeit inevitable death. Dr Naismith was the only expert that rated this case as negligent. In the absence of the drug chart, it is not possible to draw firm conclusions as to any liabilities in this case and no further investigation is advised.[WC1]

[WC1] There was no officer's report available for review in this case.

Expert Review

Harry Hadley

No. BJC/22

DIED 10/10/99

Date of Birth: Code A

Date of Death: 10 October 1999

Mr Hadley was admitted to Gosport War Memorial Hospital on 5 October 1999. At the time he was fully aware of his condition having been diagnosed with carcinoma of the bladder in July 1999. Mr Hadley was immobile and required the assistance of nurses plus aides.

Mr Hadley died on 5 October 1999. In the last five days before his death Mr Hadley was inexpertly treated with opioid analgesics although this did not in any way substantively alter the prognosis.

Expert Review

Alan Hobday

No. BJC/26

Date of Birth: Code A

Date of Death: 11 September 1998

Mr Hobday had suffered a stroke in July 1998 and was admitted to hospital. He was transferred to Gosport War Memorial Hospital on 24 July 1998 for further rehabilitation.[AH1]

On the clinical notes it would appear that he extended his stroke on 6 September 1998 and thereafter developed focal seizures with increased pain in his arm.

Diamorphine was started via a syringe driver and Mr Hobday died on 11 September 1998.

The expert report confirmed that although higher doses of opiates were used than may have been necessary, Mr Hobday's cause of death was due to his stroke.

[AH1] I have not seen A194 and M24 mentioned in the officer's report.

Expert Review

Eva Page

No. BJC/35

Date of Birth: Code A

Date of Death: 3 March 1998

Mrs Page was transferred to Gosport War Memorial Hospital on 27 February 1998 for palliative care having been treated at Queen Alexander Hospital as an emergency suffering with anorexia, decreasing mobility and dehydration.

On admission to Gosport War Memorial it was apparent that Mrs Page was dying of carcinoma of the lung. She was confused and agitated to begin with and a trial of tranquillisers did not produce any improvement. She was treated with Diamorphine and a Fentanyl patch mainly for sedation although the expert questioned whether this was appropriate in view of the lack of pain complained of. The experts agree that the cause of death was natural.

Expert Review

Gwendoline Parr

No. BJC/36

Date of Birth: Code A

Date of Death: 29 January 1999

Spelling of NAY/SMITH

Mrs Parr had been admitted to the Royal Haslar Hospit[illegible]18 following a fall where she sustained a fractured neck and f[illegible]nt surgery for a dynamic hip screw on 14 December 1998. [illegible]ne Royal Haslar Mrs Parr developed acute abdominal pain and [illegible]nt umbilical hernia repair on 24 December 1998. She was admitted to Gosport War Memorial Hospital on 31 December 1998 for rehabilitation.

The family note in the officer's report that they visited Mrs Parr daily at the Hospital and stated that "she was very chirpy and stated that she would soon be walking and going home".

Mrs Parr was noted to have deteriorated by 23 January 1999 and was commenced on Oramorph and thereafter remained poorly.

Mrs Parr died on 29 January 1999.

Dr Naismith notes that Mrs Parr was deteriorating before the opioids were started but that the first dose of Diamorphine given would have been high even for a lady with normal renal function. This contrasted with Dr Ferner who records the treatment as being optimal with the drugs being given in "proportional doses".

Expert Review

Edna Purnell

No. BJC/37

Date of Birth: Code A

Date of Death: 3 December 1998

Mrs Purnell lived at Addenbroke Residential Home at the time of her admission to the Royal Haslar Hospital to undergo surgery for a fractured neck and femur.

Following the operation on 26 October 1998 and the insertion of a dynamic hip screw, she was admitted to Gosport War Memorial Hospital for rehabilitation on 11 November 1998.

At Gosport War Memorial Hospital Dr Naismith noted there was a readiness to move quickly from a single dose of Co-codamol to Oramorph in doses of 5 to 10mgs which was given twice most days. Mrs Purnell became very drowsy on Oramorph and from that point her renal functions seem to have diminished.

The syringe driver was started with 20mgs of Diamorphine which was three times the dose Mrs Purnell was receiving orally. At this point she appeared comfortable although semi conscious.

The experts have considered this case to be a natural death albeit that the treatment was sub optimal and that the dose of opioids was markedly escalated in her final few days.

Dr Lawson notes that in his opinion Mrs Purnell would have died in any event without opiates being used. The medical records make note of the concerns expressed by Mrs Purnell's son as to the treatment that was being provided to his mother.[EP1]

[EP1] Officer's report refers to chronological list of events submitted by Mrs Purnell's son, Michael Wilson. I have not been provided with a copy of this list.

Expert Review

Margaret Queree

No. BJC/38

Date of Birth: Code A

DOB. 22/8/10
RSH, RTCO

Date of Death: 10 October 1994

Mrs Queree was admitted to the Queen Alexander Hospit re she underwent surgery for pelvic abscesses. She had a permanent colostomy put in place. She was transferred to Gosport War Memorial Hospital on 29 July 1994 for rehabilitation. As noted by the experts, Mrs Queree had significant medical problems prior to her operation and both urine and vaginal infections after the operation. She became frail and confused and was commenced on Morphine Sulphate. After three days she was then started on a high dose of Diamorphine via a syringe driver with a fivefold increase in the relative dose over two days.

The experts confirm that in their view she died of natural causes. The use of opiates and sedation was rapidly increased although this properly appears to be reasonable in response to the distress demonstrated by the patient.

Expert Review

Violet Reeve

No. BJC/40

Date of Birth: Code A

Date of Death: 14 April 1997

Miss Reeve was admitted to the Queen Alexander Hospital on 18 October 1996 following a stroke affecting her left side. She developed marked weakness and later swallowing difficulties. She was transferred on 11 November 1996 to Gosport War Memorial Hospital for rehabilitation.

During the admission she remained very distressed and was seen by Dr Gibb a neurologist.

The experts have concluded that Miss Reeve clearly had a poor prognosis and very difficult mental state problems.

Dr Lord seemed to have decided, not withstanding the advice of Dr Gibb, to continue sedation and the experts concluded that she was likely to be made more comfortable at the end with the treatment regime of Midazolam and Diamorphine.

Expert Review

James Ripley

No. BJC/42

Date of Birth: Code A

Mr Ripley was admitted in August 2002 for worsening renal function and pain from osteoarthritic hips. He was started on Morphine Sulphate, the dose of which was increased after twenty-four hours. Having become drowsy he was transferred back to the Royal Haslar as an emergency where he recovered consciousness. The expert opinion concluded that the escalation in Morphine Sulphate was rapid but non negligent.

Expert Review

Daphne Taylor

No. BJC/47

Date of Birth: Code A

Date of Death: 20 October 1996

Mrs Taylor was admitted to the Royal Haslar Hospital on 29 September 1996 after suffering a cerebrovascular accident. She was transferred to the Gosport War Memorial Hospital on 3 October 1996 for rehabilitation.

On 7 October 1996 Mrs Taylor was felt to be in pain and was prescribed Fentanyl patches.

Mrs Taylor was noted to be in a great deal of pain and the strength of the Fentanyl patches were increased.

On 18 October, following a very unsettled night when Mrs Taylor appeared to be distressed and in pain, a syringe driver was set up with 40mgs of Diamorphine and 20mgs of Midazolam over twenty-four hours.

Although Mrs Taylor had a severe stroke which left her unable to swallow or speak, she was being tube fed. However, she was prescribed rapidly escalating doses of opioids without there appearing to be a comprehensive assessment made for her pain.

The experts note that she had an irrecoverable cerebrovascular and would have died soon in any event.

Expert Review

NAISMITH

Doreen Cox

No. BJC/13

Date of Birth: Code A

Date of Death: 16 August 1999

Doreen Cox was transferred from the Queen Alexander Hospital where she had been admitted on 21 July 1999 to Gosport War Memorial Hospital on 5 August 1999 for rehabilitation and assessment.

Mrs Cox had severe heart failure and difficulty in swallowing.

Although a diagnosis had been made of depression this is disputed by Mrs Cox's husband in the officer's report.

There is a large degree of variance in the expert medical assessment of this patient.

Dr Lawson felt her care was reasonable and graded her A1 whereas Dr Naismith (3B) felt that she was given an inappropriately high dose of Midazolam on 14 August 1999 and started on Diamorphine 20mgs when she had not reported pain on 16 August 1999.

It is clear from the notes that Mrs Cox had a poor prognosis but the choice of medication was sub optimal.

Expert Review

Geoffery Packman

No. BJC/34

Date of Birth: Code A

← NA/SMITH.

Date of Death: 3 September 1999

Mr Packman was admitted to Gosport War Memorial Hospital in July 1999 following the development on an irritating rash on his side and groin.

It appears from the medical notes that he had an episode of black stools prior to being discharged from Portsmouth Hospitals NHS Trust.

Following admission to Gosport War Memorial Hospital on 23 August 1999 Mr Packman was noted as remaining very poorly with no appetite. It was noted in Mr Packman's nursing records that he was passing fresh blood per rectum on 25 August 1999.

On 26 August 1999 he complained of feeling unwell with indigestion pain in his throat together with nausea and vomiting.

At this point he was commenced on opiate medication. No active measures were taken to resuscitate Mr Packman and, following rapidly increasing doses of Diamorphine, he died on 3 September 1999.

There is a variation in the view taken of this case by the experts reviewing the Notes. Concern is expressed by Dr Lawson that the although the death was natural, the gastrointestinal bleed was potentially treatable. This contrasts with Dr Naismith's view who notes the multiple pathology existing in Mr Packman and the fact that his morbid obesity would have made him unfit for surgery.

Expert Review

Gladys Richards

No. BJC/41

Date of Birth: Code A

Date of Death: 22 August 1998

On 30 July 1998 Mrs Richards suffered a fall at the Glenheathers Nursing Home where she lived. She fractured her right neck and femur and was admitted to the Royal Haslar Hospital where she underwent a closed relocation of her right hip.

She was transferred to the Gosport War Memorial Hospital on 11 August 1998 for continuing care. She was readmitted to the Royal Haslar Hospital on 14 August 1998 for a reduction of her dislocated right hip and was readmitted to Gosport War Memorial Hospital on 17 August 1998. Plan on admission was to continue Haloperidol and only to give Oramorph in severe pain.

Mrs Richards, on the 18 August, was still noted to be in great pain at which point it was proposed that she was started on subcutaneous Diamorphine/Haloperidol/Midazolam.

Mrs Richards was noted to be much more peaceful on 21 August although her condition was noted to be very poor.

There is criticism made that the starting dose of 40mgs Diamorphine seemed excessive when starting the syringe driver but it was noted that Mrs Richards opiate requirement had increased considerably in the fifteen hours before the driver was started. Dr Lawson considered that the opiates were not considered to be implicated in her death. Dr Naismith felt the Diamorphine dose was too high and probably shortened her life but she seemed "unlikely to survive unless she had been left in severe pain (screaming)".[GR1]

[GR1] I have not seen an officer's report from the family in this case.

Expert Review

Sylvia Tiller

No. BJC/48

Date of Birth: Code A

Date of Birth: 13 December 1995

Mrs Tiller was admitted to Queen Alexander Hospital on 3 November 1995 after suffering with congestive cardiac failure and a background of ischaemic heart disease. The experts note that she was "clearly a dying woman". She was transferred to Gosport War Memorial Hospital on 4 December 1995. She was given small amounts of Oramorph and only in the last twenty-four hours was set up a syringe driver with Diamorphine, Hyoscine and Midazolam. Dr Naismith questioned the rationale for making "more adequate analgesia available" in the admission plan. The experts agree that the dose of Diamorphine was inappropriately high. Dr Lawson questions whether this may have hastened Mrs Tiller's death. Dr Naismith considered it made little difference to the outcome.

Expert Review

Edith Aubrey

No. BJC/04

Date of Birth: Code A

Date of Death: 15 June 1996

Mrs Aubrey lived at home with her husband until April 1994 when she was admitted to a nursing home. Her past medical history included probable cerebrovascular disease, depression with paranoid features, and ischaemic heart disease.

Whilst the experts have described this case as end stage dementia more probably of vascular origin, it is unclear from the medical notes what led to Mrs Aubrey's final demise. She was given transdermal Fentanyl explicitly to calm her and this dose was progressively escalated.

In June 1996 a syringe driver was prescribed as required and was commenced on 7 June 1996. The conversion of therapeutic treatment to Diamorphine via a syringe driver was reasonable in the experts' views. **Dr Naismith has marked this case as C3.**

Expert Review

Henry Aubrey

No. BJC/05

Date of Birth: Code A

Date of Death: Code A

Mr Aubrey was admitted to the Royal Haslar Hospital in May 1999. He was transferred to Gosport War Memorial Hospital on 1 June 1999. The history of the presenting complaint was noted on admission to be carcinoma of the lung, plural effusion and query cerebral secondaries. The notes also records that Mr Aubrey was depressed waiting to die.

Mr Aubrey was commenced on a Fentanyl patch at 3.30 p.m. that afternoon and 10mgs of Oramorph was given.

Mr Aubrey's treatment was continued the next morning with high dose Morphine and Midazolam.

The experts noted in their analysis that although Mr Aubrey had a terminal diagnosis and was recognised to have given up, the need for such a large dose of Diamorphine and Midazolam was not clear. **Drs Naismith and Lawson have rated this case B3.**

Expert Review

Elizabeth Rogers

No. BJC/44

Date of Birth: Code A

Date of Death: 4 February 1997

Mrs Rogers was transferred from the Royal Haslar Hospital to Gosport War Memorial Hospital on 30 January 1997.

She had been treated at the Royal Haslar Hospital with a chest infection and a urinary tract infection. She had severe Parkinson's disease. On transfer it was noted she had a catheter in place, was bed bound, slightly dysphagic and her sacrum was red but intact.

On 2 February 1997 she was prescribed oral Morphine due to an increase in pain.

On 3 February 1997 in view of the pain not being controlled by oral Morphine, a syringe driver was commenced with 40mgs of Diamorphine, 20mgs of Midazolam and 400mcgs Hyoscine.

The experts note that the dose of Diamorphine approximated to a doubling of opioid medication and question the reason for the Diamorphine increase on her final day. Dr Lawson felt the medical problems were enough to account for her death although Dr Naismith (3B) has expressed concern that "it is likely that the opioid substantially shortened this lady's life and may have produced death in a lady who would otherwise have survived for months". Note Dr Ferner categorised this case as 1A to reflect the optimal treatment of a natural death.

Other Document Form

Number 31095

Title NOTES OF DR ANNE NAYSMITH RE ANALYSIS OF 31

(Include source and any document number if relevant) CASES INCLUDING BAKER CASES.

Receivers instructions urgent action Yes (No)

LINK TO NOMINEE NAYSMITH

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Code A

O/M	SIO

Indexer

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FAX

CONSULTANT'S OFFICE

CONFIDENTIAL

To:	Owen Kenny	Fax:	Code A
From:	Code A	Date:	20 August 2004
Re:	As discussed	Pages:	15 Inc

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If any of the pages are distorted, give me a call and I'll re send

Annc

OPERATION ROCHESTER

This report, which follows exactly the format of the first, brings together the assessments of the final 31 patients screened by the clinical team.

Exhibit No	Patient Identification	Assessment Note	Assessment Score
BJC/65	Askew, Catherina N1001	Admitted by Dr Lord from home because of deterioration. Worsening, longstanding chronic renal failure. Took coproxamol 8tabs/day regularly longterm. Major problem on admission documented by Dr Barton was postural hypotension, which she noted needed documented on a regular basis. This was making her immobile. Despite her chronic renal failure, which would make morphine a very dangerous drug, especially if given regularly, she was immediately changed to oramorph 5mg 4hourly and 10mg at night on a regular, not PRN, basis, despite there being no evidence in the admission note that pain was a problem to her. By the following day she was very sleepy and drinking very little. This in turn would have exacerbated both her chronic renal failure and her retention of active morphine metabolites, making her even more toxic. Her chest was described as bubbly, ie she had so much cough suppression she could not clear her secretions. Because she could no longer swallow, she was changed over to a S/D with diamorphine 40mg, ie 4 times the oral dose of the day before, hyoscine 400mcg and midazolam 20mgs/24 hours. This lady had never been agitated – why did she need a high dose of midazolam? The inevitable result was her death the next day. I can see no reason to give this lady morphine. In view of her chronic renal failure it was a very dangerous thing to do. If she was felt to be in severe pain she should have been given small doses PRN only, to allow for the accumulation. I do not think she would have died when she did had she not been given these opioids.	3B
BJC/81	Benson, Mary Eileen N364	Very long survivor in continuing care bed after major CVA. Mute, PEG feeding. Very slow deterioration. Tended to get a rash when given antibiotics and in any case felt to be inappropriate management, so family agreed to no more (after more than a year in GWMH). Became chesty again in February 1997. No antibiotics. Deteriorating to the point that family stayed overnight in case she died that night. She became distressed by coughing and vomiting, so S/D put up at 02.10 and she died at 17.25. She had only been on cocodamol previously. She was given diamorphine 40mg and midazolam 20mgs/24 hours. These doses are far too high for a frail lady who had not previously had Step 3 opioids and cannot possibly have been required. But she was	2A

Exhibit No	Patient Identification	Assessment Note	Assessment Score
BJC/62	Burt, Margaret N996	Long history of dementia complicated by alcohol, not taking thyroxine as prescribed, profound deafness and hostility/suspicion of carers. Transferred after failing to rehabilitate from #NOF. Initially well cared for, good physio reports, Barthel improved. Began to deteriorate probably solely as end stage of dementia. Limbs becoming contracted. Painful to move her. Given oramorph 5mgs with benefit. Then refused further oral medication. Started on S/D at too high a diamorphine dose – 20mg – accompanied by midazolam 20mg when she was not agitated and had never required benzodiazepines (and had been in hospital much too long for alcohol withdrawal to be considered even if she were still drinking on admission, which she probably wasn't). Nursing notes record long periods of apnoea that night – but the doses were not reduced! Doses not increased until the day before she died, when the nurses noted she was stiff and in pain when being handled and the doses were increased to 30mgs. Failure to recognise that the apnoea was almost certainly drug induced. And too high a starting dose of diamorphine – should have been 10mg at most – with probably unnecessary midazolam (might have needed 5-10mg for stiffness). But death was inevitable and natural, just slightly over-dosed.	2A
JC/3/KMR/1	Carby, Stanley N209	Only notes are from Haslar. No notes from GWMH so unable to make any comment on the circumstances of his death	
BJC/58 JR/06	Corke, James N771	22.2.04 Haslar notes: Was discharged home from GWMH as planned despite being very sleepy that morning. By the time he reached home was essentially comatose. Immediately taken to A&E at Haslar, where he was found to have septicaemic shock secondary to UTI due to recent catheterisation. In acute renal failure. Not a candidate for ICU because of severe Parkinson's, but otherwise managed acutely. Rallied a little but died 9 days after admission to Haslar. Death unrelated to opioids! But a pity the GP caring for him at Haslar did not realise he was acutely ill on the morning of his planned discharge.	2A
BJC/77	Clements, Doris Gertrude 898	Admitted unwell with Haematuria ?cause. Hb 6.9g/dl. Refused acute transfer for blood transfusion. Continued to bleed. Collapsed on commode, probably from postural hypotension leading to CVA but possibly PE, became unrouseable. Immediately started on diamorphine 40mg and midazolam 20mg by syringe driver, diamorphine doubled next day, although she had never	2A

Exhibit No	Patient Identification	Assessment Note	Assessment Score
		been on anything stronger than paracetamol as far as I could see. Entirely unnecessary doses of opioid and probably sedation. But she would almost certainly have died in any case following this episode of collapse. Just changed the timing a little.	
BJC/59	Cox, Mary N101	Two sets of notes and the wrong date of death on the index – actually died on 31.5.96. Emergency admission to Dr Banks care on Mulberry, GWMH, with self neglect. Found to be hypercalcaemic and transferred to QAH for investigation. They excluded the common cancers, sent blood for PTH, gave pamidronate and sent her back. Dr Banks felt she was seriously depressed and deteriorating, so that she would take nil by mouth and needed NG tube feeding. Sectioned her for ECT. First treatment uneventful but on second treatment, on 31.5.96, had coffee ground vomit immediately after the ECT and aspirated, and ws not able to be revived. Sent to Coroner for PM. The night before her death she had some chest pain, referred to as Heartburn but it did not respond to MagTriSil. Given Oramorph 5mg by the duty doctor and the pain settled. Dr Barton on 31.5.96 wrote up her standard syringe driver of diamorphine 20-100mg, hyoscine 200-800mcg and midazolam 20-80mg. This was never given, since the lady died that morning. But I am unclear why Dr Barton felt she had jurisdiction to do that or why she felt it was appropriate to treat as dying a lady who had been sectioned for treatment. I do not think the single dose of oramorph had any bearing on her death.	1A
BJC/82	Cresdee, Olive N167	SUBSTANTIAL PORTIONS OF THE RECORD APPEAR TO BE MISSING. There is an unusual lacuna in the medical notes, with one page ending on 24/4/90 and the next beginning on 18/5/90 – I think there was probably a page in between. And there are no nursing notes and no drug charts for the stay in Redclyffe Annexe. Given the gaps, it is difficult to offer an opinion. My summary would be 1) her only pain appears to have been from a sacral pressure sore. She received moderately high doses of morphine (MST 50mg BD is recorded). Skin pain is not best treated with opioids. It is therefore not surprising that they seem to have been ineffectual (medical note 2/6/90). She also, from the same medical note, appears to have then been treated by CSCI – no reason to suppose that would have been any more useful.	2A

Exhibit No	Patient Identification	Assessment Note	Assessment Score
		clearly dying at that point and I am sure the opioids made little if any difference.	
BJC/80	Brennan, Irene N962.	Very frail lady with severe and very painful OA. Mobility gradually decreased over a number of admissions to GWMH. Eventually progressed from Coproxamol to MST 20mg BD, then slowly increased, always with at least one dose of breakthrough oramorph most days, to 30mg BD, 40mg BD, 50mg BD and finally 60mg BD. On 29/6/98, swallowing appears to have been problematic as she neared death and the MST was not tolerated. In the morning applied fentanyl TTS 25mcg (exact conversion). But at 1600 hrs seen by Dr Lord. In severe pain. S/D started with diamorphine 60mg, ie rather generous conversion but not unacceptable given that the lady was in pain and had just had diamorphine 10mg IM stat. Continued for 24 hours then increased to 100mg (?why – no more breakthrough that I can see) until death the next day. Might quibble with the sharp increase on the penultimate day of life, but I am sure it made no difference at all to the outcome. On the whole, steady and progressive increase in analgesia with breakthrough doses as proof that pain never over controlled. Thought of OA pain and wrote up for diclofenac suppositories at the end of life but in fact never given.	1A
BJC/73	Brown, Paula N1009.	Long term MS - >40 years. Well known to GWMH – used to go in for respite, then an inpatient in continuing care for about 5 years. Long term problem of pain, generalised and latterly abdominal. Was on Step 3 opioids, initially fentanyl TTS 25mcg then oramorph 100mg/day, since January 1997 or even earlier. Gradual deterioration over the summer/early autumn with more complaints of abdominal pain related to chronic constipation. Moved around from fentanyl (I'm not clear why it was stopped) to oramorph, then to MST because "difficulty tolerating oramorph" – not sure if that was swallowing problems. Initially avoided S/D because "SC analgesia seems excessive". Then vomiting became a major problem so started on S/D – very sensible – in July. Led to sore skin sites, so in September transferred to fentanyl TTS 75mcg – good conversion from diamorphine 100mg. Stayed on that till 6/10, when noted to have had a great deal of pain over the weekend and ?coronary event – clearly much more ill. S/D restarted with diamorphine 250mg, so a marked increase of 150% in dose. Died on 8/10. Could quibble about all the changes of formulation, on and off S/Ds etc. Could question the marked escalation of diamorphine dose in the last 48 hours, but this lady clearly already dying. I do not think anything in her analgesia caused, or even significantly hastened, an inevitable death.	2A

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		2) Relatives were concerned that she "was being pumped full of diamorphine and given no antibiotics". Since she had no recurrence of her cancer discernible, and was for long term care following multiple small strokes with resulting disability, so am I. 3) Her actual death was a sudden collapse. This is not the mode of death in opioid overdosage. The opioids therefore did not directly cause her death. No postmortem is recorded. We therefore do not know whether the cause of death was a pulmonary embolism, a myocardial infarct or a further cerebral infarct (in view of the speed of the death I think the least likely option of the 3). *If* her death were due to a pulmonary embolism, you could argue that the immobility of opioid overdosage would contribute to its occurrence – but she was very immobile anyway! 4) So the opioids and the failure to give antibiotics for the infected sacral sore were probably inappropriate management (inasmuch as one can judge with so much documentary evidence missing) but did not actually lead to her death.	
BJC/78	Donaghue, Mary N964	Dying a distressing death from rectal carcinoma, presumably recurrent after excision, causing a recto-vaginal fistula. Possible it may have been due purely to a pelvic abscess post-operatively, or even incidental diverticular disease, but in view of age and dense left hemiparesis not investigated further. Cachectic so probably cancer. Severe abdominal pain. Analgesia progressively increased from Diconal suppositories, which she could not retain, through coproxamol to regular oramorph starting at 10mg 4 hourly and gradually increased, because of inadequate pain control, to 30mg 4 hourly. Then developed intestinal obstruction with vomiting, so given diamorphine 10mg IM 4hrly, ie exact conversion. When she did not settle from the vomiting, converted to S/D with diamorphine 60mg and haloperidol 10mg, ie again exact conversion. Because she remained in pain and distressed, diamorphine dose gradually increased to 80mg, 130mg then finally 150mg on day of death. Even on diamorphine 130mg she was awake enough to sign a power of attorney, so clearly not oversedated. Good management of terminal cancer.	1A
BJC/74	Dumbleton, Harry N1010	Notes provided only contain the referral to the psychogeriatrician, the letter arranging admission to QAH in April 1993 and a GP letter confirming that death occurred under Code A	1A

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		psychogeriatrician, on 12/6/04. No other content whatever. So no comment possible. Second set of case notes is from GWMH. Transferred there on 26.5.93 with MTS 0/10, Barthel 2, for long term care. Multiple falls. Very confused and immobile. On 4.6.93 was recorded as very chesty and had oral thrush; both problems actively treated. On 7.6.93 seen by Code A Noted that he had been verbally and physically aggressive that day and was now sedated. Possibly from that point on began to deteriorate; Code A s note of 11.6.93 says "deteriorated over the last couple of days" which may be an imprecise description or may be wholly accurate. Great difficulty swallowing and chest rattly. Started high dose syringe driver (diamorphine 40mg, hyoscine 400mcg, midazolam 20mgs) in the middle of the night. Died less than 12 hours later. Rapid deterioration in general condition for about 5 weeks prior to acute admission and continued to deteriorate rapidly while in acute care so death neither unexpected nor untimely. He may have been terminally a little over-treated but it seems unlikely to have made much difference in the overall outcome. NO DRUG CHARTS so difficult to be sure what he was given to sedate him – might have been opioids but no entry to that effect in nursing notes so less likely.	
JR/01	Hadley, Harry N249	Terminally ill at Haslar with bladder cancer before transfer to GWMH. On MST 30mg daily (initially as 15mg BD, then as 20mg mane and 10mg nocte). Not stopped before transfer as appeared from the GWMH notes. Taking cocodamol 2 tabs for breakthrough about TDS on average, so appropriate to make a small increase in MST dosage on admission to GWMH. I wonder if the atypical method of giving MST caused confusion, with staff thinking he was on 20mg BD because he had had 20mg on the morning of transfer?	1A
BJC/75	Harrington, Wilfred N1011	Died of end-stage heart failure despite very active management until it became clear that he was inevitably deteriorating. In the last week of life developed contractures of arm and leg and a painful hip, but Xray showed no #. Only given Oramorph for the first time the day before he died – in too high a dose (20mg QDS) and followed by a similar S/D the following day, which was also in much too high a dose. But he was clearly already dying, and I do not think this therapy (the syringe driver was put up less than an hour before he died) significantly influenced either the time or the manner of his death.	1A

Exhibit No	Patient Identification	Assessment Note	Assessment Score
BJC/63	Horn, Frank N999.	Elderly man with multiple pathologies and general frailty. Declining function. But no indication from the Haslar assessment that he was regarded as having any mortal illness or being close to death. Geriatrician suggested 1-2 weeks assessment in GWMH then transfer to residential care. Poor note keeping. No indication between the admission note and the note of deterioration, and no indication of why he should decline at this point. Further aspiration pneumonia? No clinical description. No antibiotics. Also made DNAR and not for heroics on admission, without detailed assessment or any evidence of discussion either with patient or with family. Was not on any regular analgesia at all. The few opioid doses he had had were Nebulised and for cough; no indication of pain at all. But at the first sign of deteriorating health he was started on diamorphine 20mg, together with midazolam and hyoscine. Not surprisingly he was very sleepy within 12 hours, and by 24 hours later was twitchy, distressed and objecting to nursing care – probably opioid toxic. This was treated by doubling the doses, thus keeping him unconscious ("comfortable") until he died.	3B
BJC/66	Horne, Phyllis N1002.	This lady had severe Alzheimer's and diffuse cerebro-vascular disease, and was highly dependent. But during the initial period of her stay in GWMH she appeared medically stable, although controlling her agitation and tearfulness with drugs was proving difficult. After an interval of more than a month in which it appears she was not seen by Dr Barton, but was reviewed by Dr Lord monthly, Dr Barton found her agitated and distressed (which appears to have been not uncommon) and decided she appeared in pain. Despite the fact the lady had had no analgesia at all throughout her stay, Dr Barton started her on fentanyl 25mcg TTS, while acknowledging in the medical note that there was no clinical justification for this medication. Her note asks Dr Lord to countersign the prescription, but I see no evidence that Dr Lord did so, or indeed necessarily knew the fentanyl was prescribed. From that point Mrs Horne's condition appears to have deteriorated rapidly, and by 48 hours later she could not swallow. A syringe driver was set up containing diamorphine 40mg and midazolam 40mg (although the highest diazepam dose this lady had previously received was 10mg/day). This dose of diamorphine is the upper limit of the equivalence of the fentanyl dose. She died the following day. I find it hard to believe that she would have died when she did had opioids not been started in so high a dose in a lady in whom pain does not seem to have been a problem. However, dementia and global cerebro-vascular	3B

Exhibit No	Patient Identification	Assessment Note	Assessment Score
		disease are both terminal illnesses, and she would have had a relatively short prognosis in any case.	
BJC/83	Hurnell, Joan Mary N394	Acute admission to a psychogeriatric ward under section because of confusional state ?brain mets ?delirium. Care not optimal because her problems were physical, and nursing staff did not have relevant skills though they tried hard. Doctors perceived as unavailable over weekend, so drug chart not corrected, and then as communicating poorly on the Monday. Sudden death early Tuesday morning. Possible recurrence of pulmonary embolism. Opioids very modest, entirely appropriate, not changed or increased during terminal admission (MST 10mg BD + Oramorph 10mg PRN) and not in any way implicated in her death.	2A
BJC/67	Lake, Ruby N1003.	Transferred to continuing care after #NOF on 18.8.04 when seemed frail but OK. Next entry that she had died 3 days later. No nursing notes or drug charts from that admission in the folder so no information at all about the intervening events. No comment possible.	
BJC/68	Leek, Mabel N1004	Widespread OA and osteoporosis with multiple fractures over several years, very limited mobility and chronic pain. On MST 10mg BD + oramorph 2.5mg PRN since 1996. Spontaneous #L tib/fib, plated Haslar and sent to GWMH for rehab. Developed pressure ulcer inside POP. Considered for plastic management but not offered. Returned from Haslar to GWMH for rehab/placement. At that stage notes indicate (but cannot find drug charts to correspond) that she had been on MST 30mg BD on admission and was prescribed 60mg BD on 11/9 because of severe pain in joints and ulcer. Slow progression of doses upwards from there. 70mg BD on 23/10, 80mg BD on 28/10 but for at least a month and possibly until 14/12. At that point she had "deteriorated over the weekend" and a S/D was put up. Diamorphine dose raised by >30% at that point, but she was described as not swallowing and unresponsive before S/D started. ?Have I missed a drug chart in between? Thereafter S/D doses raised quite reasonably with frequent descriptions of pain and distress. Midazolam went up more steeply but she was on long term Temazepam 10mg so would be to some extent tolerant.	1A
BJC/70	Marshall,	Difficult problem of #acetabulum in a lady with Parkinson's and dementia who could not verbally	2A

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	Rhoda N1006	describe pain or even answer questions. Described in acute sector as being frightened of moving but not actually in pain. In GWMH this was interpreted as pain on movement, which it may well have been. Certainly was not weight bearing, and had been before the #. But instead of treating incident pain with intermittent analgesia, all staff at GWMH chose to increase regular analgesia. Deterioration seems to have started after being given Oramorph 10mg 4hrly regularly, having previously been given co-codamol 2 QDS, ie the equivalent of 1.1mg of morphine 4hrly. Mentally very frail, so may well not have been able to handle this increase and probably not needed when at rest. Described as "in pain all the time" when seen on 2.1.96 by Dr Barton, but unclear if this was a) agitation due to anxiety and confusional state, exacerbated by opioid b) opioid toxicity, with agitation and hallucinations c) hyperalgesia of opioid toxicity. Started on sc analgesia with diamorphine 40mg and midazolam 20mg per 24 hours, ie doubled the opioid dose, which would have exacerbated opioid toxicity. Thereafter opioid doses rapidly increased, reaching diamorphine 120mg by 4.1.96. By this time she would not have been drinking, further exacerbating opioid toxicity. Drug charts did not seem to have any prn analgesia available. Sensible management would have been to give analgesia 20-30 minutes before each planned move and not in between, when she was probably not in pain. It seems likely that this lady had a poor prognosis from the immobility caused by her #. She would not have returned to residential care and would probably have remained in NHS continuing care for a few weeks or months, before eventually succumbing to advanced dementia or hypostatic pneumonia. But I think her incident pain was unskilfully managed and the possibility of opioid toxicity not entertained, and that this may well have hastened her death.	
BJC/64	Miller, Vera N1000	Clearly frail on transfer. Oblique suggestion in Dr Lord's assessment letter that she may already have been deteriorating while in Haslar, ie on the way to death irrespective of treatment. On admission to GWMH was started on co-codamol regularly. No indication in the medical or nursing assessment of why this was done, or even mention that it was done. No mention of pain in anyone's notes, although she had a small pressure sore and excoriated perineal skin. It is not clear whether this was co-codamol 8/500 or co-codamol 30/500, so poor prescribing and poor	2A

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		nursing in not asking for clarification. But there may well have been a local formulary which only included co-codamol 8/500. On the day of her marked deterioration she was started on a syringe driver. Not certain what her preceding dose of codeine had been. But on the assumption it was 64mg/24 hours, the morphine equivalent is 6.4mg and the diamorphine equivalent therefore about 2mg. In fact, she had been given oramorph 5mg PRN, about a 250% dose increase, and then the diamorphine dosage was begun at 20mg/24 hours, a further doubling of the dose! But her deterioration is then listed as marked at 19.30hours, about 3 hours after the syringe driver started, when she had had about 2.5mg diamorphine and midazolam (+the oramorph). I suspect she was dying anyway, and the syringe driver merely slightly accelerated the process.	
BJC/71	Pittock, Leslie N1007	The management of this man is very difficult to understand clinically. He was transferred from psychogeriatric care to a long stay elderly care bed on Dryad ward because of progressive physical deterioration. Dr Lord, who did the assessment, felt he would not go back to residential care and had no rehab potential; this was explicitly continuing care. Noted to be physically poor at time of transfer. Hoist to move so essentially bed bound, catheterised, Barthel 0. Limited food intake and hypoproteinaemic, though would take some food with encouragement. Long history of resistant depression but not demented; very withdrawn. Neither in Dr Lord's assessment nor in Dr Barton's admission to Dryad on 5.1.96 is there any mention of pain. On 9.1.96 his right hand was painful and held in flexion ?why. No diagnosis suggested. Brief trial of Arthrotec, then on 11.1.96 started oral morphine 30mg/day (5mg QDS and 10mg at bedtime). On 15.1.96 suddenly transferred to high dose syringe driver with diamorphine 80mg, together with hyoscine and midazolam 60mg. Because of his agitated depression this man had a long term history of diazepam usage, but not at this sort of dosage! Levomepromazine added on 18.1.96. Diamorphine escalated to 120mg on 17.1.96 and haloperidol 20mg added; this was felt not to be settling him so removed and levomepromazine increased to 100mg from 20.1.96. These changes on 17.1.96 were made by verbal order and signed on 18.1.96. Did GWMH have a verbal orders policy allowing a high dose syringe driver to be prescribed for the first time by telephone? S/D started on 15.1.96 at 8.25am. By that afternoon he was recorded as "unresponsive". By 21.1.96 he had a recorded respiratory rate of 6/min! This man was seriously overdosed with opioid for no reason that I can determine from the notes. I suspect it accelerated	3C

Exhibit No	Patient Identification	Assessment Note	Assessment Score
		his inevitable death.	
JR/05	Ramsey, Joan N246	Actively and carefully managed. Demented and had multiple complications after #NOF and DHS. In among her other troubles, like sepsis and severe OA knees, her escalating pain was not localised to the DHS for some days/weeks and she was managed with increasing analgesia, apparently MST but I could not find the relevant drug chart. Eventually she managed to convey that the pain was in her left groin (the # side) and was Xrayed, whereupon prompt transfer to orthopaedic care was arranged. Eventually left Dryad successfully for a nursing home placement. Family seen by a consultant geriatrician (cannot read signature) who apologised that they had missed the dislocated DHS. Hence grading this substandard. In every other way it seems exemplary management both of pain and of complications, with the lady energetically rescued from UTI and chest infection and advice sought from Dr Banks re depression and dementia.	2A
BJC/76	Ritchie, John Ralston N321	Notes contained nothing of relevance. All related to successful surgery in 1976 and 1981	
JR/02	Rogers, Elizabeth Fiegan N291	Admitted with a marked neurological deterioration of uncertain cause, which progressively improved. But extremely dependent and not felt by Dr Lord to be a candidate for a PEG. Tended to pull out NG tubes, venflons etc. So oral intake very poor and tended to get dehydrated. Definitely improving at time of transfer. Had gone from GCS 6 to fully alert and able to hold a conversation. Only analgesia at time of transfer was cocodamol 2 tabs at night. (Had diamorphine 2.5mg sc prescribed PRN but had never been administered.)	1A
BJC/72	Service, Helena N1008	A very frail elderly lady with severe congestive cardiac failure and very deaf. Dr Barton admitted her on transfer from QAH and appears to have considered that her CCF might be terminal, as she noted "may need palliative care". However, her transfer had been because she had deteriorated to the point where her care home was struggling to cope and she was likely to need either NHS continuing care or a nursing home. At the time of transfer she was on no analgesia or sedation and apart from her deafness only appeared to get confused when acutely unwell. On the night of admission she failed to settle and sleep. There is no record that Dr Barton was contacted by telephone, but the patient was started on a syringe driver of midazolam 20mg/24	3B

Exhibit No	Patient Identification	Assessment Note	Assessment Score
		hours from the selection of drugs Dr Barton had written up in advance – I cannot believe the nurses selected this drug, dose and route without speaking to Dr Barton about it. Not surprisingly, the nursing notes record that she deteriorated overnight but remained restless. She was therefore reviewed the day after admission by Dr Barton. The midazolam dose was doubled and diamorphine 20mg added, though there is nothing in the nursing notes to suggest even discomfort, let alone pain. She died in the early hours of the following morning. While clearly a very frail and extremely old lady (she was 99 at the time of this admission) and not going to leave inpatient care I see no reason to believe that this lady was dying when admitted to GWMH and feel that this incredibly high dose of sedation was instrumental in hastening her end.	
BJC/69	Skeens, Euphemia N1005	Deteriorating following CVA. Swallow impaired. Increasingly chesty and unable to clear secretions. Pain from L arm, where she fell when she had the stroke. Became pyrexial ?cause. Dr Barton considered whether or not to give Antibiotics, talked to the son, decided on symptomatic management only. Quickly became restless and distressed. Given Oramorph 5mg PRN, then increased to 10mg the next day. Very low urine output so probably accumulating. Dr Barton found her distressed and restless in the morning, set up diamorphine 40mg and midazolam 20mg in S/D. This was at least double the oral dose. "Became peaceful and relaxed very quickly" according to the nursing notes, again suggesting excessive doses. But she was dying. I doubt the opioids made any significant difference.	2A
BJC/79	Smith, Horace Reuban N900	In GWMH for less than 24 hours. Admitted to Haslar with alcoholic pancreatitis, in association with alcoholic liver disease and COPD. Became acutely unwell the first night he was in GWMH with severe abdominal pain. By the following morning it was clear he had an acute abdomen, which was painful, distended and rigid and he was transferred straight back to B3, Haslar. He died 6 days later, presumably in Haslar. His drug treatment in GWMH included a single dose of pethidine 50mg IM for the acute abdominal pain. This is entirely appropriate medication in the circumstances and would not have influenced his death 6 days later in any way I could see.	1A

Exhibit No	Patient Identification	Assessment Note	Assessment Score
		From Haslar notes: recurrence of pancreatitis, complicated by popliteal embolus requiring embolectomy, respiratory failure and mild renal failure. Maximally managed, including finally intubation and ventilation in ITU but respiratory failure abruptly worsened and he arrested, and did not respond to CPR. Morphine and midazolam were appropriately and routinely used to sedate him while he was intubated and ventilated.	
BJC/60	Stanford, Dorothy N496.	Dense hemiplegia with NG tube feeding. Had been pyrexial with scattered creps for several days before transfer. Described as "very poorly" on arrival at GWMH. With agreement of daughter decided to stop tube feeding, and not to give antibiotics (although she had had antibiotics in QAH). Also commented "needs analgesia" but with no indication of pain, or reason to give painkillers. Had not previously been on analgesia. Unable to take anything by mouth. S/D containing diamorphine 40mg with hyoscine and midazolam set up on 25/11; patient died on 27/11/93. I am sure this lady's prognosis was very poor, particularly if NG feeding had been continued. She was likely to have died of aspiration pneumonia pretty soon. But I can see no reason at all for her to have been given diamorphine by SC infusion, and certainly not in a starting dose of 40mg.	2A
JR/04	Stevens, Jean N313	These are the Haslar notes which include the final admission. They reveal a more major pain problem than had been apparent from the GWMH notes. She had multiple episodes of surgery for diverticular disease, complicated by anastomotic leak and abscesses, then anastomotic stricture. She was left with chronic pain in the LIF for which she took codydramol (although she had been advised to use diclofenac instead in view of the constipating nature of codydramol). She had been referred to the Pain Clinic in March 1999, but was not seen before she had her final stroke. During her Haslar admission following the stroke and MI, she took regular codydramol and PRN doses of diamorphine 5mg SC (I think 2.5mg would have been more appropriate, given her background medication). But seems never to have taken more than 2 doses in 24 hours and on several days to have taken none at all. So I stand by the original conclusion that the regular opioid prescribed in GWMH was inappropriate and unnecessary, and may have hastened her death, although her prognosis was already very poor. I note there may also have been some confusion about the purpose of going to GWMH. Dr Lord's assessment letter refers to a "slow stream stroke care" bed, but the transfer letter in the Haslar notes refers to	1A

Exhibit No	Patient Identification	Assessment Note	Assessment Score
		"going for rehab" – which was not in fact what was being offered but may have been the words used to the family.	
BJC/61	Willis, Norman N497	Highly dependent following left hemiparesis. PEG fed. In NHS continuing care since 1997. NIDDM. Autumn 1998 developed bullous pemphigoid, which worsened despite topical steroids and became superinfected with MRSA. Lesions all over his body. Very itchy. Needed oral prednisolone in moderate doses (20-40mg/day) which could not be reduced below 20mg without relapse. Severe itch. Distressed by lesions. Had pre-existing pain, certainly in R hip and L shoulder, one reference also to L thalamic pain. On long term MST and amitriptyline. MST remained very low dose, 10mg BD then 20mg BD, for more than a year. Dose steadily increased with worsening of the pemphigoid, but still stepwise- 50mg BD then 60mg BD then 80mg BD then 100mg BD. PRN Oramorph dose was only 10mg – not appropriate for the MST. Tried a fentanyl patch briefly, but he picked it off. Lot of chopping and changing – MST to S/D to fentanyl to MST and finally back to S/D – seem not to have thought of using PEG for oramorph throughout. Finally felt to need large doses of midazolam to quell the distress of the itch and blisters, and calm his terror as death approached – noted several times to be agitated and frightened. Also episodes of severe pain – not clear which one but carbamazepine started so may have been thalamic. Both times he went on to S/D the conversion was over-generous – October from MST 50mg BD to diamorphine 80mg (=MST 120mg BD) and February 99 from MST 100mg BD to diamorphine 100mg (=MST 150mg BD). Diamorphine then rapidly escalated, finally to 400mg/day. But he was agitated and distressed. Motive seems solely to keep him comfortable. Felt to be unavoidably dying.	2A

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17th June 2004

Dear Ms. Alexander

I no longer wish to be on your client list and represented by Alexander Harris in respect of the Police investigations - Gosport War Memorial Hospital.

As you are aware I have been involved in this matter (with the police) since October 1998. I thought when I joined your client list in 2002 that I could let my solicitor take the strain, ask questions, write letters etc but in the event the lack of communication and ineffective action has added to the stress. Telephone messages are ignored, questions remain unanswered, your secretary and / or assistant never have any answers or are unaware of what is going on. Perhaps they have not been briefed. You are too busy to take calls or respond to messages. I enclose a copy of a letter from you dated May 2003 shortly before you went on holiday and I am still awaiting the letter you promised to write on your return approx 9th June 2003.

I am in contact with various organisations, The Office of Constitutional Affairs, The Law Society, the IPCC, HMIC etc. I can find no advantage to being your client and have given notice to the Police of this action.

Whilst I appreciate your interest in my case has caused no financial loss apart from having to travel to Gosport for group meetings arranged by yourself, I do not wish my case to be associated with your publicity, which is to your advantage and not mine.

I regret that this action is necessary.

Yours sincerely

Code A

Mrs. G.M Mackenzie

Code A solicitors

5a

Our ref:
Your ref: AA/LS/32099/1/9929
Please ask for:
Direct dial Code A

FIRST CLASS
Mrs G McKenzie
Code A

27 May 2003
(Dictated 24/5/03)

Dear Gill

Gosport

I am aware that you have left a lengthy message on my telephone answering machine at the office which I have asked Code A my secretary to type up. I am about to go away on holiday and although I will be back within the next two weeks, I shall not actually be back in the Altrincham office and working fully until 9th June. I shall then respond in detail to the message you have left in writing. I trust that will be in order.

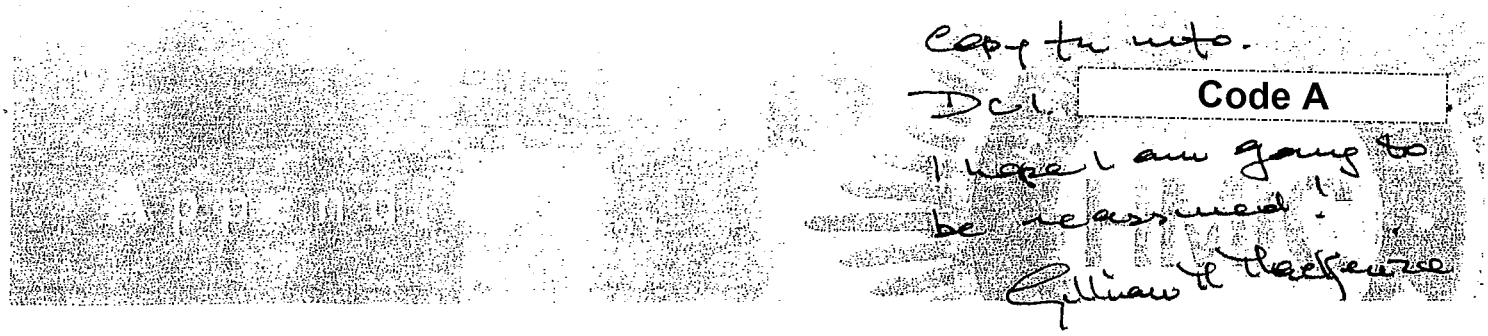
Yours sincerely

Code A
ANN ALEXANDER
SENIOR PARTNER
ALEXANDER HARRIS

Code A

DCI D. Williams
Copy to me.

Handling *with care*
Alexander Harris. Ashley House, Ashley Road, Altrincham, Cheshire WA14 2DW Tel: +44(0)161 925 5555
Fax: +44(0)161 925 5500 DX 19866 Altrincham 1 E-mail: info@alexanderharris.co.uk Website: www.alexanderharris.co.uk.
Offices also in **Central London** and the **West Midlands**
Partners: David N Harris LL.B, Ann Alexander LL.B (Hons) M.B.A. (Managing Partner), Lesley Herbertson M.A. (Cantab), Nicola Castle LL.B (Hons) LLM, Richard Follis LL.B (Hons), Jenny Kennedy, Lindsay Wise B.A (Hons), Grainne Barton LL.B (Hons), Richard Barr, Christian Beadell LL.B (Hons), Auriana Griffiths LL.B (Hons), Warren Collins LL.B (Hons), Rosie Houghton LL.B (Hons), Yee Fon Sit LL.B (Hons), Lesley A. Casey LLB (Hons)



30th June 2003

Dear Keith

HER MAJESTY'S INSPECTORATE OF CONSTABULARY - REMIT

1. The National Policing plan sets out the government's commitment to improving police performance, reducing crime and anti-social behaviour, and to increasing public reassurance.

2. One of the critical success factors in meeting these goals is an effective inspection regime, and in this Her Majesty's Inspectorate of Constabulary (HMIC) has a key role to play.

3. The role, and independence, of HMIC is set down in legislation, principally the Police Act 1996. Within this context, I now wish to set out my expectations of the inspectorate in supporting the implementation of the National Policing Plan.

OPERATIONAL FRAMEWORK

4. HMIC's stated purpose is:

- To promote, and report on, the efficiency and effectiveness of policing in England, Wales and Northern Ireland through inspection of police organisations and functions to ensure: agreed standards are achieved and maintained; good practice is spread; and performance is improved.
- To provide advice and support to the Home Secretary and tripartite partners.

5. We have agreed that you will adopt a framework for future inspections that is based upon the comprehensive assessment of performance and I welcome the focus within that framework upon: performance against targets; leadership and corporate governance; and partnership and community engagement. The first of these new inspections, to take place this summer, will constitute a "baseline assessment" against which a force's progress will be monitored in future years.

REMIT

6. Within this framework, the primary goal of HMIC's inspection regime should be to support the strategic priorities of delivering improved performance and greater public reassurance with particular emphasis upon:

- The Home Office's Public Service Agreements;
- The four key priorities outlined within the National Policing Plan;
- The milestones set out in the National Policing Plan;
- Achieving greater convergence between the best and worst performing forces and BCUs; and
- The implementation and further development of the police reform programme - particularly the work on getting the best leaders into the most demanding roles within the service.

7. HMIC is already working closely with the Police Standards Unit - work which we expect will develop and strengthen - and other Home Office units to support the implementation of the reform programme and the development of the Policing Performance Assessment Framework (PPAF). The latter, together with the annual risk assessment process, will inform HMIC's tailored three-year inspection programme and, where appropriate, trigger inspections.

8. I am aware that one of the products of this year's assessment will be a progress report on performance and reform issues within each force and I look forward to receipt of these reports. I welcome the trend of recent reports which the Inspectorate has set out, in unambiguous terms, those areas requiring improvement.

9. I also welcome in particular the developing activity with the Police Standards Unit, other Home Office units, and key stakeholders in engaging collaboratively with poorer performing and failing forces and BCUs, and look forward to improved performance outcomes as a consequence. This work includes the development of a formal protocol to clarify the process for escalating HMIC/PSU support and engagement in such circumstances, including any recommendation for formal intervention where appropriate.

HMIC'S WIDER ROLE

10. In addition to HMIC's role as an Inspectorate, you also have a central role in:

- The Senior Appointments Panel
- The recently introduced PDR process for chief officers.

11. You have rightly identified that effective partnerships with other stakeholders in the inspection process will be crucial to the success of much of your planned work and in particular, I endorse the need for a close working relationship with sister Inspectorates within the Criminal Justice System. This has set an important precedent and I hope to see further developments in this area.

Best wishes

DAVID BLUNKETT

RECEIVED
06 MAY 2004

Code A solicitors

5a

Our ref: Code A
Your ref:
Please ask for:
Direct dial Code A

F.A.O Code A
Police Headquarters
West Hill
Winchester
Hampshire
SO22 5DB

4 May 2004

Dear Mr Watts

Further to our recent meeting with Gillian McKenzie and Lesley Richards we have been asked to seek clarification from you in respect of a number of points.

I would be grateful if you could advise as to precisely what information has been sent to the experts and if you have chosen not to send any information, what this information is and why have you decided not to send it. In particular, please can you let me know the details of the medical records that have been sent, including the dates covered and from which institutions.

Also, I have noted that both Mrs McKenzie and Mrs Richards are becoming increasingly more stressed with the length of time it is taking for information regarding their case to be given to them and any reassurance you can provide as to when they may receive some more substantive information as to progress would be appreciated.

I look forward to hearing from you.

Yours sincerely

Code A
ANN ALEXANDER
SENIOR PARTNER
ALEXANDER HARRIS

Code A

Other Document Form

Number 1083.

Title LIST OF ACTIONS FOR ELSE LAUENER

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Document registered / indexed as indicated

No(s) of actions raised As indicated on document

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further actions no(s)

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

O/M	SIO

Indexer

ACTIONS FOR
OPERATION ROCHESTER
ELSIE LAVENDER

BJC/30 Elsie LAVENDER

Action 1 TST Doctor BARTON re her entry on page 9 of the medical notes. Clarify with Doctor BARTON the date of death and also what diagnosis is written in the top right corner of the page. What involvement did Doctor BARTON have in the care and treatment of Elsie LAVENDER. A1173.

Action 2 TST Doctor J.C TANDY, Consultant Physician in Geriatrics at QA Hospital, Cosham. Doctor TANDY is the author of a letter as at page 11 and 13 of the medical notes. Clarify with Doctor TANDY what his involvement with the patient Elsie LAVENDER was. Ascertain in layman's terms what the content of the letter means. A1174

Action 3 TST Doctor E.J PETERS, The Surgery, 149 Forton Road, Gosport. Doctor PETERS was the GP of Elsie LAVENDER. Ascertain from Doctor PETERS was his involvement and knowledge of Elsie LAVENDER was. A1175

Action 4 TST Sister S JOYNES, Daedalus Ward. Sister JOYNES is mentioned in the letter as at page 13, clarify with Sister JOYNES what her involvement was with the care and treatment of Elsie LAVENDER. A1176

Action 5 TST Surgeon Commander TAYLOR, RNH Haslar. Ascertain from Commander TAYLOR what his involvement in the care and treatment of Elsie LAVENDER was. A1177

Action 6 TST Doctor BARTON regarding her entries in the medical notes on page 85, dated 22nd February, 23rd February, 26th February, 5th March and 6th March 1996. Clarify with Doctor BARTON what her involvement with the patient was. What care plan was to be followed and what diagnosis had been made. Clarify with Doctor BARTON what the entries state. A1178

Action 7 TI author of note at the foot of page 85 of the medical notes dated 6th March 1996, timed at 21:28. Note continues overleaf at page 87 and is signed by an RGN. Clarify with the Nurse that this if the verification of the death of Mrs LAVENDER. Ascertain whether or not it was standard practice for Nurses to verify death and sign the medical notes. A1179

Action 8 TI author of note on page 87, reads 'death verified by (C.J MARJORAM). Ascertain who this Nurse is and what is meant by this entry in the medical notes. A1180

Action 9	TST Staff Nurse RIGG, RGN, regarding her entries on the medical notes at pages 91 and 93, Nursing Referral Form. Clarify with the author of the note what is being recorded. Ascertain whether or not this Nurse was the named Nurse Mrs LAVENDERS care. Clarify with her what involvement she had in the care and treatment of Elise LAVENDER.	A1191
Action 10	TST Staff Nurse Y ASTRIDGE. She is recorded as the named Nurse for Elsie LAVENDER on page 95. Clarify with Staff Nurse ASTRIDGE what her involvement with Elsie LAVENDER was. What she knew of the treatment of Elsie LAVENDER and whether or not she was involvement in the administration of any drugs for Mrs LAVENDER.	A1192.
Action 11	TST author of entry on page 97 of records, dated 27th February 1996, commencing 'analgesia administered'. Clarify with the author what drugs had been administered to address Mrs LAVENDER'S pain at that time and how effective it had been. Clarify with the author what involvement she'd had with Mrs LAVENDER.	A1193.
Action 12	Cross refer action 11. TI author of note on page 97 of notes dated 28th February 1996. Ascertain from the author what pain relieving drugs Mrs LAVENDER had had at that point to relief her pain.	A1194
Action 13	TI author of note on page 97 dated 29th February 1996 believed C TAYLOR. Clarify with the author what involvement he or she had had with Elsie LAVENDER. Ascertain why it had been recorded that Mrs LAVENDER was able to move arms for washing and dressing. Query is this because her pain had been relieved.	A1195
Action 14	TI author of entry on page 97 of notes dated 1st March 1996 reads, 'complaining of pain in shoulders on movement'. Believed author M COUCH. Ascertain from the author why this was recorded and what care was given to Mrs LAVENDER in order to relieve the pain that she was suffering.	A1196.
Action 15	TST Staff Nurse ASTRIDGE regarding her entry in the notes at page 97 dated 2nd March 1996 reads, 'slight pain in shoulders when moved'. Clarify with the author why this was written and equally ascertain why there are two signatures for this simple entry, Y ASTRIDGE and J MOSS.	A1197
Action 16	TST Staff Nurse J MOSS regarding entry in medical notes on page 97 dated 2nd March 1996 what involvement did Staff Nurse MOSS have with the patient Elsie LAVENDER.	A1196
Action 17	TST Staff Nurse C TAYLOR or C TYLER regarding entry in medical notes on 3rd March 1996. Entry appears to be dated 3rd March 1996 and is dittoed from the line above. Explain why this process was followed.	A1199.

Action 18 TI author of note on page 97 dated 4th March 1996, commences 'seen by physio'. Clarify with the author what has been recorded. Ascertain why the entry analgesia increased has been added. Did this refer to increase in Mrs LAVENDERS pain or an increase in the drugs, if so clarify how this was dealt with or addressed. A1190

Action 19 TST Staff Nurse M COUCHMAN regarding her entry in the medical notes at page 97 dated 5th March 1996, commences 'pain uncontrolled patient distressed'. Clarify with Staff Nurse COUCHMAN why Mrs LAVENDER was put on a syringe driver. What was the content of that syringe driver. Had COUCHMAN received training in the administration of drugs via a syringe driver. A1191

Action 20 TST Staff Nurse W EDGAR regarding entry in medical notes on page 97 dated 6th March 1996, commences 'pain well controlled'. Clarify what this entry says and try and ascertain the time of this entry on this particular day. Ask Staff Nurse EDGAR if the pain was well controlled why a further syringe driver was renewed at 09:45. Secondly, clarify with EDGAR what training she'd received in the administration of drugs by way of syringe driver. A1192.

Action 21 TST Doctor BLACK, Medical Expert, regarding entries in medical notes on page 85 and prescription sheet page 141. Question why would a Doctor on the 26th of February prescribe SC analgesia if necessary and write up diamorphine 80 to 160 mg and yet not administer it and then make a second entry on the 5th March 1996 stating, 'therefore start SC analgesia' and write out a separate prescription on page 137 for diamorphine 100 to 200 mg. (Flag for attention of DS GROCOTT). A1193.

Action 22 TST Staff Nurse Y ASTRIDGE regarding page 99 of the medical notes. She has started the nursing care plan with regards to restricted mobility on the 22nd February 1996. Can she account for all of the entries on the page meaning that bed rest was maintained as a result of directions for physiotherapist or does each individual Nurse have to be seen to explain this. This is also the case for page 101 of the notes. A1194

Action 23 TST Staff Nurse ASTRIDGE regarding entries in the medical notes at pages 103 and 105, 107, 109, these relate to Mrs LAVENDER'S ability to care for hygiene and treatment of leg ulcers on the right leg and dry skin. Ascertain from Staff Nurse ASTRIDGE what care plan was to be followed in respect of these incidents and how members of staff would interact with Mrs LAVENDER on a daily basis and record this in the notes. A1195

Action 24	TST Staff Nurse ASTRIDGE regarding entries in the medical notes at page 111 and 113. This revolves around the insertion and cleaning of the urinary catheter. Ascertain from Staff Nurse ASTRIDGE what care plan was followed. Equally clarify with Staff Nurse ASTRIDGE what the process regarding the catheter was likely to be.	A1196.
Action 25	TST Staff Nurse ASTRIDGE regarding entries on page 115 and 117 of the medical notes regarding the care plan in respect of a red and broken sacrum. Clarify with Staff Nurse ASTRIDGE what treatment and procedures were to be followed in resolving this care plan. From reading the entries on page 115 and 117 can she clarify what treatment was given to Mrs LAVENDER.	A1197
Action 26	TST Staff Nurse Yvonne ASTRIDGE regarding entries on page 119 of the medical notes this regards a care plan surrounding an issue of constipation due to medical problems. Clarify with Staff Nurse ASTRIDGE how this care plan was to be administered and what the entries in the medical notes relate to.	A1198
Action 27	TI the author of page 121 of the medical notes possibly Staff Nurse Yvonne ASTRIDGE. This is a nursing care plan which states, 'requires assistance to settle for the night'. Ascertain from author whether this page is linked to page 123 of the medical notes.	A1199
Action 28	TI author of entry on page 123 of medical notes dated 22nd of February 1996, commences 'settled and slept well'. Clarify what the entry says. Where the entry states analgesia given cross refer this to the prescription sheet to identify specifically what was administered.	A1200.
Action 29	TI the author of the entry on page 123 of the medical notes dated 23rd February 1996 commences, 'analgesia given before settling'. Clarify with the author that DF 118 is in fact dihydrocodeine and cross refer when the tablets were given to the prescription sheet on page 141 of the notes.	A1201.
Action 30	TI the author of the entry on page 123 of the notes dated 24th February 1996. Clarify what the entry states.	A1202
Action 31	TST Staff Nurse DOLAN believed author of entry on page 123 on the 25th February 1996. Clarify with the Nurse what the entries meant to say as there appears to be nothing on the records bar a signature.	A1203
Action 32	TI the author of the entry on page 123 of the notes dated 26th February and 27th February 1996 believed nursed on alternate sides. Clarify with the author what this mean and what was the purpose of the entry. Secondly, why there is no entry on the 27th February, just a signature and a date.	A1204
Action 33	TST Staff Nurse M MARTIN regarding her signature on page 123 of the medical notes for the date 28th February and 29th February 1996.	A1205

She's put a date for both and signed for both but put no entry. What is this meant to reflect.

Action 34 — TI the author of the entry on page 123 of the notes dated 1st March 1996 commences, 'refused medication at 22:00 hours'. Clarify with the author what medication specifically was refused and what the author can remember of Mrs LAVENDER'S condition. A1206

Action 35 — TI the author of the entry on page 123 of the notes dated 2nd March 1996 believed commences, 'took medication well'. Clarify with the author what was written and what was meant by the phrase 'took medication well'. A1207

Action 36 — TST Doctor BARTON regarding her entry on page 127 of the medical notes prescription sheet and prescribing hyoscine on 5th March 1996. Why was this prescribed but never administered. A1208

Action 37 — Research with Doctor BLACK and WILCOCK the procedure whereby Doctors can prescribe medicines and yet these medicines are never administered. What would be the purpose of this prescription in the first place. A1209/1210

Action 38 — TI the author of entry on page 131 of the medical notes dated 23rd February 1996 believed Staff Nurse JONES. Query what this entry says and what it refers to. A1211

Action 39 — TI the author of the entries on page 133 of the medical notes dated 5th March 1996. Clarify with the author the following:- A1212

1. Why are these entries on a separate sheet and not following on from the entries on page 131 of the notes.
2. Why was oramorph administered to Mrs LAVENDER. Where is this reflected on the prescription sheet or the medical records.
3. Why on the first entry does it say 'all times' next to oramorph.
4. What do all the other entries refer to in respect of these medical notes.

Action 40 — TST Doctor BARTON regarding her entry on page 135 of the medical notes regarding her prescription of what is believed ferris sulphate. A1213

Action 41 — Research with Doctor BLACK why ferris sulphate would be prescribed to Mrs LAVENDER. Would Doctor BLACK expect to see entries in the prescription sheets for the administration of this drug as is indicated here. A1214

Action 42 — TST Doctor BLACK, Medical Expert regarding the prescription and administration of all drugs in relation to the case of Elsie LAVENDER. A1215

In the absence of any Consultant overseeing Mrs LAVENDER'S case was the prescription of all these drugs appropriate in the circumstances.

Action 43 TI the author of signatures on page 137 of the medical notes in relation to the administration of diamorphine and midazalam on 5th March 1996. Identify who administered these drugs and whether or not they had received any training in the use of syringe drivers. A1216

Action 44 TST Staff Nurse Yvonne ASTRIDGE believed to be the author of entries on page 137 of the medical notes administering diamorphine and midazalam to Mrs LAVENDER on 6th March 1996. Clarify with her what time these drugs were administered. What training she had received in the use of syringe drivers. A1217

Action 45 TST Doctor BLACK, Medical Expert regarding the drug and prescription charts have been completed for pages 139, 141, 143, 145 of Elsie LAVENDERS medical records. Ascertain from Doctor BLACK whether there are any concerns over these records and areas for the Police to further investigate. A1218

Action 46 TI author of entry in medical notes at page 51 dated 22nd February 1996, timed at 17:00. Ascertain from the author what has been written and what is meant by this entry. (Possibly Staff Nurse ASTRIDGE). A1219

Action 47 TI author of entry in medical notes at page 151 dated 23rd February 1996, timed at 11:00. Ascertain from the author what this entry is and what it means. Cross refer with Action 46. A1220

Action 48 TI author of note on page 151 of medical records, timed at 17:20 hours believed author (Staff Nurse S.A JONES). Entry commences, 'pathology phoned platelets 36'? Ascertain from the author what this entry means. Attempt to cross refer the full blood count record with the Chemical Pathology records held at the rear of the file around pages 200 to 228. A1221

Action 49 TST Staff Nurse JONES regarding entry in medical records on page 151 dated 24th February 1996, commencing, 'Pain not controlled properly by DF118'. Clarify with Staff Nurse JONES how she knew that the pain was not being controlled and what action she undertook as a result of this observation. Cross refer this entry with any entries by Doctor BARTON in the medical records or an increase in the prescription on the prescription charts. How was the pain controlled. A1222

Action 50 TI the author of entry in medical records at the foot of page 151 commences, 'Night 24 February 1996 comfortable night'. Clarify what has been recorded and what the entry states. A1223

Action 51 TST Staff Nurse JONES regarding entries on page 153 of the medical notes dated 25th February 1996 and 26th February 1996. In particular A1224

clarify with Staff Nurse JONES at the 14:30 hour entry what is meant by, 'Son is happy for us just to make Mrs LAVENDER comfortable and pain free, syringe driver explained'. Cross refer these entries to entries by Doctor BARTON in the medical records and also any particular increases in the drugs on the prescription charts.

Action 52 TI the author of entry on page 153 of the medical notes dated 27th February 1996. Reads, 'bloods taken'. (Possibly Staff Nurse ASTRIDGE). Clarify with the author what this entry means. Ascertain why bloods were taken. Who authorised this blood to be taken. Is this done by the Nurse or by a Doctor. What are the circumstances that surround this entry. A1225

Action 53 TST believed Staff Nurse M COUCHMAN, regarding entry on medical notes page 153 dated 29th February 1996. Clarify what the entry says and what it means, in particular where the entry states Doctor BARTON contacted ordered 10 units of what? Cross refer this entry to entries in medical records, or increases in prescription or drug charts. A1226

Action 54 TI author of entry in medical notes at page 153 dated 4th March 1996, commencing, 'Patient complaining of pain'. Clarify with the author what this entry states and what it means. Where the entry reads, 'Having extra analgesia PRN'. Whose decision and authority was this made upon, as there does not appear to be any entry in the medical notes to this effect. Clarify where Doctor BARTON has made entries in the medical records or the drugs prescription charts to reflect this entry in the Nursing Notes. Lastly, 'Tablets dose increased to 30mg is dated on the 4th of March 1996'. Cross refer to page 133 of the prescription sheet. It appears that this is not increased until the 5th March 1995. Have the author clarify any inconsistencies. A1227

Action 55 TST believed Staff Nurse COUCHMAN regarding entries in the medical records on page 153, dated 5th March 1996, commences, 'patients pain uncontrolled very poor night'. Clarify with the author what this entry means. Ascertain whether this was the start of the first syringe driver administration. Ascertain from the author of the record on whose authority the syringe driver was commenced and cross refer this to entries on the medical records at page 85. A1228

Action 56 TI author of entry on medical notes on page 155 dated 6th March 1996, commences, 'Seen by a Doctor BARTON'. Clarify with the author what this entry means. Entry appears to be incomplete as the last line says, 'discontinued as patient unable'. Clarify this issue with the author. A1229

Action 57 TI the author of entry in medical records at page 155, timed at 21:28. Cross refer this action with action 7 and page 87 of the medical records. Clarify with the author what the purpose of this entry was. A1230

Action 58	TST Doctor LORD, Consultant in Charge of Elsie LAVENDER. Ascertain from Doctor LORD what her involvement with the patient Elsie LAVENDER was. Mrs LAVENDER having been admitted to Gosport War Memorial from Ward A4 at Haslar.	A1231
Action 59	TST Staff Nurse ASTRIDGE in her capacity as the named Nurse for Elsie LAVENDER. Discuss with Staff Nurse ASTRIDGE the implications of the readings on pages 167, 169, 171, 173 of the medical records. What do these charts refer to and what is the interpretation of the results.	A1232
Action 60	TST Doctor LORD as the Consultant in charge of the patient Elsie LAVENDER. Discuss with Doctor LORD what the Chemical Pathology results as at page 189 represent. What action would Doctor LORD expect to be taken upon having read and interpreted these results.	A1233
Action 61	TST Doctor Jane BARTON regarding the results from the Chemical Pathology Department on page 189 of the medical records. Clarify that Doctor BARTONS signature appears on the page bottom right. What action would Doctor BARTON take on reading and interpreting these results.	A1234

Other Document Form

Number D1082

Title UNDATED LETTER 2001? ANN REEVES TO DSUPT **Code A**

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further actions no(s)

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

O/M	SIO

Indexer

Mr. J. James
(Detective Superintendent)
Hampshire Constabulary
Major Incident Complex
Kingston Crescent
North End
Portsmouth
PO2 8BU

Mrs. A. Reeves

Code A

Dear Mr. James

Ref: Gosport War Memorial Hospital

Thank you for your letter dated 15th Nov 2001 following my telephone call to you regarding my mother's care at the GWM. As you are aware I told you at the time that I would be going abroad, I have now returned.

I contacted Julie Millar as you had said in your letter that she had asked you to write to me. However, she told me that she did not know of any conversation she had with you regarding my case but she would be happy to hear my comments.

I would like to point out that having since been in touch with Julie Millar at CHI and given her my correspondence she informed me that they are only there to introduce changes. What I ask of the Police is for them to investigate the terrible misdoing that led to our mother's death. I understood from your letter that investigations were going on and still are but I did not think that they included what happened to our mother because you have never asked for her medical records.

Yours sincerely

Code A

Mr. A Reeves

cc. Mr. R. Kernaghan
(Chief Constable)

Other Document Form

Number D1074

LETTER DSUPT WILLIAMS TO MRS MACKENZIE RE SISTER & CONTACT

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further actions no(s)

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

O/M	SIO

Indexer

HAMPSHIRE CONSTABULARY

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Fareham Police Station
Quay Street
Fareham
Hampshire
P016 ONA

Tel. 0845 0454545
Fax. 023 92891663

Our Ref. Op Rochester

Your Ref.

6th August 2004

Mrs G Mackenzie

Code A

Dear Mrs Mackenzie

Re: Operation Rochester

May I confirm that following recent discussions with the Legal Medico Lawyer retained to this investigation I have asked that your sister Lesley RICHARDS be statemented in respect of issues previously raised by yourself, particularly the alleged lack of bruising to your mothers body prior to death, acceptance of the death certificate and the issue of whether or not your mother was suffering Bronchopneumonia immediately prior to death.

I am meeting with our retained Lawyer next week to discuss the categorisation of your mother's case.

As soon as I am in a position to indicate the likely course of the investigation into your mothers death I will let you know.

In the interim may I ask you to refrain from making regular contact with various members of the investigation team who are actively pursuing the investigation and who will not have detailed knowledge of your particular case.

As previously indicated in my telephone conversation with you of the 13th July 2004 any contact you make with this investigation should be made through the dedicated Family Liaison Officer Kathryn Robinson.

Continued/.....

I will be asking all staff to refer you to Kate in the future to ensure that you receive consistency of response.

Yours Sincerely.

David WILLIAMS.
Detective Superintendent.

Other Document Form

Number 1073

Title JOB DESCRIPTION FOR POST CLINICAL ASSISTANT GOSPORT

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / (No)

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further actions no(s)

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

O/M	SIO

Indexer

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

JOB DESCRIPTION FOR THE POST OF CLINICAL ASSISTANT
TO THE GERIATRIC DIVISION IN GOSPORT

LOCATION	GOSPORT WAR MEMORIAL HOSPITAL	11 PATIENTS
	NORTHCOTT ANNEXE	12 PATIENTS
	REDCLYFFE ANNEXE	23 PATIENTS

ACCOUNTABLE TO:- CONSULTANT PHYSICIANS IN GERIATRIC MEDICINE

LIAISES WITH:-

INTERNAL
- CONSULTANT PHYSICIANS IN GERIATRIC MEDICINE
- LOCAL MANAGER FAREHAM/GOSPORT
- HOSPITAL/PREMISES MANAGER GOSPORT
- WARD SISTERS
- MEDICAL RECORDS DEPARTMENT
- HEADS OF PARAMEDICAL SERVICES
- PHARMACY
- DIETICIANS

EXTERNAL
- GENERAL PRACTITIONERS
- SOCIAL SERVICES
- VOLUNTARY SERVICE ORGANISATIONS

JOB SUMMARY

This is a new post of 5 Sessions a week worked flexibly to provide a 24 hour Medical Cover to the Long Stay patients in Gosport. The patients are slow stream or slow stream rehabilitation, but holiday relief and shared care patients are admitted. An important aspect of this role is for the postholder to be seen not only as a medical adviser but as a friend and counsellor to patients, relatives and staff.

All Consultant Physicians in Geriatric Medicine have an equal right of Admission, but at present the beds in Gosport are under the control of Dr Wilkins and Dr Grunstein.

DUTIES

1. To visit the Units on a regular basis and to be available "On Call" as necessary.
2. To ensure that all new patients are seen promptly after Admission.
3. To be responsible for the day to day Medical Management of the patients.
4. To be responsible for the writing up of the initial case notes and to ensure that follow up notes are kept up to date and reviewed regularly.
5. To complete, upon discharge, the Discharge Summary and HRM 60.
6. To ensure the prompt preparation of death certificates and for cremation certificates where appropriate.
7. To take part in the weekly Consultant rounds.

8. To prescribe, as required, drugs for the patients under the care of the Consultant Physicians in Geriatiric Medicine.

9. To participate wherever possible in multi-disciplinary case conferences and discussions related to the patients in the Unit.

10. To provide clinical advice and professional support to other Members of the Caring Team.

11. To identify opportunities to improve services so that a high level of care can be provided within the resources available.

12. To be available when required to advise and counsel relatives.

13. To be responsible for liaison with the General Practitioners with whom the patient is registered, and with other Clinicians and Agencies as necessary.

There may be a possibility that the sessions can be split between two separate General Practitioners, ideally from the same Practice.

Other Document Form

Number D1068

LETTER DR Code A TO DSUPT JAMES RE ERRORS PROF FORDS REPORT

(Include source and any document number if relevant)

Receivers instructions urgent action Yes (No)

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further actions no(s)

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

O/M	SIO

Indexer

Portsmouth HealthCare NHS
NHS Trust

Department of Medicine for Elderly People
Queen Alexandra Hospital
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PO6 3LY

Tel 023 9228 6000
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Detective Superintendent John James
Major Incident Room
Hampshire Constabulary
Kingston Crescent
Portsmouth

08 March 2002

RIR/cmp

Dear Superintendent James

Further to you letter of 5th February 2002, to Mr Millett regarding Police enquiries at Gosport War Memorial Hospital and our subsequent discussion, we are considering within the Trust what further appropriate action we need to take as the employer of the staff named in the three reports commissioned by the Police.

In the course of this we have identified several inaccuracies in the text of one of the reports (that from Professor Ford). I am quite sure that these are to do with a misreading of the draft when finally being typed up, but given that the GMC and UKCC, along with ourselves, are considering individual staff on the basis of these reports, I felt that I should write highlighting the points so that they can be corrected:

- **Page 17, paragraph 3.13, fourth sentence**

  This reads "poor assessment by Dr. Lord"

  However in view of the subsequent sentence (which reads that "the assessment by Dr Lord was thorough and competent") and of the context of the patient's medical notes (where there is a comprehensive note by Dr Lord but only four lines by Dr Barton), we assume that this should read "poor assessment by Dr Barton".

- **Page 21, paragraph 4.1, line seven**

  This reads "... she is not refusing fluids ..."

  The G.P. letter referred to states "... she is now refusing fluids".

- **Page 26, paragraph 5.5**

This lists the dates of prescriptions as in September, whereas the prescription chart for the patient shows them as in October.

❖ **Page 27, paragraph 5.9, line one**

This reads as ".. deteriorated on 15 September..."

This should read "October". The patient was admitted on 22 September and was not an in-patient on 15 September.

In paragraph 5.9 there is a reference to Mr Wilson having been seen by the "on-call Doctor". The on-call Doctor concerned was Dr A C Knapnan.

❖ **Page 34, paragraph 6.16, final sentence**

This reads "... was likely to have resulted could have resulted..."

We assume that only one of these statements is meant to be there.

Yours sincerely

Code A

Dr R I Reid
Medical Director

cc: GMC
UKCC
CHI

Other Document Form

Number D1065

Title REVISED LIST OF ACTIONS FOR LESLIE PITTOCK

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Document registered / indexed as indicated

No(s) of actions raised See D1020 & as on document.

Statement readers instructions

Indexed as indicated

(s) of actions raised

Examined - further action to be taken

Further actions no(s)

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

O/M	SIO

Indexer

OPERATION ROCHESTER
ACTIONS
FOR
LESLIE PITTOCK

BJC/71	Leslie PITTOCK
Action 1	TI Doctor Vicky BANKS, Consultant in Old Age Psychiatry, Mulberry A Ward, Gosport War Memorial Hospital. Ascertain from Doctor BANKS the care and treatment that was provided to Mr PITTOCK at the end of 1995 and the beginning of January 1996 in respect of his case. Ascertain from the Doctor what her involvement with Mr PITTOCK was.
Action 2	TST Doctor Vicky BANKS, Gosport War Memorial Hospital, regarding a letter she received on 8th January 1996 in respect of Mr PITTOCK. Have Doctor BANKS explain plain language what the content of the letter means.
Action 3	TI Doctor ASBRIDGE regarding his or her involvement with the patient Leslie PITTOCK in January 1996, as per the letter on page 5 of the microfilm notes of Leslie PITTOCK.
Action 4	TST Sister HAMBLIN, Dryad Ward, Gosport War Memorial Hospital, regarding her involvement with the patient Leslie PITTOCK in January 1996 as per the letter at page 5 of the medical notes, (microfilm).
Action 5	TST Doctor A LORD, Consultant Physician in Geriatrics, Gosport War Memorial Hospital. Doctor LORD was the author of a letter as at page 5 of the medical notes, (microfilm). Clarify with Doctor LORD what her involvement with the patient Leslie PITTOCK was. What her diagnosis was and what care plan was put forward in respect of his treatment.
Action 6	TST Doctor Jane BARTON re prescribing Leslie PITTOCK nozinan tablets. This was prescribed on the 18th January 1996, as per page 6 of the medical notes, (microfilm). What was the purpose behind the prescription of this drug?
Action 7	TI expert in Pharmacy to explain what the implications are of prescribing nozinan to a patient with a condition such as Mr PITTOCKS.
Action 8	TST Doctor BRIGG regarding his prescription of the drug nozinan on 20th January 1996 as per page 6 of the medical notes, (microfilm). Ascertain from Doctor BRIGG why 100mg was prescribed. What the meaning of verbal order is and what was the purpose of prescribing this drug.

Action 9	TST person identified as DOUGLAS who wrote out the prescription for nozinan in respect of Mr PITTOCK on page 6 of the medical notes, (microfilm). Ascertain with DOUGLAS the circumstances surrounding this prescription.
Action 10	TST Doctor Jane BARTON, Gosport War Memorial Hospital regarding the prescribing of various drugs as contained on page 7 of the medical notes, (microfilm). Ascertain from Doctor BARTON the prescribing policy for diamorphine, midazalam, hyocine, halpadrol, nozinan. All of these drugs were prescribed to the patient Leslie PITTOCK on the same day 17th January 1996.
Action 11	TST independent medical expert. Ascertain whether the prescription of all the drugs on page 7 of the medical notes, (microfilm) was appropriate in the circumstances in respect of the condition of Leslie PITTOCK.
Action 12	TST Doctor BRIGGS, regarding his entry in the medical notes on page 8, (microfilm). Why did Doctor BRIGGS omit the prescription of halpadrol on 20th January 1996 as stated? What was the reasoning behind this?
Action 13	TST Staff Nurse DOUGLAS re her entry on page 8 of the medical notes, (microfilm). What was the purpose behind this entry?
Action 14	TST Doctor BRIGGS regarding the entries in page 7 of the medical notes, (microfilm). Was Doctor BRIGGS responsible for suspending the prescription of all the drugs on 20th January 1996 as annotated by the crosses at 15:30, if so why was this?
Action 15	TST Doctor J.C TANDY, Speciality Elderly Medicine. As per page 9 of the microfilm medical notes. Ascertain from Doctor TANDY what his involvement with the patient Lesley PITTOCK was.
Action 16	TST Doctor Jane BARTON, re page 9 of the microfilm medical notes. Clarify that she was the person who signified the date of death of Mr PITTOCK as the 24th January 1996.
Action 17	TST Doctor M AZBRIDGE, 2 Gregson Avenue, Bridgemary, Gosport. Doctor AZBRIDGE was the GP of Lesley PITTOCK. Ascertain what he knows of Mr PITTOCKS condition.
Action 18	TST Doctor BANKS, Consultant in charge of Lesley PITTOCK. Establish with Doctor BANKS what his involvement with Mr PITTOCK was.

Action 19 — Code A Staff Nurse Code A He was the named Nurse for Lesley PITTOCK. Establish with Code A what his involvement was with the care and treatment of Lesley PITTOCK.

Action 20 — TST Staff Nurse Code A regarding his entries in the medical notes at page 12 of the microfilm, Lesley PITTOCK. Establish what is written and what care plan was to be followed in respect of Lesley PITTOCK.

Action 21 — TST Doctor Jane BARTON, regarding her entries on the notes of Lesley PITTOCK as at page 13, dated 5th January 1996 and 9th January 1996. Ascertain from Doctor BARTON a) what is recorded, b) what diagnosis she had made and c) what care plan she devised for the care of Mr PITTOCK.

Action 22 — TST Doctor BARTON regarding her entry in the medical notes at page 13, dated 9th January 1996. Clarify the last line of the entry '? Needs opiates'. Establish with Doctor Code A what this sentence means and why she felt that Mr PITTOCK needed opiates.

Action 23 — TI author of entry in medical notes on page 13, dated 10th January 1996, entry reads 'for TLC and discussed with wife agrees in view of poor quality TLC' appears to be initialled JT. Identify author. Establish what is recorded in the notes. Establish why this entry was made.

Action 24 — TST Doctor BARTON regarding her entry in the medical notes at page 15, dated 18th January 1996. Clarify what is written in the entry. Establish with Doctor BARTON how she knew that there had been a further deterioration in Mr PITTOCK'S condition. Where is this reflected in the medical notes.

Action 25 — TI the author of entry in medical notes at page 15, dated 20th January 1996 commences 'has been unsettled on haloperidol' (believed Doctor BRIGGS). Establish with the author what is written in the notes. Identify how the Doctor knows that Mr PITTOCK had been unsettled on haloperidol in the syringe driver. What was the purpose in prescribing nozinan and doubling the size of the dose in 24 hours. Establish with the Doctor what verbal order actually means and when this would have been written up on the medical notes.

Action 26 — TST Doctor BRIGGS regarding his entry in the medical notes at page 15 dated 21st January 1996, commences 'much more settled'. Establish with Doctor BRIGGS what his involvement with Mr PITTOCK had been on 21st January 1996. Clarify what Doctor BRIGGS means by, 'respiratory rate 6/minutes not

distressed continue'. What did Doctor BRIGGS mean by the word 'continue'.

Action 27

TST Staff Nurse Code A regarding his or her entry in the medical notes on page 15 dated 24th January 1996, commences 'death verified at 1:45 a.m.' Establish with Staff Nurse Code A Clarify with Staff Nurse Code A what the procedure was for verifying the death of patients. Did a Doctor have to be called. Was there any policy or procedure that Nurses have to follow in relation to verifying death. Was it normal practice for Nurses to make entries in the Clinical Notes as opposed to the Nursing Notes. Was it acceptable for death to be verified in the presence of a Nursing Auxiliary.

Action 28

TST Nursing Code A regarding her involvement with the patient Lesley PITTOCK on 24th January 1996 as at page 15 of the medical notes. Nursing Code A was present when the death of Mr PITTOCK was verified by Staff Nurse Code A Establish with Code A what his or her involvement was with the patient. Establish what they understood their roles and responsibilities to be whilst working on the ward at that time.

Action 29

TST Doctor BANKS, Consultant in Charge of Lesley PITTOCK. Establish with Doctor BANKS a) what the policy and procedure was for entries in the Clinical Notes by Doctors responsible for the care of patients i.e. entries in notes every 3 to 4 days. Was this normal. Was this considered acceptable at the time. What was the procedure for verifying death of patients on the Ward and how as this to be recorded. In particular in the case of Mr PITTOCK a Staff Nurse certifying death in the presence of a Nursing Auxiliary.

Action 30

TST Doctor BARTON regarding her entries on the prescription sheet on page 16 of the medical notes. Establish with Doctor BARTON what each drug was. What the dose rate was and what the purpose was for prescribing each individual drug.

Action 31

TST Doctor BARTON with regards to her prescription of arthrotec to Mr PITTOCK as per page 16 of the notes. What was the purpose behind the prescription of this drug.

Action 32

TST Doctor BARTON regarding her prescription of oramorph to Mr PITTOCK on 10th January 1996 as per page 17. What was the purpose behind prescribing morphine to Mr PITTOCK. Ascertain why this drug has been prescribed on this date, yet there is no corresponding entry in the clinical notes to justify its prescription.

Action 33	TI author of signature regarding the administration of oramorph on page 17 of 49, at 22:00 on the 10th January 1996 (believed Staff Nurse Code A). Establish with author if the entry at 22:00 should correspond to oramorph. If this is correct why is it written in this way. Establish with the author the reasoning for administering this drug at this time.
Action 34	TST Doctor BARTON regarding her entries at the foot of page 17 of the medical notes prescription sheet commencing 'diamorphine'. Establish why these drugs were written up for prescription, yet no date was ever entered and it appears that these drugs were never prescribed. What was the purpose of writing these entries.
Action 35	Cross refer with Action 34. (The entries made for Action 34 may be an error). TST Doctor BARTON in respect of prescribing all the drugs on page 18 of the medical notes. Ascertain why all these drugs have been prescribed and yet there appear to be no entries in the Clinical Notes to justify the prescription.
Action 36	TI the author of the signature for administering diamorphine on 15th January 1996 as per page 18. Ascertain from this person how the diamorphine was administered to the patient. If by way of syringe driver, what training had they received and on what paperwork was the administration of diamorphine recorded, i.e. there is normally a small graph or chart to show the flow rate of a syringe driver.
Action 37	TI the author of the entry in respect of the administration of diamorphine on 16th January 1996. Ascertain from this person how the diamorphine was administered. If by way of syringe driver, what training had they received and on what paperwork was the administration of diamorphine recorded, i.e. there is normally a small graph or chart to show the flow rate of a syringe driver.
Action 38	TI authors of entries for administering hyoscine as at page 18 of the medical notes for the 15th, 16th and 17th.
Action 39	Research with medical expert Doctor WILCOX apparent incidences of double dosing of diamorphine, hyoscine and midazalam in respect of Lesley PITTOCK as at page 18 of the prescription notes on the 16th January 1996. It appears Mr PITTOCK was administered these medicines at 08:25 and 13:00 hours that day. Could this of had an impact on Mr PITTOCK'S condition.
Action 40	TI the author of the entries on the 16th January 1996 as per page 18 of the medical notes, entries timed at 13:00 and initialled

believed W.B. Ascertain from this person why all of these drugs were administered to Mr PITTOCK at this time.

Action 41 — Research with expert Doctor WILCOX whether the medicines prescribed on page 18 of the medical notes were appropriate for Mr PITTOCK'S condition. In particular the ranges of prescription hyoscine 200 to 400 and yet 400mg was only ever prescribed. Establish whether or not all of the drugs on page 18 would have been administered by way of syringe driver at the same time on page 143 dated 13th March 1998 commencing 'for ACE test. Establish what is written in this entry and obtain an explanation of the content. Specifically dealing with the final line, 'do not give new medicine but keep in DH'. Establish what this means.

Action 42 — TST Doctor BARTON with regards to all of the drugs that were prescribed as at page 19 (tape went blank), PITTOCK. Identify what each drug is that's been prescribed, its dosage and the reasoning behind its prescription.

Action 43 — Research with medical expert Doctor WILCOX whether all of the drugs that were given to Mr PITTOCK between 5th January and 21st January 1996 were appropriate for his condition. Consider the possibility of Mr PITTOCK being opiate toxic and this being a contributing factor to his death.

Action 44 — TST Doctor BARTON regarding the medicines that she prescribed for Lesley PITTOCK as at page 20 of the medical notes. Ascertain from Doctor BARTON the reason why the diamorphine dose was increased from 80mg to 120 on 17th January.

Action 45 — Research with medical expert Doctor WILCOX whether the increase in medicines for Mr PITTOCK was appropriate on 17th January. Diamorphine increased to 120mg, hyoscine increased to 600.

Action 46 — TST Staff Nurse P RIGG. On page 23 of the medical notes RIGG is identified as the named Nurse for Mr PITTOCK. Ascertain from Staff Nurse RIGG what her involvement with Mr PITTOCK was. Which entries in the notes appertain to her. What care plans were in place for Mr PITTOCK whilst she was in charge.

Action 47 — TI Doctor TANDY, Consultant for Mr PITTOCK as described on page 23 of the medical notes. Ascertain from Doctor TANDY what his involvement with the patient Lesley PITTOCK was and what involvement he had with Mr PITTOCK'S case. Clarify with Doctor TANDY what his involvement with Gosport War Memorial Hospital was and

what involvement he had with the drug regime for Mr PITTOCK.

Action 48 — TST Nurse SHAW regarding her entry on the top of page 25 of the medical notes dated 5th January 1996. Clarify with Nurse SHAW what the note says. Ascertain what treatment was to be given to Mr PITTOCK and what care plan was to be followed. Clarify with Nurse SHAW whether she is the signatory for any of the drugs prescribed to Mr PITTOCK.

Action 49 — TI author of note on 7th January 1996 and 9th January 1996 as at page 25 of the notes, believed to be Staff Nurse [Code A] Clarify what is recorded in the notes and ascertain from Staff Nurse [Code A] where she states that Mr PITTOCK is a pyrexial. What was done to remedy this.

Action 50 — TI author of note on page 25 of medical notes dated 10th January 1996, commences 'condition remains poor'. Author possibly Sister HAMBLIN. Clarify with author what is written in the note. Ascertain what care plan was to be followed specifically why oramorph was to be given 4 hourly.

Action 51 — TST Doctor TANDY regarding his visit to Mr PITTOCK on 10th January 1996 cross refer with Action 23, potential author. Clarify with Doctor TANDY was his diagnosis of Mr PITTOCK was and what involvement Doctor TANDY had with the drug regime for Mr PITTOCK.

Action 52 — TST Staff Nurse RIGG regarding entry on page 25 of the medical notes dated 13th January 1996. Clarify with Staff Nurse RIGG what the note says. What involvement he or she had with Mr PITTOCK and ascertain whether or not she or he is a signatory for the administration of any of the drugs.

Action 53 — TST Doctor BARTON. Clarify with her the entry made by Staff Nurse RIGG on 15th January 1996 at the bottom of page 25. Staff Nurse RIGG says, 'Mr PITTOCK was seen by Doctor BARTON and has commenced on syringe driver with diamorphine and various drugs'. Ascertain from Doctor BARTON if this is correct and if it is why there is no entry on the clinical notes to this effect.

Action 54 — TST Staff Nurse RIGG regarding the entry made at the foot of page 25 of the medical notes and the top of page 26. Relates to Doctor BARTON seeing Mr PITTOCK. Clarify with Staff Nurse RIGG that Doctor BARTON did see the patient. Ascertain from Staff Nurse RIGG if it was he or she that started the syringe driver as recorded in the notes with the midazalam, hyoscine and diamorphine. If so what training has Staff Nurse RIGG in the setting up of syringe drivers. Clarify with Staff

Nurse RIGG whether or not you would normally expect an entry in the clinical records for the administration for these kind of drugs.

Action 55 — TST Staff Nurse RIGG describing what syringe drivers were used at the time. Explain the process of setting up and administering drugs using a syringe driver.

Action 56 — TST Staff Nurse T DOUGLAS, regarding entry in medical notes on page 26 commencing, '15th January 1996 daughter informed of father's deterioration'.

Action 57 — TI author of note on page 26 that reads, 'Night comfortable night syringe driver replaced at 07:05 hours'. Ascertain from the author what the note says and what it means. If the author changed the syringe driver ascertain what training that person has received in syringe drivers and clarify what kind of syringe driver was being used at the time.

Action 58 — TST Staff Nurse BARRETT regarding the entries on the 16th January 1996 on page 26. First entry is timed at 20:00 hours second entry is timed at 13:00 hours. Clarify with Staff Nurse BARRETT when these notes were made.

Action 59 — TST Staff Nurse BARRETT regarding entries on page 26 of the medical notes. Clarify with BARRETT that Doctor BARTON saw Mr PITTOCK at 20:00 hours on 16th January 1996. With regards to the haloperidol question when was this to be added to the syringe driver.

Action 60 — TST Staff Nurse BARRETT. Clarify the date of the entry on page 26 of the notes. Was this the 16th of January or the 17th of January. Ascertain from Staff Nurse BARRETT what the entry says and what it means. Clarify with BARRETT why the previous driver dose was discarded at 13:00. Cross refer this entry with that on the prescription chart at page 20 where 5mg of haloperidol is administered on the 16th but 10mg is administered on the 17th. (Please speak to DS GROCOTT for further explanation).

Action 61 — (Blank) Nurse BARRETT. Identify what training she has received in respect of preparing and administering drugs by way of syringe driver.

Action 62 — TST Staff Nurse Code A regarding entry in the medical notes at page 26, foot of the page commences, 'Night condition remains poorly'. Clarify with Staff Nurse Code A what this entry says. Identify what involvement Staff Nurse Code A has had with Mr PITTOCK and cross refer any entries made in the prescription charts etc. Clarify with Staff Nurse Code A

what training he or she has received in respect of preparing and administering drugs by way of syringe driver.

Action 63 — TST Doctor BARTON. Clarify with her that Staff Nurse Code A states she saw Mr PITTOCK on the 16th January and prescribed further medicine to him. Ask Doctor BARTON why there is no entry in the clinical notes regarding this visit.

Action 64 — TST Staff Nurse Code A regarding her entries in the medical notes as at page 27 dated 17th January 1995 (Did you mean 96). Clarify with Code A what the entry states and what it means. Confirm that Doctor BARTON saw the patient at 09:00 on the 17th. Ascertain from Code A the reasons why she believes that the medication was increased. Identify which medication was increased and in what doses.

Action 65 — TST Staff Nurse Code A Ascertain what training she has received in the administration of drugs by way of syringe driver. Clarify with Code A the entry that's timed at 14:30 hours on page 27. Confirm that Doctor BARTON saw the patient at 14:30 and the medication was reviewed and altered, explain what this means. Clarify with Code A why two syringe drivers were operating at the same time and what the content of these drivers was.

Action 66 — TST Doctor BARTON. Clarify with her the notes made by Code A on page 27 of the medical notes. If Doctor BARTON saw the patient on the 17th January why is there no entry in the clinical notes. Explain why the medication was increased. What diagnosis was made in order to come to the conclusion that the medication needed to be increased. Ascertain what is meant by using two syringe drivers at the same time.

Action 67 — TST Sister HAMBLIN regarding her entry in the medical notes at page 27, timed at 23:30 commencing, 'Further deterioration in already poor condition'. Clarify with Sister HAMBLIN what her involvement with the patient Lesley PITTOCK was and what the note that she has recorded states.

Action 68 — TST Staff Nurse Code A regarding her entry in the medical notes on page 27 commencing, 'Night little change in poor condition'. Ascertain what is recorded.

Action 69 — TST Staff Nurse Code A regarding her entries in the medical notes on page 27 and 28, dated 18th January and timed firstly at 20:00 and secondly at 15:00. Clarify with Code A why she times and dates her notes in this way.

Action 70

TST Staff Nurse Code A regarding her entry in the medical notes on page 27 timed at 15:00 hours. Confirm what is recorded and ascertain from her the reasons why the driver was recharged and recommenced as she states. Under whose direction was this made. (Doctor BARTON or Doctor BRIGGS).

Action 71

TST Staff Nurse Code A regarding her entries on the medical notes page 28 dated 19th January 1996. Ascertain from Code A what she has recorded and the reasons for it. Clarify with her why the syringe driver has been recharged and whether or not Doctor BARTON had visited the patient on the 19th January.

Action 72

TST Staff Nurse RIGG regarding the entry on page 28 of the notes dated the 20th January 1996 commencing, 'Mrs PITTOCK and both daughters have visited'. Clarify with RIGG what has been recorded and the reasons for this. Clarify what drugs were put into the syringe driver and why there has been an increase from the previous 24 hours.

Action 73

TST Staff Nurse RIGG regarding entry on page 28 of the notes dated 20th January 1996. Clarify whether or not it was Staff Nurse RIGG that contacted Doctor BRIGGS. If so why was the Doctor contacted. Having spoken to Doctor BRIGGS what was the reasoning behind the verbal order to change the prescriptions. What were Staff Nurse RIGG'S concerns at the time. (Cross refer action with entries on page 15 of the medical notes and link to action 25).

Action 74

TI author of entry in medical records as at page 29 commences 'PM 18:15 condition remains unchanged' (author possible Staff Nurse S RING). Ascertain from the author what is recorded in this entry and what the entry means. Cross refer this entry to the prescription sheets to clarify what has gone in the syringe driver and at whose request. Clarify with the author of the entry what training they'd had in respect of setting up and administering drugs via syringe driver.

A1169

Action 75

TST Staff Nurse Code A regarding her entries in the medical records on page 29, dated 22nd January 1996 and 23rd January 1996. Clarify with Code A what she has recorded in the notes and the reasons for this. Cross refer the entries regarding the syringe driver with those on the prescription sheet. Clarify with Staff Nurse Code A why on the previous day the syringe driver was running at 58 millilitres as opposed to on the 22nd and 23rd it was only running at 43. Ascertain the reason for this.

A1170

Action 76	TST Staff Nurse Code A regarding her entry in the medical notes on page 29, final entry commences, 'night patient condition deteriorated'. Ascertain from Staff Nurse Code A what she can remember regarding the circumstances of the death of MR PITTOCK.	A1171
Action 77	TST Staff Nurse Pamela RIGG regarding entries in the medical notes from page 34 to 46, these are the Nursing Care Plans. Staff Nurse RIGG is recorded as the named Nurse. Establish with her what she understood this role to be in respect of Leslie PITTOCK and obtained from her a detailed explanation of what each of those nursing care plans represented with regards to Mr PITTOCK'S treatment.	A1172

Other Document Form

Number D1029

Title LETTER PAUL CLOSE CPS RE NON PROSECUTION RICHARDS CASE

(Include source and any document number if relevant)

Receivers instructions urgent action Yes (No)

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Code A

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

C W P Newell
Director, Casework

CPS

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Our Reference: LB3/108/01

Your Reference: D.SUPT. JAMES

7 August 2001

Dear Sir

GLADYS MABEL RICHARDS

I write as requested by Detective Chief Inspector Clarke during our telephone conversation last Friday, to confirm the advice given to the police in this matter.

At the meeting at Ludgate Hill on 20 July 2001, the police requested that the CPS took no action pending confirmation from the police as to the steps it proposed to take with regard to the other associated complaints.

I am not sure if the police have now reached conclusions about those matters. It is of course entirely for the police to decide what, if any, investigations are made.

I confirm that having considered this matter, I am not satisfied that there is sufficient evidence to provide a realistic prospect of a conviction, against anyone, in respect of any criminal offence alleged in the papers. I have, therefore, advised that criminal proceedings should not be instituted.

We have discussed this advice and the various issues arising from it, in some detail, following the conferences with David Perry of Counsel.

I do not propose to recite here the facts giving rise to the allegations or the relevant law which have been discussed and considered with you in great detail.

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 Professor Livesley, Detective Superintendent James and Detective Chief Inspector Clarke.

During that conference the following matters emerged:

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 18 August 1998 that Mrs Richards was near to death. She is supported on this point by Philip 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 19 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.

I note that following the meeting on 20 July last the police agreed to notify all interested parties, or all their representatives, of the agreed decision not to prosecute in this matter. I assume that such notification has now been given.

Yours faithfully

Code A

Paul Close
Casework Directorate

Other Document Form

Number D 1020

Title LIST OF ACTIONS FOR LESLIE PITTOCK

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Code A

Document registered / indexed as indicated

Code A

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Statement readers instructions

Statement Code A

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Code A

No(s) of actions raised

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

OPERATION ROCHESTER
ACTIONS
FOR
LESLIE PITTOCK

BJC/71	Leslie PITTOCK
Action 1	TI Doctor Vicky BANKS, Consultant in Old Age Psychiatry, Mulberry A Ward, Gosport War Memorial Hospital. Ascertain from Doctor BANKS the care and treatment that was provided to Mr PITTOCK at the end of 1995 and the beginning of January 1996 in respect of his case. Ascertain from the Doctor what her involvement with Mr PITTOCK was. A1046
Action 2	TST Doctor Vicky BANKS, Gosport War Memorial Hospital, regarding a letter she received on 8th January 1996 in respect of Mr PITTOCK. Have Doctor BANKS explain plain language what the content of the letter means. A1047
Action 3	TI Doctor ASBRIDGE regarding his or her involvement with the patient Leslie PITTOCK in January 1996, as per the letter on page 5 of the microfilm notes of Leslie PITTOCK. A1048
Action 4	TST Sister HAMBLIN, Dryad Ward, Gosport War Memorial Hospital, regarding her involvement with the patient Leslie PITTOCK in January 1996 as per the letter at page 5 of the medical notes, (microfilm). A1049
Action 5	TST Doctor A LORD, Consultant Physician in Geriatrics, Gosport War Memorial Hospital. Doctor LORD was the author of a letter as at page 5 of the medical notes, (microfilm). Clarify with Doctor LORD what her involvement with the patient Leslie PITTOCK was. What her diagnosis was and what care plan was put forward in respect of his treatment. A1050
Action 6	TST Doctor Jane BARTON re prescribing Leslie PITTOCK nozinan tablets. This was prescribed on the 18th January 1996, as per page 6 of the medical notes, (microfilm). What was the purpose behind the prescription of this drug? A1051
Action 7	TI expert in Pharmacy to explain what the implications are of prescribing nozinan to a patient with a condition such as Mr PITTOCKS. A1052
Action 8	TST Doctor BRIGG regarding his prescription of the drug nozinan on 20th January 1996 as per page 6 of the medical notes, (microfilm). Ascertain from Doctor BRIGG why 100mg was prescribed. What the meaning of verbal order is and what was the purpose of prescribing this drug. A1053

Action 9	TST person identified as Code A who wrote out the prescription for nozinan in respect of Mr PITTOCK on page 6 of the medical notes, (microfilm). Ascertain with Code A the circumstances surrounding this prescription.	A1054
Action 10	TST Doctor Jane BARTON, Gosport War Memorial Hospital regarding the prescribing of various drugs as contained on page 7 of the medical notes, (microfilm). Ascertain from Doctor BARTON the prescribing policy for diamorphine, midazalam, hyocine, halpadrol, nozinan. All of these drugs were prescribed to the patient Leslie PITTOCK on the same day 17th January 1996.	A1055
Action 11	TST independent medical expert. Ascertain whether the prescription of all the drugs on page 7 of the medical notes, (microfilm) was appropriate in the circumstances in respect of the condition of Leslie PITTOCK.	A1056
Action 12	TST Doctor BRIGGS, regarding his entry in the medical notes on page 8, (microfilm). Why did Doctor BRIGGS omit the prescription of halpadrol on 20th January 1996 as stated? What was the reasoning behind this?	A1057
Action 13	TST Staff Nurse Code A re her entry on page 8 of the medical notes, (microfilm). What was the purpose behind this entry?	A1058
Action 14	TST Doctor BRIGGS regarding the entries in page 7 of the medical notes, (microfilm). Was Doctor BRIGGS responsible for suspending the prescription of all the drugs on 20th January 1996 as annotated by the crosses at 15:30, if so why was this?	A1059
Action 15	TST Doctor J.C TANDY, Speciality Elderly Medicine. As per page 9 of the microfilm medical notes. Ascertain from Doctor TANDY what his involvement with the patient Lesley PITTOCK was.	A1060
Action 16	TST Doctor Jane BARTON, re page 9 of the microfilm medical notes. Clarify that she was the person who signified the date of death of Mr PITTOCK as the 24th January 1996.	A1061
Action 17	TST Code A Code A was the GP of Lesley PITTOCK. Ascertain what he knows of Mr PITTOCKS condition.	A1062
Action 18	TST Doctor BANKS, Consultant in charge of Lesley PITTOCK. Establish with Doctor BANKS what his involvement with Mr PITTOCK was.	A1063

Action 19	TST Staff Nurse Code A He was the named Nurse for Lesley PITTOCK. Establish with Code A what his involvement was with the care and treatment of Lesley PITTOCK.	A 1064
Action 20	TST Staff Nurse Code A regarding his entries in the medical notes at page 12 of the microfilm, Lesley PITTOCK. Establish what is written and what care plan was to be followed in respect of Lesley PITTOCK.	A1065
Action 21	TST Doctor Jane BARTON, regarding her entries on the notes of Lesley PITTOCK as at page 13, dated 5th January 1996 and 9th January 1996. Ascertain from Doctor BARTON a) what is recorded, b) what diagnosis she had made and c) what care plan she devised for the care of Mr PITTOCK.	A1066
Action 22	TST Doctor BARTON regarding her entry in the medical notes at page 13, dated 9th January 1996. Clarify the last line of the entry '? Needs opiates'. Establish with Doctor BARTON what this sentence means and why she felt that Mr PITTOCK needed opiates.	A1067
Action 23	TI author of entry in medical notes on page 13, dated 10th January 1996, entry reads 'for TLC and discussed with wife agrees in view of poor quality TLC' appears to be initialled JT. Identify author. Establish what is recorded in the notes. Establish why this entry was made.	A1068
Action 24	TST Doctor BARTON regarding her entry in the medical notes at page 15, dated 18th January 1996. Clarify what is written in the entry. Establish with Doctor BARTON how she knew that there had been a further deterioration in Mr PITTOCK'S condition. Where is this reflected in the medical notes.	A1069.
Action 25	TI the author of entry in medical notes at page 15, dated 20th January 1996 commences 'has been unsettled on haloperidol' (believed Doctor BRIGGS). Establish with the author what is written in the notes. Identify how the Doctor knows that Mr PITTOCK had been unsettled on haloperidol in the syringe driver. What was the purpose in prescribing nozinan and doubling the size of the dose in 24 hours. Establish with the Doctor what verbal order actually means and when this would have been written up on the medical notes.	A1070
Action 26	TST Doctor BRIGGS regarding his entry in the medical notes at page 15 dated 21st January 1996, commences 'much more settled'. Establish with Doctor BRIGGS what his involvement with Mr PITTOCK had been on 21st January 1996. Clarify what Doctor BRIGGS means by, 'respiratory rate 6/minutes not	A1071

distressed continue'. What did Doctor BRIGGS mean by the word 'continue'.

Action 27

TST Staff Nurse Code A regarding his or her entry in the medical notes on page 15 dated 24th January 1996, commences 'death verified at 1:45 a.m.' Establish with Staff Nurse Code A Clarify with Staff Nurse Code A what the procedure was for verifying the death of patients. Did a Doctor have to be called. Was there any policy or procedure that Nurses have to follow in relation to verifying death. Was it normal practice for Nurses to make entries in the Clinical Notes as opposed to the Nursing Notes. Was it acceptable for death to be verified in the presence of a Nursing Auxiliary. A1072

Action 28

TST Nursing Code A regarding her involvement with the patient Lesley PITTOCK on 24th January 1996 as at page 15 of the medical notes. Nursing Code A was present when the death of Mr PITTOCK was verified by Staff Nurse Code A Establish with Code A what his or her involvement was with the patient. Establish what they understood their roles and responsibilities to be whilst working on the ward at that time. A1073

Action 29

TST Doctor BANKS, Consultant in Charge of Lesley PITTOCK. Establish with Doctor BANKS a) what the policy and procedure was for entries in the Clinical Notes by Doctors responsible for the care of patients i.e. entries in notes every 3 to 4 days. Was this normal. Was this considered acceptable at the time. What was the procedure for verifying death of patients on the Ward and how as this to be recorded. In particular in the case of Mr PITTOCK a Staff Nurse certifying death in the presence of a Nursing Auxiliary. A1074

Action 30

TST Doctor BARTON regarding her entries on the prescription sheet on page 16 of the medical notes. Establish with Doctor BARTON what each drug was. What the dose rate was and what the purpose was for prescribing each individual drug. A1075

Action 31

TST Doctor BARTON with regards to her prescription of arthrotec to Mr PITTOCK as per page 16 of the notes. What was the purpose behind the prescription of this drug. A1076.

Action 32

TST Doctor BARTON regarding her prescription of oramorph to Mr PITTOCK on 10th January 1996 as per page 17. What was the purpose behind prescribing morphine to Mr PITTOCK. Ascertain why this drug has been prescribed on this date, yet there is no corresponding entry in the clinical notes to justify its prescription. A1077

Action 33	TI author of signature regarding the administration of oramorph on page 17 of 49, at 22:00 on the 10th January 1996 (believed Staff Nurse Code A. Establish with author if the entry at 22:00 should correspond to oramorph. If this is correct why is it written in this way. Establish with the author the reasoning for administering this drug at this time.	A1078
Action 34	TST Doctor BARTON regarding her entries at the foot of page 17 of the medical notes prescription sheet commencing 'diamorphine'. Establish why these drugs were written up for prescription, yet no date was ever entered and it appears that these drugs were never prescribed. What was the purpose of writing these entries.	A1079
Action 35	Cross refer with Action 34. (The entries made for Action 34 may be an error). TST Doctor BARTON in respect of prescribing all the drugs on page 18 of the medical notes. Ascertain why all these drugs have been prescribed and yet there appear to be no entries in the Clinical Notes to justify the prescription.	A1080
Action 36	TI the author of the signature for administering diamorphine on 15th January 1996 as per page 18. Ascertain from this person how the diamorphine was administered to the patient. If by way of syringe driver, what training had they received and on what paperwork was the administration of diamorphine recorded, i.e. there is normally a small graph or chart to show the flow rate of a syringe driver.	A1081
Action 37	TI the author of the entry in respect of the administration of diamorphine on 16th January 1996. Ascertain from this person how the diamorphine was administered. If by way of syringe driver, what training had they received and on what paperwork was the administration of diamorphine recorded, i.e. there is normally a small graph or chart to show the flow rate of a syringe driver.	A1082
Action 38	TI authors of entries for administering hyoscine as at page 18 of the medical notes for the 15th, 16th and 17th.	A1083.
Action 39	Research with medical expert Doctor WILCOX apparent incidences of double dosing of diamorphine, hyoscine and midazalam in respect of Lesley PITTOCK as at page 18 of the prescription notes on the 16th January 1996. It appears Mr PITTOCK was administered these medicines at 08:25 and 13:00 hours that day. Could this of had an impact on Mr PITTOCK'S condition.	A1084
Action 40	TI the author of the entries on the 16th January 1996 as per page 18 of the medical notes, entries timed at 13:00 and initialled	A1085

believed W.B. Ascertain from this person why all of these drugs were administered to Mr PITTOCK at this time.

Action 41

Research with expert Doctor WILCOX whether the medicines prescribed on page 18 of the medical notes were appropriate for Mr PITTOCK'S condition. In particular the ranges of prescription hyoscine 200 to 400 and yet 400mg was only ever prescribed. Establish whether or not all of the drugs on page 18 would have been administered by way of syringe driver at the same time on page 143 dated 13th March 1998 commencing 'for ACE test. Establish what is written in this entry and obtain an explanation of the content. Specifically dealing with the final line, 'do not give new medicine but keep in DH'. Establish what this means. A1086.

Action 42

TST Doctor BARTON with regards to all of the drugs that were prescribed as at page 19 (tape went blank), PITTOCK. Identify what each drug is that's been prescribed, its dosage and the reasoning behind its prescription. A1087

Action 43

Research with medical expert Doctor WILCOX whether all of the drugs that were given to Mr PITTOCK between 5th January and 21st January 1996 were appropriate for his condition. Consider the possibility of Mr PITTOCK being opiate toxic and this being a contributing factor to his death. A1088

Action 44

TST Doctor BARTON regarding the medicines that she prescribed for Lesley PITTOCK as at page 20 of the medical notes. Ascertain from Doctor BARTON the reason why the diamorphine dose was increased from 80mg to 120 on 17th January. A1089

Action 45

Research with medical expert Doctor WILCOX whether the increase in medicines for Mr PITTOCK was appropriate on 17th January. Diamorphine increased to 120mg, hyoscine increased to 600. A1090

Action 46

TST Staff Nurse P RIGG. On page 23 of the medical notes RIGG is identified as the named Nurse for Mr PITTOCK. Ascertain from Staff Nurse RIGG what her involvement with Mr PITTOCK was. Which entries in the notes appertain to her. What care plans were in place for Mr PITTOCK whilst she was in charge. A1091

Action 47

TI Doctor TANDY, Consultant for Mr PITTOCK as described on page 23 of the medical notes. Ascertain from Doctor TANDY what his involvement with the patient Lesley PITTOCK was and what involvement he had with Mr PITTOCK'S case. Clarify with Doctor TANDY what his involvement with Gosport War Memorial Hospital was and A1092.

what involvement he had with the drug regime for Mr PITTOCK.

Action 48 — TST Nurse SHAW regarding her entry on the top of page 25 of the medical notes dated 5th January 1996. Clarify with Nurse SHAW what the note says. Ascertain what treatment was to be given to Mr PITTOCK and what care plan was to be followed. Clarify with Nurse SHAW whether she is the signatory for any of the drugs prescribed to Mr PITTOCK. A1093.

Action 49 — TI author of note on 7th January 1996 and 9th January 1996 as at page 25 of the notes, believed to be Staff Nurse BENNETT. Clarify what is recorded in the notes and ascertain from Staff Nurse BENNETT where she states that Mr PITTOCK is a pyrexial. What was done to remedy this. A1094

Action 50 — TI author of note on page 25 of medical notes dated 10th January 1996, commences 'condition remains poor'. Author possibly Sister HAMBLIN. Clarify with author what is written in the note. Ascertain what care plan was to be followed specifically why oramorph was to be given 4 hourly. A1095

Action 51 — TST Doctor TANDY regarding his visit to Mr PITTOCK on 10th January 1996 cross refer with Action 23, potential author. Clarify with Doctor TANDY was his diagnosis of Mr PITTOCK was and what involvement Doctor TANDY had with the drug regime for Mr PITTOCK. A1096.

Action 52 — TST Staff Nurse RIGG regarding entry on page 25 of the medical notes dated 13th January 1996. Clarify with Staff Nurse RIGG what the note says. What involvement he or she had with Mr PITTOCK and ascertain whether or not she or he is a signatory for the administration of any of the drugs. A1097

Action 53 — TST Doctor BARTON. Clarify with her the entry made by Staff Nurse RIGG on 15th January 1996 at the bottom of page 25. Staff Nurse RIGG says, 'Mr PITTOCK was seen by Doctor BARTON and has commenced on syringe driver with diamorphine and various drugs'. Ascertain from Doctor BARTON if this is correct and if it is why there is no entry on the clinical notes to this effect. A1098

Action 54 — TST Staff Nurse RIGG regarding the entry made at the foot of page 25 of the medical notes and the top of page 26. Relates to Doctor BARTON seeing Mr PITTOCK. Clarify with Staff Nurse RIGG that Doctor BARTON did see the patient. Ascertain from Staff Nurse RIGG if it was he or she that started the syringe driver as recorded in the notes with the midazalam, hyoscine and diamorphine. If so what training has Staff Nurse RIGG in the setting up of syringe drivers. Clarify with Staff A1099

Nurse RIGG whether or not you would normally expect an entry in the clinical records for the administration for these kind of drugs.

Action 55 — TST Staff Nurse RIGG describing what syringe drivers were used at the time. Explain the process of setting up and administering drugs using a syringe driver. A1100

Action 56 — TST Staff Nurse Code A regarding entry in medical notes on page 26 commencing, '15th January 1996 daughter informed of father's deterioration'. A1101

Action 57 — TI author of note on page 26 that reads, 'Night comfortable night syringe driver replaced at 07:05 hours'. Ascertain from the author what the note says and what it means. If the author changed the syringe driver ascertain what training that person has received in syringe drivers and clarify what kind of syringe driver was being used at the time. A1102

Action 58 — TST Staff Nurse Code A regarding the entries on the 16th January 1996 on page 26. First entry is timed at 20:00 hours second entry is timed at 13:00 hours. Clarify with Staff Nurse Code A when these notes were made. A1103

Action 59 — TST Staff Nurse Code A regarding entries on page 26 of the medical notes. Clarify with Code A T that Doctor BARTON saw Mr PITTOCK at 20:00 hours on 16th January 1996. With regards to the haloperidol question when was this to be added to the syringe driver. A1104

Action 60 — TST Staff Nurse Code A. Clarify the date of the entry on page 26 of the notes. Was this the 16th of January or the 17th of January. Ascertain from Staff Nurse Code A what the entry says and what it means. Clarify with Code A why the previous driver dose was discarded at 13:00. Cross refer this entry with that on the prescription chart at page 20 where 5mg of haloperidol is administered on the 16th but 10mg is administered on the 17th. (Please speak to DS GROCOTT for further explanation). A1105

Action 61 — (Blank) Nurse BARRETT. Identify what training she has received in respect of preparing and administering drugs by way of syringe driver. A1106

Action 62 — TST Staff Nurse Code A regarding entry in the medical notes at page 26, foot of the page commences, 'Night condition remains poorly'. Clarify with Staff Nurse Code A what this entry says. Identify what involvement Staff Nurse Code A has had with Mr PITTOCK and cross refer any entries made in the prescription charts etc. Clarify with Staff Nurse Code A A1107

what training he or she has received in respect of preparing and administering drugs by way of syringe driver.

Action 63 — TST Doctor BARTON. Clarify with her that Staff Nurse Code A states she saw Mr PITTOCK on the 16th January and prescribed further medicine to him. Ask Doctor BARTON why there is no entry in the clinical notes regarding this visit. A1108

Action 64 — TST Staff Nurse Code A regarding her entries in the medical notes as at page 27 dated 17th January 1995 (Did you mean 96). Clarify with Code A what the entry states and what it means. Confirm that Doctor BARTON saw the patient at 09:00 on the 17th. Ascertain from Code A the reasons why she believes that the medication was increased. Identify which medication was increased and in what doses. A1109,

Action 65 — TST Staff Nurse Code A Ascertain what training she has received in the administration of drugs by way of syringe driver. Clarify with Code A the entry that's timed at 14:30 hours on page 27. Confirm that Doctor BARTON saw the patient at 14:30 and the medication was reviewed and altered, explain what this means. Clarify with Code A why two syringe drivers were operating at the same time and what the content of these drivers was. A1110

Action 66 — TST Doctor BARTON. Clarify with her the notes made by Code A on page 27 of the medical notes. If Doctor BARTON saw the patient on the 17th January why is there no entry in the clinical notes. Explain why the medication was increased. What diagnosis was made in order to come to the conclusion that the medication needed to be increased. Ascertain what is meant by using two syringe drivers at the same time. A1111

Action 67 — TST Sister HAMBLIN regarding her entry in the medical notes at page 27, timed at 23:30 commencing, 'Further deterioration in already poor condition'. Clarify with Sister HAMBLIN what her involvement with the patient Lesley PITTOCK was and what the note that she has recorded states. A1112

Action 68 — TST Staff Nurs Code A regarding her entry in the medical notes on page 27 commencing, 'Night little change in poor condition'. Ascertain what is recorded. A1113

Action 69 — TST Staff Nurse Code A regarding her entries in the medical notes on page 27 and 28, dated 18th January and timed firstly at 20:00 and secondly at 15:00. Clarify with Code A why she times and dates her notes in this way. A1114

Action 70	TST Staff Nurse Code A regarding her entry in the medical notes on page 27 timed at 15:00 hours. Confirm what is recorded and ascertain from her the reasons why the driver was recharged and recommenced as she states. Under whose direction was this made. (Doctor BARTON or Doctor BRIGGS).	A1115
Action 71	TST Staff Nurse Code A regarding her entries on the medical notes page 28 dated 19th January 1996. Ascertain from Code A what she has recorded and the reasons for it. Clarify with her why the syringe driver has been recharged and whether or not Doctor BARTON had visited the patient on the 19th January.	A1116
Action 72	TST Staff Nurse RIGG regarding the entry on page 28 of the notes dated the 20th January 1996 commencing, 'Mrs PITTOCK and both daughters have visited'. Clarify with RIGG what has been recorded and the reasons for this. Clarify what drugs were put into the syringe driver and why there has been an increase from the previous 24 hours.	A1117
Action 73	TST Staff Nurse RIGG regarding entry on page 28 of the notes dated 20th January 1996. Clarify whether or not it was Staff Nurse RIGG that contacted Doctor BRIGGS. If so why was the Doctor contacted. Having spoken to Doctor BRIGGS what was the reasoning behind the verbal order to change the prescriptions. What were Staff Nurse RIGG'S concerns at the time. (Cross refer action with entries on page 15 of the medical notes and link to action 25).	A1118

Other Document Form

Number 1008

Title LETTER GMC TO HR 7 Code A RE DISCLOSURE OF DOCUMENTATION

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Code A

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Statement readers instructions

Statement

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Code A

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O/M	SIO

Further actions-no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Your reference: Code A

In reply please quote: 2000/2047

7 February 2002

First Class Post

Det Supt James
Major Incident Complex
Kingston Crescent
North End
Portsmouth
PO2 8BU

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Det Supt James

Dr Jane Barton

I write further to your previous correspondence with my colleague Jackie Smith regarding the above case. Ms Smith has now moved to a new role within the GMC and responsibility for this case has passed to me. I tried contacting you by telephone today but was informed that you were out of the office.

I have today been informed that your investigation is now complete and that it has recently been that no criminal charges should be brought against Dr Barton. I should be grateful if you would confirm in writing, at your earliest possible convenience, that this is indeed the case.

As the statutory body responsible for regulating the medical profession, we are obviously concerned to learn of any doctor who is, or who has been, the subject of a criminal investigation. Whilst acknowledging the decision not to prosecute Dr Barton, before closing our file we must nevertheless satisfy ourselves that that there are no matters relating to her professional conduct or performance which may warrant formal action under the Council's fitness to practise procedures. I understand that you may be in possession of expert witness reports which are critical of the practices of both Dr Barton and a Dr Althea Lord.

In order to assist us in this regard I should be grateful if you would arrange for the following documentation to be forwarded to this office:

1. A brief case summary

2. Copies of witness statements

3. Copies of expert reports

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

4. Copies of relevant medical records, if available

We appreciate that when disclosing confidential information you need to balance the rights of privacy of the individual against a necessary need to protect the public.

For your information I am enclosing under cover of this letter a copy of the Medical Act 1983 (Amendment) Order 2000. In particular I would draw your attention to Section 35A of the Amendment Order which, in broad terms, gives the GMC the right to demand disclosure of information in certain circumstances where it is considered necessary for the purpose of assisting us to carry out our statutory regulatory role. I trust that on reviewing the legislation you will agree that, given both the nature of the original concerns about Dr Barton's practice and her public position, our request for information is be both reasonable and relevant.

It may also be helpful in this respect if I draw your attention to the comments of *Kennedy LJ* in the case *of Woolgar v Chief Constable of Sussex Police (2000) 1 WLR 25* where he stated:

> *Obviously in each case a balance has to be struck between competing public interests and at least arguably in some cases the reasonableness of the Police view may be opened to challenge. If they refuse to disclose, the regulatory body may, if aware of the existence of the information, make an appropriate Application to the Court."*

Should you have any further questions please do not hesitate to contact me. Thank you for your assistance in this matter. I look forward to hearing from you at your earliest possible convenience.

Yours sincerely

Code A

Michael Hudspith
Fitness to Practise Directorate
Direct Line: **Code A**
Fax Line: (
e-mail: Code A

Other Document Form

Number D992

Title Minutes of conference GMC 27/2/04

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / (No)

Receiver
Code A

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mined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Minutes of conference held at the General Medical Council 27/02/04
In respect of Dr Jane Barton

Persons Present.

Paul Phillip (PP) GMC
Jackie Smith (JS) GMC
Linda Quinn (LQ) GMC
Mathew Lohn (ML) Field Fisher Waterhouse

DCS Watts (SW)
DI Niven (NN)
DS Grocott (DG)

The meeting commenced at 1215 hrs in the conference room at GMC HQ Great Portland St

ML opened the meeting for all parties and stated that the meeting would be split into 3 sections.

1. An explanation of the GMC position and the information they are seeking and why
2. The Police's need for an agreement to confidentiality before they can discuss any matters
3. Once an agreement has been reached a briefing by the police of the current position.

PP explained that the GMC want to look at what issues currently surround Dr Jane Barton. He explained that the GMC need to provide evidence to the same standard as the Police to the Interim Orders Committee in order to review the situation in respect of Dr Barton's registration. PP described how he had recently held a meeting with the Chief Medical Officer Sir Liam Donaldson (LD) who had expressed concern re the conduct of Dr Barton. PP had explained to LD that the GMC's position had not changed and that they had not received any further evidence from the police to date.

PP explained to those present that the GMC had to balance public interest re this doctors continued registration against any other issues. The GMC want to know if there is any evidence so that they can be clear as to why they wont disclose should they be asked in the future.

SW stated that he wanted to keep the GMC fully briefed as best as the Police can. The police would like to give a full briefing but we need to be able to demonstrate at all times that the police have conducted an ethical investigation. To that end the police seek to have an agreement that the information given will be held in confidence and not disclosed to any other party. SW pointed out that the police investigation is not an investigation into JB it is an investigation into a series of deaths of patients that occurred at GWMH over a number of years.

PP agreed to give a confidential undertaking.

NN then briefed the conference as to the depth of the investigation which is titled Op Rochester and that this particular phase commenced in Sept 2002. NN described how LD had commissioned Prof Baker to compile a report re GWMH. As a result of the publicity that surrounded this, nurses who were working at the hospital at the time handed in a number of documents. From this 63 cases were identified for review. Together with the CPS a plan was decided upon to look at the cases. A team of experts were commissioned the details of these experts were explained as were their terms of reference. NN explained the mechanism surrounding the matrix. This identified approx 25% optimal care, 50% further work needed and 25% involved concerns. NN went onto explain FFW's role re quality assuring.

PP asked whether the quality assuring involved just the just the top 25%

NN explained that the quality assuring was taking place for all the cat 2 & 3

SW, then went onto describe and explain the police views on resource management for investigations such as these.

ML, explained to the conference the definition of "Angels" & "Gods" and the fact that currently the role of the experts has been to screen the cases and that they have only provided minimal reports. There are not reports in existence that would satisfy an IOC.

PP asked whether or not there was a common theme regarding prescriptions etc

SW stated it was a recurring theme and explained what has been found.

PP stated that this was not dissimilar to the findings of CHI and again was not dissimilar to concerns around prescribing protocols. He asked about whether there were any protocols.

SW, Confirmed that there were Wessex protocols.

NN then explained the role played by the firm of solicitors called Ann Alexander.

SW, Explained that it will take some time to progress the enquiry. The police were focused upon pushing the enquiry as quickly as is practicable for an ethical investigation. SW explained that he thought it would be unlikely that the enquiry would be concluded before the end of the year.

PP described that the Chief Medical Officer is going to discuss the content of the Baker report with the GMC but under a similar confidentiality agreement.

NN explained how the purpose of the Baker report was to look specifically at a number of cases that had involved Dr Barton. NN also explained that the team of medical experts were currently screening these cases for the police team.

PP admitted to having nervous anxiety re what else could be done to deal with Dr Barton. He explained that he hoped to discuss these matters with the CMO. He had been asked by the CMO why the GMC had not applied to use Sect 35 of the Medical

Act in respect of requiring the police to provide information. PP stated that he wouldn't be applying for Sect 35 as the police would obviously object and the matter would be unseemly for all authorities.

SW discussed how he would be happy to explain to anybody how the police have invested vast amounts of funds and resources into this investigation and he wondered whether the GMC could utilise this info.

PP explained why the GMC needed to rely upon prima facie evidence

ML & NN explained how they appreciated what PP was saying ut that at this time the police did not have the evidence to proceed with a prosecution and therefore could not assist the GMC.

SW stated that the police position was that we have a heightened level of concern but we are not in an evidential position re the enquiry to satisfy the GMC demands.

NN explained that the screening process was coming to an end but it would be some considerable time before the police had any evidential reports.

ML asked the conference whether it would assist if the police could make disclosure if anyone was arrested.

SW stated that he would consider this at the time and would only disclose to relevant authorities as necessary. He then asked NN to talk about the Wessex protocols.

NN stated that it appears there have been occasions whereby JB has prescribed outside of protocol

ML explained that the police have yet to look at the area of causation

NN has broached the subject of the investigation and the potential for exhumation with the Coroner, but not the families. The police are going to speak with the "Gods" re the necessity. There are three cases in the Cat 3's were the victims have been buried.

PP reiterated that he is shortly to discuss the Baker report with the CMO but feels it is likely to be unfruitful until such time as the police have finished their enquiries. He would like to be kept updated as to the progress of the enquiry.

SW would like to keep dialogue open between all parties. The use of the confidentiality enables good communication between all.

ML Police have not tasked experts to look at specific doctors

SW Happy to tell CMO that we've met, the fact that the meeting was confidential and that the police do not at this stage have the information/ evidence to take a prosecution forward. The information that the police have is not however for discussion or disclosure to any third party.

SW is not happy to say that the GMC don't have enough to go forward, that is a matter for them.

PP agreed and understood but ultimately it would be something to be tested under section 35 of the Medical Act

SW accepted this

PP will write to the CMO informing him of the meeting that had been held and teling him that there were open lines of communication.

PP further stated that from the GMC's point of view JB was not under any form of restriction in respect of her registration.

NN asked for the GMC to formally inform the police of the current standing of Dr Barton.

PP will await further update from police. Everyone present felt that the meeting had been beneficial and a three monthly update was suggested.

Meeting concluded at 1310 hrs.

Other Document Form

Number D980

Title SITUATION REPORT 24th JUNE 2004

(Include source and any document number if relevant)

Receivers instructions urgent action (Yes) / No ① TST PROF RICHARD BAKER RE CONTENTS OF REPORT (ALLOCATE TO DC Code A)

	Code A
Document registered / indexed as indicated	Code A
No(s) of actions raised A1024	
Statement readers instructions	Code A
Indexed as indicated	Code A
No(s) of actions raised	
Examined - further action to be taken	O/M | SIO
Further actions no(s)	Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Operation ROCHESTER

Situation Report 29th June 2004

Crown Prosecution Service

A strategy/update meeting with Code A and Paul CLOSE of CPS has been arranged for 1100 hours on Tuesday 6th July 2004 at Ludgate Hill.

Dr Jane BARTON

The solicitor representing Dr BARTON, Ian BARKER, has requested an update on the enquiry regarding his client – particularly in respect of time scales. A meeting has been arranged with Mr BARKER at his office in London at 1300 hours on Friday 9th July 2004.

Strategic Health Authority/Primary Care Trust

A request has been made to the SHA/PCT for details of the restrictions on Dr BARTON'S prescribing practices and for consent to disclose those restrictions to Ann ALEXANDER, solicitor representing family group members. Details of restrictions were sent to us on 17th June, however these are outdated and no longer in force. We are awaiting details of the current restrictions. In the meantime, Ian BARKER is enquiring with Jane BARTON as to whether or not she will consent to disclosure to Ann ALEXANDER.

General Medical Council

On 15th June 2004 Ms POVEY of the GMC rang the incident room at Fareham stating that the GMC have taken further legal advice in relation to proceedings against Jane BARTON. They have been told that they can proceed and a letter will be sent to us shortly to confirm this. To date no such letter has been received at the incident room.

On 21st June 2004 a letter from DCI Williams was sent to the GMC updating them on the current position of the enquiry and informing them of our strategy in respect of disclosure as agreed with the Chief Medical Officer.

On 23rd June 2004 the Chief Constable received a telephone call from Mr SCOTT, Chief Executive of the GMC, stating that the GMC are not keen to complicate our work by initiating their own investigation but he is concerned that the GMC should be seen to do something. He is contemplating placing the matter before his interim measures committee. Mr SCOTT asked to be supplied with some specific information regarding the enquiry, as listed in an e-mail from the CC to DCI Williams. He also acknowledged good liaison with the investigation and was grateful for the letter from DCI Williams, dated 21/6/04.

Family Group Member Bulletin

An FGM update Bulletin (Bulletin 5) dated 21st June has been sent to families of cases in categories 2 & 3.

Letters from Ann ALEXANDER

Ann ALEXANDER held individual meetings with family group members on 27/4/04 and later wrote letters raising issues on their behalf to Mr Watts. All of these letters (10 in number) required some research before they could be properly responded to. DCI Williams acknowledged receipt of them by e-mail. To date 7 of the letters have been responded to and the remaining 3 are partly prepared.

Key Clinical Team

The clinical team are currently reviewing inserts in respect of cases in category 2. They are also reviewing the 3 additional cases which we received from ALEXANDER HARRIS late into the enquiry. On completion of these reviews they will be given the last of the inserts which are in respect of 6 category 2 Baker cases.

Arrangements are in hand for a further/final meeting with the KCT in order to discuss the above cases and a number of other issues including disclosure, finances, any future roles etc.

Matthew Lohn

Matthew Lohn is currently quality assuring category 2 cases (other than Baker cases). He anticipated that this work would be completed within 2 weeks from 14th June so DCI Williams will be contacting him for an update on Friday 2nd July.

Identification of Geriatrician

Research is currently being conducted in order to identify and recruit a suitable geriatrician to work in conjunction with Andrew WILCOCK (palliative care expert) as our Clinical Review Team. Ten eminent geriatricians are currently being researched by DC Tenison, including Code A who appears to be the most suitable at this stage.

Case in Durham

The Chief Medical Officer mentioned during a recent meeting with Det.Ch/Supt Watts and DCI Williams that an investigation by Durham Police regarding a doctor may be similar to Operation Code A and worthy of research.

The Durham case is Operation CROSSWORD and the SIO is D/Supt Harry STEVENSON. It involves a GP, Code A, who prescribed a large dose of diamorphine to a patient who had recently been released from hospital following chemotherapy treatment for cancer. The patient had become unwell and the doctor stated that he had only hours/days to live before prescribing the diamorphine. The patient subsequently died and was buried. The body was exhumed and it was

discovered that the chemotherapy had worked and the cancer had gone. Code A is on bail until mid August. The PCT have set up a help desk and information line for other concerned families to make contact. To date only 2 or 3 people have expressed minor concerns about Code A. The contact in Durham is DS Code A

Professor Baker

DC Kate Robinson (FLO/Investigator) has been tasked to identify and make initial contact with the families of all 16 cases identified by Professor Baker as of concern. She has been provided with specific instructions in order to ensure consistency of information and support to the families.

Families in respect of the 2 cases in category 3 will be visited and briefed by DS Kenny and DC Robinson. Statements will be taken from key family group members by DC Robinson.

The remaining 14 cases in category 2 have been divided between Code A and DC Yates, who will visit the families and brief them as specifically instructed. Details of the visits and families views/concerns will be documented on officer reports.

Professor Baker has agreed to provide a witness statement in respect of the content of his report and the Chief Medical Officer is aware/supportive of this.

Exhumations

Of the cases in 3b there are 4 burials, which are Elsie DIVINE, Sheila GREGORY, Elsie LAVENDER and Jean STEVENS. The coroner, David Horsley, is aware that exhumations may be considered in respect of these cases.

Prioritising of cases

Dr Peter Lawson and Dr Anne Naysmith were asked by DCI Williams to nominate what in their considered opinions are the four most serious cases in terms of potential negligence of care/treatment afforded. To date only Dr Lawson has responded and his nominations are Elsie LAVENDER, Leslie PITTOCK, Helena SERVICE and Henry AUBREY.

Media

Code A has been tasked to produce a joint 'if asked' Police/Health Authority press release in respect of the current phase of the investigation. A lengthy press release has been prepared but to date there have been no calls for it's release.

Health and Safety Executive

Contact has been made with HSE at their Basingstoke office, which covers Gosport. Martin VAN LANKER at that office has been given brief details of Rochester by telephone. Arrangements are in hand for Mr VAN LANKER and/or his manager Bob MELDRUM to attend the incident room for a meeting in the near future.

Commission for Health Improvement

Consideration is to be given to obtaining evidence from the CHI report. This matter will be discussed at the meeting with CPS on 2/7/04.

Owen Kenny
Detective Sergeant

Other Document Form

Number 0972

Title Report by DCI Code A re - Contact with FFG

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Receiver Code A

Document registered / indexed as indicated

(s) of actions raised

Code A

Statement readers instructions

Statement Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken	O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

OP ROCHESTER/HAMPSHIRE CONSTABULARY CONTACT FIELD FISHER WATERHOUSE

11.10.2002. Judith CHRYSTIE FFW solicitor notifies Supt JAMES of her instructions to act on behalf of GMC in respect of investigation into conduct of Dr Jane BARTON.

1.11.2002. Judith CHRISTIE notifies DCI DUNCAN that GMC Professional Conduct Committee hearing scheduled for April 2003.

20.11.2002. Meeting Judith CHRISTIE, John OFFORD (FFW) Michael KEEGAN (GMC Caseworker) DI NIVEN and DS KENNY.

Issues discussed

- Criminal rules of evidence apply to GMC hearing.
- History of Police investigations DCI BURT and Det Supt JAMES.
- Overview of current investigation. Rationale to prove causation developing theme diamorphine/syringe drivers. Investigation to consider the practices of practitioners, including Dr BARTON.
- Noted that Professor BAKER had been asked to perform statistical analysis by CMO.
- Ms CHRISTIE advised that GMC had the power to make an interim order suspending or placing conditions upon a Medical Practitioners Registration notwithstanding that there had been no finding of guilt. In this case the IOC had decided not to place such an interim order (Dr BARTON convincingly argued a lack of resources and supervision and poor working conditions.)
- If information was disclosed by the police investigation, the GMC would be forced to disclose any document they wished to present to the IOC(Interim Order Committee) in reliance of a request for an interim order.
- Formal letters to be written outlining information that would be possible to disclose.
- Alexander HARRIS to be advised that formal lines of communication had been developed but not of content.
- Ms CHRISTIE would contact DI NIVEN monthly so that she may include information in her monthly reports to the GMC.
- Ms CHRISTIE had received a report from the CHI, she wished to analyse the witness statements taken. This did not prejudice police investigation. Agreed that CHIRSTIE and OFFORD will proceed with this aspect of the police enquiry.
- DI NIVEN to provide letter to GMC for use in IOC hearing, which will formally ask GMC to stay their investigations.

2.12.2002. Letter Nigel NIVEN to Judith CHRISTIE. Confirms that CPS meeting took place 28.11.2002. Agreed to expand investigation. SIO WATTS formally requests that IOC hearing of April 2003 is pended.

23.12.2002. Judith CHISTIE confirms that she has received formal instructions from GMC that the GMC proceedings will be stayed pending outcome of police enquiries.

23.12.2002. Judith CHRISTIE confirms that she is to review commission for Health Improvement documents on 14/15th January 2003. Will not take any other action other than assessing which of the CHI witnesses should be seen following police investigations.

30.06.2003. Letter Nigel NIVEN to Mathew LOHN, re assistance to OP ROCHESTER and meeting with Key Clinical Team 6/7th September 2003.

14.08.2003. Mathew LOHN, Letter / Standard terms of Business Document. In essence, Mathew LOHN will carry out all of the work and will have ultimate responsibility. Will advise of progress and likely timeframe for each piece of work, reserve the right to disclose files to regulatory bodies. Hourly rate £255. FFW will only stop acting for the client with good reason and on giving reasonable notice.

04.09.2003 Mathew LOHN, letter, varying Standard terms of business document in respect of hourly rate, £215 per hour, + rates for assistants.

16.9.2003. Mathew LOHN E mail to Nigel NIVEN. Mathew undertakes to:-

- Produce a file for each individual including a copy of medical records, copy of each individual expert report, and a copy of summary report (produced during KCT meeting 6/7th Sept).
- Expert analysis. 1's. ML to ensure that the decision taken is capable of justification, and exit strategy for this group at the end of the year.
- 2's. Ensure consistency of decision over the period of analysis to ensure that no case should have otherwise been classified a 3. Explore possibility that sub optimal 2 treatment may in fact be negligent, and worthy of further scrutiny. Prepare exit strategy to explain why sub optimal is not criminal. Consider the case law test for gross negligence. (nb a recent report of the DPP being judicially reviewed for failing to take a case forward on a gross negligence manaslaughter).
- 3's. In these cases further work will need to be taken to determine whether there is a demonstrable causative link between the negligence and the ensuing outcome including an analysis of the hastening effect of treatment. Further expert opinion will be needed to understand the degree of negligence and to what extent it could be said to be criminal or otherwise.
- Recommend that LAWSON and NAISMITH from KCT produce summary reports of findings.
- All serious cases to be considered by a fresh team including experts in palliative care, and consultant geriatrician who has had experience in caring for patients in a community nursing home.
- Recommends that work undertaken by investigation team on the pattern of prescribing of opiates at GWMH by the doctors involved in this enquiry.
- Will review relevant statements taken, having regard to Wessex protocol and British National Formulary.

24.9.2004. Meeting with Mathew LOHN Manchester + DI NIVEN and DS KENNY. Mathew LOHN received patient record DVD's and clinical team briefing pack. Consideration to cold calling 16 Family Group members as identified by Professor BAKER.
ML will review cases using medical records clinical team comments and officers reports and will devise questions for Peter LAWSON and Ann NAYSMITH.
ML will review cases which currently fall into categories 1A and 2A as a priority with a view to disengaging cases of no concern asap.
Agreed timescales for work by the review team.
Other issues raised:-
Wessex Protocol.
Patterns of prescribing.
Professor BAKER report.
Causation. Toxicology. Exhumation.
ML suggest obtaining copy of interim audit from GMC.
Nigel Niven to meet with Chief Executives of Primary Healthcare trust and Strategic Health Authority to discuss the current state of the investigation includingthe IOC in respect of DR BARTON.

7.10.2003. Letter Mathew LOHN to Nigel NIVEN re potential conflict issue, ie FFW acting both for GMC and Hampshire police. FFW content that no conflict arises.To ensure transparent integrity Mathew LOHN has written to GMC informing them that he no longer acts for them in respect of case of Dr BARTON. This is not a corrective measure but one of proceeding with excessive caution.

23.2.2004. Meeting with Mathew LOHN DI NIVEN and DS KENNY. Actions agreed as follows.

1. DS GROCOTT to compile information re legal authorities gross negligence manslaughter/CPIA.
2. Mathew LOHN to arrange meeting with GMC. 1st or 3rd March 2004.
3. Meeting to be arranged with Nursing and midwifery council.
4. ML suggests liaison with Royal Pharmaceutical Society to involve Pharmacist.
5. ML to approach Code A re her availability to lead new clinical team.
6. Enquiry team will take statements from FGM's in group 3.
7. Mathew LOHN will commence work on group 2's and will meet in a month or so to discuss findings. During assessment he will pass on any 3's identified.
8. In respect of category 1, where FGM's not content ML suggests obtaining their concerns in writing for consideration.
9. FGM's in respect of cases identified by Professor BAKER to be visited in due course, and officers reports to be submitted as previously.

?... Mathew LOHN supplies analysis report in respect of category 1's, and copies forwarded to family group members.

26.5.2004. ML informs SIO Steve WATTS that GMC seeking counsels advice on the issue of disclosure by the police to the GMC during the course of an ongoing police investigation. There are nationally several similar cases present including OP

ROCHESTER. SW agrees that an independent view should be sought, and content that ML can act for GMC.

2.6.2004. SIO WATTS e MAIL TO Mathew LOHN agreeing that disclosure issues to GMC need to be clarifed but raising conflict arising by ML directly acting for GMC. SW would wish to give the GMC as much information as possible to ensure that public and patient safety are maximised. He has informed the GMC that he would be willing to give evidence to a committee giving a general indication of the nature of the investigation. He has given a detailed confidential briefing to GMC members. SW cannot give written information to the GMC since it may be detrimental to the conduct of the investigation.

DCI WILLIAMS. D/SIO.
9TH June 2004.

Code A

From: Williams, David (DCI)
Sent: 09 June 2004 11:32
To: Grocott, David
Cc: Kenny, Owen; Stephenson, Roy; Quade, Geoffrey; Law, Dick
Subject: FW: OP ROCHESTER. CONFIDENTIAL.

For Info..DW.

-----Original Message-----
From: Williams, David (DCI)
Sent: 09 June 2004 11:28
To: Code A
Subject: OP ROCHESTER. CONFIDENTIAL.

Mr Code A
Please find attached a summary of previous contacts between Code A and Hampshire Constabulary which I would like to use as a template for our discussion this afternoon.

OP ROCHESTER
W Mathew LOHN.d.

Thanks.
Dave WILLIAMS.

Other Document Form

Number D966

e Report by DCI WILLIAMS RE 3B CASES

(Include source and any document number if relevant)

Receivers instructions urgent action Yes (No)

Receiver

Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Code A

Indexed as indicated

No(s) of actions raised

Code A

xamined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

OP ROCHESTER. June 2004.

CONFIDENTIAL. Detail of individual cases not to be released without the authority of SIO or Deputy.

Subject Areas for discussion.

- Ongoing work of the clinical assessment team prioritising the nine, 3b category cases ie 'negligent care that is to day outside the bounds of acceptable clinical practice, and cause of death unclear.'

- 3b Cases are :-

1. Arthur CUNNINGHAM. 79. 21st September 1998 – 26th September 1998. Gosport War Memorial Hospital. Parkinson's disease, dementia, myelodysplasia, admitted from a nursing home with difficult behaviour. In June 1998 he was using a mobile telephone, and taking a taxi journey. Admitted from day hospital with a large necrotic sacral sore. The sore would have been painful but the reasons quoted for starting the diamorphine/midazolam infusion were related to behaviour. No mention of pain on the 25th and 26th September but the dose of diamorphine was increased on both days. Cause of death was bronchopneumonia although the medication might have contributed to it. Several Doctors involved in care. Rapid escalation of Diamorphine and High doses of Midazolam.

2. Elsie DEVINE. 88. 21st October 1999 – 21st November 1999. Gosport War Memorial Hospital. Multi-Infarct dementia. Moderate/Chronic renal failure, paraproteinaemia. Occassionally aggressive and restless. Prescribed thioridazine for this. When she became more agitated, she was started on fentanyl, and then converted to large doses of diamorphine and midazolam via a syringe driver. Pain was not raised as an issue. Cause of death is not clear and the use of opiods questionable, especially when considering doses. Issue over whether or not she was dying before given Fentanyl, which was inappropriately prescribed for sedation.

3. Sheila GREGORY. 91. 3rd September 1999 - 22nd November 1999. Gosport War Memorial Hospital. Fractured neck of the femur and other medical problems. The original aim was rehabilitation, but there was an early entry about keeping her comfortable. There was a suggestion of a stroke early in her stay, at GWMH and she deteriorated. The decision was made to refer her to Nursing Home for care because she was unlikely to improve further. She then deteriorated with distress and breathlessness. The staff wondered about a chest infection but did not start antibiotics. Oromorph helped the distress and breathlessness, so she was started on a reasonably low dose of diamorphine

through a syringe driver. Frusemide as a diuretic was given in case the breathlessness was due to fluid on the lungs. In the end the cause of death was not entirely clear. Should they have tried antibiotics or explained why they were not used? She probably would have died whatever was done from 15.11.1999.

4. Elsie LAVENDER. 83. 22nd February 1996 – 6th March 1996. Head Injury or brain stem stroke. She had continued pain around the shoulders and arms for which the cause was never found. It was possibly musculoskeletal pain from a fall downstairs. Other forms of analgesia such as anti-inflammatory drugs or hot/cold packs might have worked. The most worrying aspect is the large dose escalation when converting Morphine to diamorphine via syringe driver (Five fold increase). The cause of death is unclear and the dose escalation might have contributed.

5. Enid SPURGIN.92. 26th March 1999 – 12th April 1999. Gosport War memorial hospital. Had suffered a fractured hip repaired with a dynamic hip screw. She could get from a bed to a chair with the help of 2 nurses before the transfer, and had paracetomal as required for pain relief. Pain became an issue as soon as she arrived at Dryad. Analgesia started with Oramorph regularly and then regular codydramol and then MST at low dose. The dose was increased after continued pain was noted. She had deteriorated on the day a syringe driver was started, but she is reported as denying pain. Diamorphine was started at 80mg per 24hrs via a syringe driver. This is a very high dose 5-6 fold increase. It is not clear who chose this dose but the way the drug was prescribed the nurses could have used a dose anywhere between 20 to 200 M/G a day. It had to be reduced, because she was too drowsy and it probably contributed to her death. No evidence of consultation with appropriate specialist over management of her operation wound infection. Rapid escalation of opiate dose. Poor drug prescription when diamorphine infusion was commenced, nurse could have set up anything from a dose of 20-200 mg per day and still been in compliance.

6. Jean STEVENS. 73. 20th May 1999 – 22nd May 1999. Gosport War Memorial Hospital. This woman had suffered a stroke with marked weakness of the left side complicated by a myocardial infarction and aspiration pneumonia. On the day of transfer she had suffered chest pain all day. But had not told anyone. A strange decision was made to stop her prophylactic anti-anginal treatment, and use the GTN as required and oramorph. She was reported to be uncomfortable on the day of conversion to diamorphine via syringe driver. She then deteriorated rapidly. The pain was likely to be cardiac, and specific angina treatment should have been tried before resorting to regular opiates. The use of opiates was overdone. Pain not mentioned in initial clerking. Alert on admission. Immediately started on Morphine with a rapid dose escalation.

7. Robert WILSON. 74. 22nd September 1998 – 18th October 1998. Gosport War memorial Hospital. Recorded as having a high alcohol intake and poor nutritional status. He was admitted with a left humerus fracture. During his

last days on dickens ward, he was on regular paracetomal, and codeine as required needing one dose of codeine most days. On transfer to dryad, he received 2 doses of oramorph and was then put on a moderate dose of oramorph every 4 hours with paracetomal as required. Liver and kidney problems make the body more sensitive to the effects of oramorph. He had both of these problems. He deteriorated, and was converted to a syringe driver at a dose, which was a close conversion from the oramorph dose. Over the next 2 days the dose was increased without obvious indication. Death was presumably from overdose of opiates, in a man with a poor opiate metabolism, and reduced tolerance. Unless the decision had been taken to treat pain regardless then this was negligent. Initial dose of Morphine inappropriate in a person with known alcoholic liver disease. Rapid increase in body weight documented in notes, with no apparent clinical response.

8. Leslie PITTOCK. 82. 5th January 1996 – 24th January 1996. Gosport War Memorial Hospital. He was physically and mentally frail, deteriorating on a mental health ward. Medical notes state pain in flexed right hand. Nursing notes state generalised pain. Arthrotec tried plus oramorph. Syringe driver started five days later with a large dose increase when converting from oramorph to diamorphine. Notes on the 21st January 1996 record a respiratory rate of 6 per minute, likely as a reflection of the dose of opiates ie he was probably opiate toxic but the dose was not reduced. Cause of death unclear, although he was very frail, but opiates could have contributed.

9. Helena SERVICE. 99. 2ND June 1997 – 5th June 1997.Gosport war memorial hospital. This lady was very old, and had many medical problems, eg diabetes, heart failure, confusion and sore skin. She was agitated in the Queen Alexandra hospital but they accepted it and used thioridazine orally. On transfer to Gosport War Memorial Hospital, they put her on sedation via a syringe driver at night. She was less well the next day and diamorphine was added to the driver (she had not required analgesia other than paracetomal at the Q.A.H). She died the next day. Medication could have contributed towards her death. Need for such medication not clear.

- As agreed by SIO WATTS, 4 Four of these cases are to be prioritised and fast -tracked to CPS, with a view to an early decision to be taken on the sufficiency of evidence to support continuing investigation/prosecution. This strategy will also have the effect of engaging counsel early into the process. It is hoped that the first cases will be forwarded to CPS by September 2004.

- Liaison with the Fareham and Gosport primary healthcare trust is ongoing. It is anticipated that the witness interview of 30 or so healthcare professionals in respect of the DEVINE case should commence from Thursday 17th June 2004 under the supervision of DS STEPHENSON. Potential media issues arising are currently being considered by relevant stakeholders.

- Dr Andrew WILCOCK (Nottingham University) has been commissioned to provide the relevant expert evidence commencing with the priority cases from late July 2004.

- Once Dr WILCOCK'S expert evidence is available then having regard to his professional opinion, Healthcare professionals may be interviewed under caution in respect of allegations of Gross negligence manslaughter.

- Liaison continues with the Crown Prosecution Service, Anne ALEXANDER solicitor representing 43 families, and the Chief Medical officer and General Medical Council in respect of ongoing investigation.

- Priority is to be given to the appointment of a police family Liaison co-ordinator DI BISSELL.

- One significant issue to be addressed is informing the families of 16 deceased named as 'cases of concern' in the Baker report commissioned by the CMO. Two of these cases, PITTOCK and SERVICE identified through the independent work of Professor BAKER have been assessed as 3b's by the experts commissioned through the police investigation.

- Mathew LOHN (Field Fisher Waterhouse) indicated on the 9th June 2004 that he required 10 days to complete his quality assurance work on the 54 cases categorised as 2's ie.. care assessed as sub optimal but not negligent, ie outside the bounds of acceptable clinical practice.

DW.DCI 7227.
10.6.2004.

Other Document Form

Number D965

Title PRINTED COPY ANALYSIS BY ROBIN FERNER OF ADDITIONAL PAGES

(Include source and any document number if relevant) LINK TO NOMINAL FERNER

Receivers instructions urgent action Yes / No	Code A
Document registered / indexed as indicated	Code A
No(s) of actions raised	
Statement readers instructions	Code A
xed as indicated	Code A
o(s) of actions raised	
Examined - further action to be taken	O/M / SIO
Further actions no(s)	Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

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Other Document Form

Number D962

Title NOTES BY DC ROBINSON RE CONVERSATION WITH MACKENZIE.

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Marriott
HOTELS · RESORTS · SUITES

My Code A files > fast.

A/A said Code A files not gone.

Hanee Code A file gone

Ruby " Code A records all gone"

Was my sister ours thanks +

Q. Do you have any other info in records

R No. - I'll double check.

- If you couple me out of loop you

- Need some recommendations

AA nothing but an outstanding closer.

8/6/04

Original notes Conversation Gillian Mackenzie

0930 – 8/6/04

Code A

Sent Code A 8/6/04

1st reply this week.

Should discuss on my case

→ Sol. but he tell me.

– told Police tell family

Ann Alexander

0930 – Mrs McKenzie:

Who allocated to my case.

– Me know before her.

[illegible] the name – publicity – me [illegible]

Other Document Form

Number D959

Title COPY LETTER TO MR QUINN GMC 21/6/64

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No	Code A
Document registered / indexed as indicated	Code A
No(s) of actions raised	
Statement readers instructions	Code A
Indexed as indicated	Code A
(s) of actions raised	
Examined - further action to be taken	O/M | SIO
Further actions no(s)	Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

HAMPSHIRE CONSTABULARY

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Fareham Police Station
Quay Street
Fareham
Hampshire
PO16 ONA

Tel. 0845 0454545
Fax. 023 92891663

Our Ref.

Your Ref.

21st June 2004

Ms L Quinn
Conduct Case Presentation Section
General Medical Council
178 Great Portland Street
London, W1W 5JE

Dear Ms Quinn,

Re: Operation Rochester, Investigation into deaths of Patients at Gosport War Memorial Hospital

I am writing to you today to further update the GMC regarding the above investigation as promised at our meeting on the 27th February this year.

The police have now received the findings of the key clinical team in relation to the reported deaths of patients at the hospital and have prioritised the further investigation of a number of these cases. In respect of these cases we have identified a large number of key medical staff who we intend to interview and obtain witness statements from. It is possible that these interviews could be protracted and therefore take some time.

Once these statements have been obtained and reviewed they will be served on all the relevant parties. The police in consultation with the Crown Prosecution Service will at that stage seek to review our position in respect of disclosing these papers to you as soon as possible thereafter. This strategy has been discussed with the Chief Medical Officer who is in agreement with our course of action.

If there are any further questions that I can answer at this stage of the investigation please do not hesitate to contact me or any of my officers.

Yours Sincerely,

David Williams
Detective Chief Inspector

Other Document Form

Number D955

Title MINUTES TEAM MEETING 8/6/04

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / (No)

	Receiver Code A
Document registered / indexed as indicated	Code A
No(s) of actions raised	
Statement readers instructions	Code A
Indexed as indicated	Code A
No(s) of actions raised	
Examined - further action to be taken	O/M | SIO
Further actions no(s)	Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

OP ROCHESTER.

Team meeting/Situation Report.

1000 – 1100hrs. Tuesday 8th June 2004.

Present.

DCI WILLIAMS.
Code A
DS STEPHENSON.
Code A
DC ROBINSON
DC QUADE.

1.General overview.

Meeting commenced with DCI WILLIAMS and DS GROCOTT giving a broad overview of the investigation to date.

Investigation has now reached a phase where 13 cases have been identified and categorised by the key clinical team as '3b's' ie where the care has been assessed as 'negligent that is to say outside the bounds of acceptable clinical practice and causation of death is unclear.'

Resources been reviewed by level 2 TCG and as a result additional staff have been seconded to the investigation to complete the next phase, ie the progression of 4 cases to the stage that they can be submitted to the CPS for advice/ consideration for prosecution.

The objective process of selection of these cases will be informed by 2 of the clinical team of experts Ann NAYSMITH and Peter LAWSON.

To date DS GROCOTT has raised approx 119 actions in relation to the death of DEVINE from her medical notes identifying 20+ healthcare professionals, consultant, GP and nurses etc and work will commence on this case by DS STEPHENSON and DC'S Code A Code A and QUADE.

2. Liaison with GWMH and Q/A Hospital.

The healthcare professionals to be interviewed in the DEVINE case will receive a letter of introduction explaining the proposed framework of the interview, and inviting a venue convenient to the witness.

Relevant Hospital management will be informed when this process is due to start and given that this stage of the investigation could take up to 6 months the Deputy SIO will make contact with the authorities to consider impact assessment and arrangements for interviews upon hospital premises if that is required.

It is the experience of the investigation to date that most hospital staff will prefer to be interviewed at their home addresses.

All investigators will conduct witness interviews in accordance with the investigation strategy prepared by DCS GROCOTT March 2004.

In addition the investigators will be given a prepared response to questions that will inevitably be posed by witnesses and other interested stakeholders.

3.Media.

The Healthcare Primary trust, are represented by Code A, of the media and Communications Service. Hampshire police media services manager Code A Code A represents the police.

Given that the next phase of investigation activity will inevitably draw local media interest then our immediate media response to issues raised will need to be considered, taking into account that a decision is yet to be taken and notified as to the disposal of cases falling under the 2 category ie 'sub optimal care, but death either natural, causation unclear, or unexplained by natural disease.'

The decision in respect of category 2 cases can only be made when Mathew LOHN (medico /legal solicitor for Field Fisher and Waterhouse) has completed his Q/A work around the category 2 cases. It is anticipated that the individual summaries provided in respect of these cases by Mr LOHN will be used to inform the family members of the status of their case of interest. It is not anticipated that OP ROCHESTER will enter into lengthy dialogue or appeal in respect of the 2's, as the focus of the investigation must remain with those cases that provide sufficient concerns to warrant further police investigation and submission of papers to CPS.

Other media stakeholders will also be notified in advance to any release, and relevant family members informed.

4. Commission Palliative Care expert.

Andrew WILCOX (Nottingham University) has been commissioned to complete the evidential assessment of the most serious cases he will commence this work in late July, cases being prioritised. His fees are still to be negotiated. Dr WILCOX recommends that a geriatrician is also sought to provide general expert evidence in respect of healthcare of the elderly.

5. Stakeholder visits.

DCI WILLIAMS is updating the Chief Medical Officer, family members solicitor Anne ALEXANDER and Mathew LOHN during the course of this week.

6. Finance.

The imperative is to complete investigations as thoroughly but expeditiously as possible. Therefore reasonable overtime as authorised by detective sergeants will be met through payment. DS KENNY to review the budget position periodically.

7. Transport.

Most of the existing team remain essential users as authorised by ACCSO. There is a requirement for the 3 month hire of two vehicles to accommodate new team members and to provide for the effective deployment of staff. Local authority car passes to be costed on a three monthly basis, and requisite AD 100 to be submitted by DS STEPHENSON.

8. Communications/briefing.

The investigation will be briefed/debriefed weekly Mondays at 0930hrs with all staff to attend. These meetings will be minuted by rota including all staff.

9. Duties/destination.

A 2 weekly destination/duties board to be maintained within the main squad office, all staff to endorse their commitments thereon. Core duty hours should be within 0800 – 1800hrs band, but these may be varied by staff according to operational/personal need. Code A to administrate the destination board please, although all officers have a responsibility to ensure that it is updated.

DW. DCI Code A 8.6.2004.

Other Document Form

Number D947

Title LETTER FROM SWT WHITING TO MRS MACKENZIE 26/3/01

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / (No)

Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Code A

exed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Superintendent
Professional Standards Department

Police Headquarters
West Hill
Winchester
Hampshire
SO22 5DB

Tel.
Fax. Code A

Our Ref. Code A

Your Ref.

Mrs G M MacKenzie

Code A

26th March 2001

Dear Mrs MacKenzie,

Following our recent telephone conversation I am writing to confirm that DI Morgan and DC Maddison have both received operational advice as set out in the letter sent to you by Mr Gear of the Police Complaints Authority.

Also I can confirm that you are entirely right in your assertion that a copy of the notes made by your sister was obtained by DC Maddison, and that the advice DI Morgan received in relation to them was that she should of ensured they were *exhibited.*

In closing I offer my apologies, on behalf of the Constabulary, that you did not receive the service you ought to have done, as is evidenced by the need for officers to receive advice.

I am pleased that you are very much happier with the further investigation being led by DCI Ray Burt, and I have ensured that your kind comments about him have been brought to his attention, and to that of his senior officer.

Yours sincerely,

Code A

Adrian Whiting,
Superintendent

Other Document Form

Number D946

Title LETTER FROM DWT WRITING TO MRS MACKENZIE 5/12/00

(Include source and any document number if relevant)

Receivers instructions urgent action Yes (No)

Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Code A

Indexed as indicated

) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Superintendent
Professional Standards Department

Police Headquarters
West Hill
Winchester
Hampshire
SO22 5DB

Tel. Code A
Fax.

Our Ref. P 418/98 AW

Your Ref.

5/12/00

Mrs G MacKenzie

Code A

Dear Mrs MacKenzie,

Thank you for your letter of the 9th November 2000, which has been forwarded to me by the Police Complaints Authority. I believe you will have had a letter from them, and a further one from Chief Superintendent Basson, dated 21st November 2000.

I am writing to tell you that I have now interviewed both DC Maddison and DI Morgan. Accordingly I shall complete my report for the Police Complaints Authority, and they will decide upon any further action to be taken. They will be in contact with you once they have made their decision.

In your letter you mentioned the possible involvement of officers senior to DI Morgan in the supervision of the investigation. I can confirm that this is the case, and that this aspect will be included in my report.

To confirm, my report will consider the questions you raise regarding the conduct and efficiency of the investigation, the conduct of DI Morgan and the delay in progressing the investigation of your complaints. The matters surrounding the will are being considered separately by DCI Burt.

Please do not hesitate to contact me, as above, if I can assist further.

Yours sincerely,

Code A

Adrian Whiting,
Superintendent

Other Document Form

Number 3945

Title LETTER FROM MRS MACKENZIE TO MR WATTS 19/2/04

(Include source and any document number if relevant)

Receivers instructions urgent action Yes (No)

Receiver Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Statement Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

19. February 2004

Steve Watts
Det. Chief Supt.
Hampshire Constabulary
Police Headquarters
West Hill
Winchester
Hampshire SO22 5DB

Dear Mr Watts

Thank you for your personal letter 28 January 2004 which I now understand went to the other 62 families so I do not comprehend the sentiments of your first paragraph.

I note that the quality assurance process has validated the analysis of the clinical team. Given the credentials of Prof. Forest, this is not surprising and I can see no reason why there was any query over the cases of 'natural deaths'. Some families at least could have been informed that there was no cause for concern last September or earlier. I do not consider the delay was necessary or ethical. There seems to be a total lack of basic training in understanding the psychological stress caused although empathy is a personal gift and cannot be taught.

I cannot agree that all available records were submitted to the clinical team. The Haslar file 30th July 1998 –11th August and further records 14th August – 17th August were not included in my mother's case although in Police possession together with the internal investigation carried out prior to Mr Millets letter dated 22 September 1998 (in response to our complaints 17 August). They have recently been found and DC Robinson knew exactly to which papers I was referring.

"Filling gaps" in information going back over ten years is not a substitute for the information on the Haslar file prior to admittance to Gosport or for that matter the views expressed by ex-Haslar staff stationed in Germany circa 2000. Some papers were totally misleading.

Finally I would draw your attention to Chapter 16 of Report No. 2 of the Shipman Inquiry. A far worse can of worms will be revealed eventually regarding the Gosport case and those responsible overall for the basic mistakes made over a period of five years will have to face the consequences, however senior they are. I can accept that those who hold the purse strings are not always detectives – perhaps they should be!

Signed statements.

The whole subject of personnel management and personnel recruitment within the Police Force needs scrutiny. "You cannot make a silk purse out of a sow's ear" is a very old saying before your time but you cannot make a good detective out of anyone with only an average IQ and lack of knowledge of basic criminal law. (Actus reus and Mens Rea in murder and gross negligence manslaughter bearing in mind negligence rulings in Tort, duty of care etc.) Something will have to be done in the future. Fitting square pegs into round holes never works if you are to improve the quality of your workforce and increased salaries or promotion are not the answer. A little training in public relations would not go amiss.

The basic recommendations in the Shipman Report should have been available from your Force Solicitor – presumably he has a copy of the Legal 500 and medical directory. The CPS should never have referred my case to Treasury Counsel (who is not a QC nor a specialist in clinical cases). The alleged reasoning of David Perry is not logical, let alone legal in terms of law or medicine. Palliative care leading to death is legal but Euthanasia is not whatever the age of the patient.

Yours sincerely,

Code A

P.S. Were you responsible for John James as well as Ray Burt? I am under the impression that Mr Readhead had more say in John James' investigation that you did. In my opinion Mr Readhead has far too much say in passing information or opinion on to individuals when he is not in charge of the case.

Other Document Form

Number **Code A**

Title COPY LETTER FROM MR WATTS TO MRS MACKENZIE 24/3/05

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / (No)

Receiver

Code A

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

COPY

Hampshire Constabulary
Police Headquarters
West Hill
WINCHESTER
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SO22 5DB

Tel: 01962 871404
Fax: 01962 871251

S Watts MSc DPM MCIM
Detective Chief Superintendent
Head of CID

email: Code A

24 February 2004

Mrs G. MacKenzie

Code A

Dear Mrs MacKenzie

Thank you for your letter dated 19 February 2004, the contents of which I note. I have passed the letter to DCI Niven who will deal with the detailed matters you refer to. Indeed, I understand that in respect of the matter you raise concerning the notes in relation to your mother, he is already in touch with you.

Yours Sincerely

Steve Watts
Detective Chief Superintendent
Head of CID

Other Document Form

Number D943.

Title LETTER FROM MRS MACKENZIE TO DI SIVEN 19/2/04

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / (No)	Code A
Document registered / indexed as indicated No(s) of actions raised	Indexer Code A
Statement readers instructions	Statement Code A
Indexed as indicated (s) of actions raised	Indexer Code A
Examined - further action to be taken	O/M / SIO
Further actions no(s)	Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

19. February 2004

Nigel Niven
Deputy Senior Investigating Officer
Western Area HQ
12-18 Hulse Road
Southampton
Hants. SO15 2IX

Dear Det. Inspector Niven, (Operation Rochester)

Thank you for Bulletin No. 4, 28 January. I have replied separately to the letters from Mr Readhead and Mr Watts which did not provide reassurance or clarity – events have now overtaken the situation since receipt.

Although not 'politically correct' I enclose copy letters 5 December 2000 and 26 March 2001 to make the point that senior officers both in the Shipman Report and Gosport CID apparently do not carry the can when things go wrong but pass the buck down the line. The DI and DC only received operational advice from the PCA – hence my concern for all at Operation Rochester with Mr Watts going part-time in a supervisory role (which is no criticism of you as individuals).

Should there be any 'queries' in the future I shall endeavour to make it plain that the buck stops elsewhere. Please note that the DI did not ensure my sister's notes were exhibited and presumably the Portsmouth Healthcare Trust's letter from Mr Millet 22 September 1998 in reply. The internal investigation notes should have also been obtained and this was done by DCI Ray Burt. I refer to it in my statement.

Could 'something' be done about Mr Readhead passing on information, comments and opinions to individuals instead of to us all. I thought Mr Watts and yourself were in charge of Operation Rochester and information. Mr Readhead's comments just add to the stress – but as you know he is not my favourite pin-up – nor I his!

Yours sincerely,

Code A

Other Document Form

Number **Code A**

Title LETTER FROM THE GMC TO MR WATTS 5/5/04

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / (No)

Receiver **Code A**

Document registered / indexed as indicated

No(s) of actions raised **Code A**

Statement readers instructions

Statement **Code A**

Indexed as indicated

No(s) of actions raised **Code A**

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

RECEIVED

06 MAY 2004

Our Ref: Code A
Your Ref:

5 May 2004

Detective Chief Superintendent Steve Watts
Head of CID
Police Headquarters
West Hill
Romsey Road
Winchester
Hampshire SO22 5DB

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear DCS Watts

Operation Rochester – Investigation into Deaths at Gosport War Memorial Hospital

I am a Solicitor and Principal Legal Advisor at the General Medical Council. I am writing in relation to the ongoing police investigation into possible criminal charges concerning deaths at Gosport War Memorial Hospital.

As you know from discussions with officers at the GMC, we are also investigating conduct issues concerning Dr Jane Barton arising out of the same facts as those which refer to your investigation.

GMC Involvement

The case against Dr Barton began in July 2000 when your force began an investigation into the circumstances surrounding the death of Gladys Richards, a geriatric patient at Gosport War Memorial Hospital ('the hospital'). The investigation was subsequently extended to four other deaths, Arthur "Brian" Cunningham, Alice Wilkie, Robert Wilson and Eva Page.

In February 2002, the Crown Prosecution Service decided against a criminal prosecution. At this point the relevant papers were disclosed to the GMC to decide on any issues of serious professional misconduct or seriously deficient performance. In August 2002, the case was referred by the GMC's Preliminary Proceedings Committee for hearing before the Professional Conduct Committee ('PCC').

The case has been referred on 3 occasions (June 2001, March 2002 and September 2002) for consideration of whether Dr Barton's registration should be restricted prior to hearing before the PCC.

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

On 28 May 2002, Mrs Mackenzie (daughter of the late Gladys Richards) wrote to the GMC. She copied the letter to David Blunkett MP, your force, Nigel Waterson MP, Peter Viggers MP, the Police Complaints Authority, the CPS and David Parry of Treasury Counsel. She was concerned about the failures of the police investigation. As a result, your investigation was reopened. In July 2002, the then Commission for Healthcare Improvement published a report entitled "Gosport War Memorial Hospital Investigation into the Portsmouth Healthcare NHS Trust". The report did not name Dr Barton specifically, but referred to the criminal investigations and criticised the systems in place at the time.

On 30 July 2002, Mrs Mackenzie informed the GMC that the police were seeking advice from the CPS about the investigations and as a result were reconsidering the 5 cases.

The GMC and the police investigation

On 20 November 2002 Detective Inspector Niven and Detective Sergeant Kenny met Judith Christie of the GMC's solicitors, Field Fisher Waterhouse ('FFW'). Ms Christie was informed that a meeting was arranged between your force and the CPS on 28 November 2002. The result of that meeting was that the investigation should be continued and expanded. By letter dated 2 December 2002, FFW were asked to consider postponing the PCC hearing (which at that point was anticipated to take place in April 2003).

Accordingly the case was removed from the GMC's lists.

On 30 September 2003, you and DI Niven met with Linda Quinn of the GMC to discuss progress in the investigation. You reported that the view of the all the deaths of patients under Dr Barton's care at the hospital had suggested that the treatment of some 15 or 16 fell into the category of "negligence, cause of death unclear". At that point, you anticipated interviewing Dr Barton, once a second team of experts had reviewed these cases, which you believed would be January 2004. You also indicated that you were unable to provide full details of your investigation, as this could jeopardise further investigations and your proposed interview of Dr Barton.

On 2 October 2003, Linda Quinn wrote to you indicating that the GMC was considering referring Dr Barton's case yet again to the Interim Orders Committee and requesting that you supply the GMC with a detailed written summary of the evidence you had obtained, including any report prepared by the team of experts. You replied on 6 October 2003, confirming the content of your discussions with Linda Quinn on 30 September 2003 and stating: *"... our primary concern always is the safety of the public. That said, we are also expected to investigate serious allegations such as those involved here in a professional and ethical manner. We therefore have to strike a balance between conducting our investigation in the appropriate fashion whilst realistically assessing the risk to public. Put simply, our ability to disclose information would need to be based on an assessment of the risk that was presented now by Dr Barton."*

A Medical Screener of the GMC again considered the case with a view to referring Dr Barton to the Interim Orders Committee in November 2003. However, the Screener felt that as a result of the lack of new evidence, the IOC would come to the same decision as previously.

On 7 January 2004, Linda Quinn wrote to you asking for an update on progress. DI Niven replied on 28 January 2004, indicating that Hampshire Constabulary were unable to provide any further information at that point.

Linda Quinn wrote again on 6 February 2004 saying that the GMC had no further information about the case and that the GMC's inquiries were on hold pending conclusion of the police investigations.

Your investigation into Dr Barton

Throughout your investigation you have kindly kept us informed of the actions being taken by you and your colleagues. However, it seems that some two years after the investigation was recommenced, no decision has yet been reached in relation to bringing any charges against Dr Barton.

It would seem that further investigation is still required in relation to a number of matters before you are able to either bring charges or disclose any further information to the GMC.

The GMC's position

The General Medical Council, as a public authority, has a duty to bring matters concerning the fitness to practise of registered practitioners to a hearing within a reasonable time. Undue delay can seriously prejudice our function and may result in successful abuse of process applications.

I am very concerned that Dr Barton's GMC case has now been open for almost four years without any substantive progress.

Conclusion

The GMC is required to progress complaints against doctors, regardless of the circumstances, as expeditiously as possible. Such information as the GMC has received would suggest grave concerns about Dr Barton's fitness to practise. The current situation, in which the GMC is awaiting developments in the police investigation, without any indication when this may be concluded, is deeply unsatisfactory.

I should be very grateful if you could take the following steps:

a. indicate when you think it likely your investigations will be concluded and with what result; and

b. consider again whether there is any further information which you may be able to release that would allow the GMC to progress its own investigation.

In this respect, I would remind you that there is no principle of law which would require any GMC case to await the conclusion of any criminal proceedings against Dr Barton, though the GMC appreciates that in certain circumstances this may be desirable.

The GMC remains concerned that in this very troubling case, it is unable to take the steps that may be required to protect the public, as it is required to do by statute. Whilst we recognise the issues involved from the perspective of the police investigation, our view must be that, should you have information available to you that suggests any risk to public safety is posed by Dr Barton continuing to practise as a doctor, the protection of the public must be both your own and the GMC's primary interest and, as such, it is imperative that this is disclosed to the GMC at the earliest juncture.

I look forward to your early reply.

Yours sincerely

Code A

Peter Steel
Solicitor
Direct Dial Code A
Direct Fax
Email Code A

Other Document Form

Number D925

Title COPY ADDITIONAL NOTES ALICE WICKES

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Receiver Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Statement Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

Code A

Other Document Form

Number D914

Title LETTER FROM MRS MACKENZIE TO DCC ROADHOUSE 15/4/04

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further actions no(s)

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

O/M	SIO

Indexer

Code A

15 April 2004

21/4/04.

I R Readhead LL.B
Deputy Chief Constable
Hampshire Constabulary
Police Headquarters
West Hill
Winchester
Hampshire SO22 5DB

Code A

I do not intend to reply. Please have liaison at Op. Rolvaston.

Code A

Dear Mr Readhead,

I confirm receipt of your letter dated 15 March, postmarked 23 March and arrival 24 March.

I note your remarks concerning the complaints relating to CID Gosport – first raised with the Chief Constable 20 November 1998, 'supervised' by HQ for a period of two years and dealt with by the PCA in March 2001. I enclose the relevant copy letters referring to senior officers.

The complaint concerning John James has been in your court since April 2002 with countless delays in the investigation. The latest information conveyed to me by the PCA is that the hold up is at your end. You were in receipt of the Somerset and Avon Report 9 February 2004 – the formal complaints raised in April 2002.

At the meeting 11 September 2002 despite the CHI Report July 2002, you categorically stated that there would be no further investigations into deaths at Gosport War Memorial Hospital. In my opinion this puts you in the same position as John James. You stated before the families at the meeting that you did not want any further questions from me and later produced minutes of the Meeting upon which I commented by letter. I assumed that the contents of that letter conveyed my dissatisfaction with your conduct. Events then overtook your decision and no doubt letters to the Attorney General in August 2002 played some part.

At the meeting 11 September 2003 when I brought up an issue you questioned why had I not brought up the matter before. I replied because you had told me at the meeting 2002 you did not want to hear anything further from me. You later went on to state in front of witnesses 'Do you want to make an allegation against me? Make an allegation against me Mrs MacKenzie.' I replied 'when I think it is appropriate and the timing is right I will.'

I am well aware of the Hampshire Police Authority and they have been aware of my concerns for a considerable time. I am also aware of the IPCC and their powers. I do not need to make a complaint at this time and as expressed in previous correspondence a possible Public Inquiry at a later stage would cover my concerns.

Your continued assumption that DCS Watts is the national authority regarding criminal allegations in relation to death associated with medical authorities beggars belief. Are you aware that the previous investigation findings carried out 1999-2001 were not brought to the attention of Professor Forrest i.e. the Haslar files (in my case), the internal investigation carried out by Portsmouth Healthcare Trust, the statements made by Haslar medical staff, the statements from my sister and myself and the fact that my sister has still not made a statement regarding the lack of symptoms for pneumonia (cause of death) and the lack of a haematoma the reason given to us by Beed for the syringe driver. Despite correspondence there has been no logical explanation. I fail to understand how Professor Forrest could categorise my case without the relevant paperwork prior to last September.

The investigations since October 1998 have been a continuing catalogue of incompetence. I hope it is not too late for someone at HQ to take action. (See Cl. 16 Shipman Report)

As I have said on many occasions my mother's case will be fully exposed in due course. This also applies to the behaviour of Hampshire Constabulary who still have an opportunity to save face.

Yours sincerely,

Code A

P.S. Perhaps you could clarify the situation with Professor Forrest?

Hampshire Constabulary
Police Headquarters
West Hill
WINCHESTER
Hampshire
SO22 5DB

Tel: 01962 871404
Fax: 01962 871251

S Watts MSc DPM MCIM
Detective Chief Superintendent
Head of CID

email: Code A

24 February 2004

Mrs G. MacKenzie

Code A

Dear Mrs MacKenzie

Thank you for your letter dated 19 February 2004, the contents of which I note. I have passed the letter to DCI Niven who will deal with the detailed matters you refer to. Indeed, I understand that in respect of the matter you raise concerning the notes in relation to your mother, he is already in touch with you.

Yours Sincerely

Code A

Code A Steve Watts
Detective Chief Superintendent
Head of CID

No written explanation or logical verbal explanation given to date 15.04.04.

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Superintendent
Professional Standards Department

Police Headquarters
West Hill
Winchester
Hampshire
SO22 5DB

Tel. 01962 871164
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Our Ref. Code A

Your Ref.

Mrs G M MacKenzie

Code A

26th March 2001

Dear Mrs MacKenzie,

Following our recent telephone conversation I am writing to confirm that DI Morgan and DC Maddison have both received operational advice as set out in the letter sent to you by Mr Gear of the Police Complaints Authority.

Also I can confirm that you are entirely right in your assertion that a copy of the notes made by your sister was obtained by DC Maddison, and that the advice DI Morgan received in relation to them was that she should of ensured they were *exhibited.*

In closing I offer my apologies, on behalf of the Constabulary, that you did not receive the service you ought to have done, as is evidenced by the need for officers to receive advice.

I am pleased that you are very much happier with the further investigation being led by DCI Ray Burt, and I have ensured that your kind comments about him have been brought to his attention, and to that of his senior officer.

Yours sincerely,

Code A

Adrian Whiting,
Superintendent

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Superintendent
Professional Standards Department

Police Headquarters
West Hill
Winchester
Hampshire
SO22 5DB

Tel. Code A
Fax.

Our Ref. Code A

Your Ref.

5/12/00

Mrs G MacKenzie

Code A

Dear Mrs MacKenzie,

Thank you for your letter of the 9th November 2000, which has been forwarded to me by the Police Complaints Authority. I believe you will have had a letter from them, and a further one from Chief Superintendent Basson, dated 21st November 2000.

I am writing to tell you that I have now interviewed both DC Maddison and DI Morgan. Accordingly I shall complete my report for the Police Complaints Authority, and they will decide upon any further action to be taken. They will be in contact with you once they have made their decision.

In your letter you mentioned the possible involvement of officers senior to DI Morgan in the supervision of the investigation. I can confirm that this is the case, and that this aspect will be included in my report.

To confirm, my report will consider the questions you raise regarding the conduct and efficiency of the investigation, the conduct of DI Morgan and the delay in progressing the investigation of your complaints. The matters surrounding the will are being considered separately by DCI Burt.

Please do not hesitate to contact me, as above, if I can assist further.

Yours sincerely,

Code A

Adrian Whiting,
Superintendent

Other Document Form

Number 1908

Title RESULT OF ANALYSIS OF ADDITIONAL NOTES 21 CASES BY DR FERNER

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Receiver
Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Statement
Code A

Indexed as indicated

No(s) of actions raised

Indexer
Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

Code A

Code A

Code A

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Code A

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Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Other Document Form

Number 1496

Title ANALYSIS BY DR ANNE NAYSMITH OF ADDITIONAL/MISSING PAGES

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / (No) PLEASE X REF WITH NOMINALS.

	Code A
Document registered / indexed as indicated	Indexer
No(s) of actions raised	Code A
Statement readers instructions	Statement
	Code A
Indexed as indicated	Code A
No(s) of actions raised	
Examined - further action to be taken	O/M / SIO
Further actions no(s)	Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

OPERATION ROCHESTER
ADDITIONAL NOTES 3.4.04

ID	NOTES	GRADING CHANGE?
BJC/10 CLARKE Hubert	Nothing in these pages germane to his final illness	No change
BJC/14 CRESDEE Ronald	These nursing notes confirm the clinical signs of opioid toxicity in the final days, especially from 3/7-6/7. This was treated with increased sedation instead of by reducing the opioid, ie the terminal management was unskilful. But he was dying of lung cancer, and I still doubt the mismanagement contributed significantly to shortening his life.	No change
BJC/15 CUNNINGHAM Arthur	Almost all Day Hospital notes. The only notes relevant to his final illness are 2 pages of uneventful nursing notes which contribute no new information.	No change
BJC/19 GERMAN Marie	No content – only blank mount sheets	No change
BJC/20 GRAHAM Leonard	No relevant notes	No change
BJC/21 GREGORY Sheila	Mostly blank sheets. Nothing relevant.	No change
BJC/24 HALL Norah	GP referral letter only.	No change
BJC/25 HILLIER Eileen	Mainly nursing notes from her psychiatric admissions. Nothing relevant.	No change
BJC/27 HOOPER Albert	No relevant notes	No change
BJC/29 JARMAN Thomas	Only 1 drug chart from QAH prior to transfer to GWMH which has no problematic drugs.	No change
BJC/30 LAVENDER Elsie	Old notes only	No change
BJC/32 MARTIN Stanley	Old notes only	No change
BJC/33 MIDDLETON Dulcie	Some medical and nursing notes from the early phase of her stroke rehab. Nothing relevant to her death.	No change

ID	NOTES	GRADING CHANGE?
BJC/45 SPURGIN Enid	Old notes only	No change
BJC/46 STEVENS Jean	Old notes only	No change
BJC/51 WELLSTEAD Walter	Nursing charts from Mulberry Ward only	No change
BJC/53 WILLIAMSON Ivy	Nothing relevant	No change
BJC/54 WILLIAMSON Jack	Mainly surgical notes. Nursing note of the day of his death, with no entry between 0300 (incontinent of loose faeces, unable to drink unaided) and 2155 (certified dead).	No change
BJC/55 WILSON Robert	Nothing relevant	No change
BJC/56 WINDSON Norma	Only 1 page of notes from her final ITU admission which add nothing relevant	No change
BJC/71 PITTOCK Leslie	No new information. These notes have already been seen.	No change

Kenny, Owen

From: Anne Naysmith Code A
Sent: 03 April 2004 16:33
To: Kenny, Owen
Subject: Gladys Richards

I have now reviewed the new notes, my previous notes on this lady and Peter's comments, and my overall note is below:

Gladys Richards

Additional notes from Haslar:
Did not receive any morphine during the period 14/8 to 17/8, ie between reduction of her dislocated hip and return to GWMH. Did have episodes of screaming and agitation on the ward at Haslar but this was not interpreted as pain and was treated with haloperidol, then thioridazine, to achieve sedation. But immediately she returned to GWMH her screaming was treated with morphine 10mg repeatedly and then a high dose S/D.

There is not enough evidence to change her overall score. But I am slightly more concerned than before about a) the culture, which interpreted apparently any agitated behaviour as physical pain, and b) the doses prescribed, which were certainly too high given her previous levels of analgesia in Haslar. She should only have had 2-5mg of morphine orally, as prescribed at Haslar, and not started on 10mg as initial dose. Given her severe dementia (and the "extremely sensitive to oramorph" judgement previously made) she was bound to develop side-effects from doses of this magnitude.

I wonder if there is any possibility that her hip dislocated again during the ambulance journey back from Haslar to GWMH? If so, that would explain an apparent dramatic difference in pain between one institution and the other. She was unable to give any history and extremely hard to examine, especially when distressed, so it might have been missed again, as it was the first time.

OPERATION ROCHESTER
ADDITIONAL NOTES 3.4.04

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Code A

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Other Document Form

Number 1895

Title CORRS BTN ANN REEVES & PETER VIGGERS MP.

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

PETER VIGGERS MP

House of Commons, London SW1A 0AA

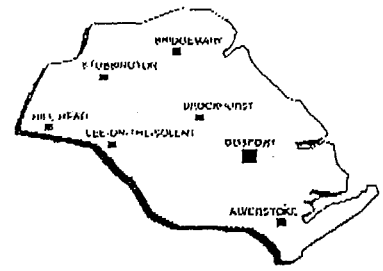
Private Secretary: 020 7219 4091

Private Secretary Fax: 020 7219 3985

Constituency Office: 023 92 52 21 21

Website: www.peterviggers.co.uk

Working for the constituency of Gosport



ATTENTION DS Quinn Kelly

30th March 2004

Mrs Ann Reeves

Code A

Dear Mrs. Reeves,

Thank you for your letter of 24th March.

I note what you say. If you would care to let me know what your intentions are in relation to the Gosport War Memorial enquiries, I would be interested to hear these.

I recognise that this whole issue has caused great strain and worry to very many people, and I hope that at least we can agree it would be very good for it to be drawn to a conclusion.

Yours sincerely,

Code A

Mrs A Reeves

Code A

Mr P Viggers, MP
House of Commons
London, SW1A 0AA

24 March 2004

Dear Mr Viggers

I am writing in response to your comments as outlined in the recent News articles regarding the Gosport War Memorial Hospital.

I have written to you several times in the past but you have always failed to give me a response; other than that of a system generated letter acknowledging receipt. To that I can only understand that you are incapable of answering my letters.

Your comments to the press 'When will these people be satisfied?' I find utterly offensive and without justification; I would appreciate you writing to me and asking me personally when I will be satisfied? You have chosen to detach yourself from the Gosport War Memorial inquiry and have even ignored the findings of the CHI Report for reasons unknown to us.

If you had given up some of your time to your constituents with regards to this investigation when it was requested, you may be in a better position to pass comment. Your current concerns for the staff of the hospital and public disregard for the families who are suffering as a result of its poor practices, I find totally disgraceful. You have failed to realise that it is people like my self who questioned the care at the hospital and brought malpractices out into the open, that has made it a safer place. If you are so concerned regarding the stress that it is causing in the Gosport area, perhaps it would be a good idea to put pressure on the Chief Medical Officer to release Professor Baker's report!

Believe me Mr Viggers, justice will be done and the truth will be ousted. I shall then look forward to speaking with you at one of your public meetings.

Regards

Ann Reeves

Other Document Form

Number D 8885

Title LETTER FROM GMC TO NIGEL NIVEN RE DR J. BARTON

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / (No)

	Code A
Document registered / indexed as indicated No(s) of actions raised	Code A
Statement readers instructions	Code A
Indexed as indicated No(s) of actions raised	Code A
Examined - further action to be taken	O/M | SIO
Further actions no(s)	Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

In reply please quote Code A

Please address your reply to
Conduct Case Presentation Section, FPD
Fax Code A

16 March 2004

Mr Nigel Niven
Deputy SIO
Operation Rochester
Fareham Police Station
Quay Street
Fareham
Hampshire
PO16 0NA

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Mr Niven

Dr J Barton

You will recall that it was agreed at our meeting on 27 February 2004 that I would check the GMC files to see if there was any mention of a voluntary undertaking by Dr Barton.

There is no record of Dr Barton having made a voluntary undertaking to the GMC. However, it would appear that she did agree with the Isle of Wight, Portsmouth and South East Hampshire Health Authority in February 2002 that she would voluntarily stop prescribing opiates and benzodiazepines. By September 2002, when the Interim Orders Committee last considered Code A case, her legal team informed the IOC that the Health Authority had lifted the condition.

Yours sincerely

Code A

Linda Quinn
Conduct Case Presentation Section
Fitness to Practise Directorate
Direct Line: Code A
E-mail address: Code A

Other Document Form

Number J884

T● COPY LETTER FROM MR READHEAD TO MRS MACKENZIE 15/3/04

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Code A

Indexed as indicated

No(s) of actions raised

Code A

●amined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Hampshire Constabulary
Police Headquarters
West Hill
WINCHESTER
Hampshire
S022 5DB

Tel: 0845 045 45 45
Fax: 01962 871189

I.R Readhead LL.B
Deputy Chief Constable

Your Ref:
Our Ref: IR/DCC/hjs

Date: 15th March, 2004.

Mrs. G. Mackenzie

Code A

Dear Mrs. Mackenzie,

Thank you for your letter dated 19th February, 2004. It is obviously regrettable that you continue to believe that the Hampshire Constabulary are not committing significant resources and the highest level of professional expertise into the investigation of the deaths at Gosport War Memorial Hospital.

The Hampshire Constabulary accepts that when this matter was first drawn to our attention operational advice was given to two of our officers involved in that investigation as a result of a complaint that was made by you and which was subject of supervision by the Independent Police Complaints Authority.

The complaints against Chief Superintendent James are currently with the Police Complaints Authority and it would be inappropriate to make any further comment at this stage.

It is regrettable that meetings that we have had with you since September, 2002 do not seem to have reassured you about our commitment to investigate this matter in order to determine whether or not any criminal offences have occurred. I frankly have no idea what you are talking about with regard to my personal behaviour towards you on 11th September, 2003. This is the first time that you have suggested that my conduct was anything less than professional. If you have any specific complaint that you wish to make against me, then I will of course forward that to the Hampshire Police Authority for their attention.

Detective Chief Superintendent Watts is the author of national advice for senior investigating officers regarding criminal allegations made in relation to deaths associated with medical authorities. It would be inappropriate for me to comment upon your assertion that there is nothing complex in law or medicine relating to

your mothers case. Clearly the investigation into the circumstances of your mothers death are continuing in order to establish, as far as we are able, what the medical legal situation actually is.

Yours sincerely,

I.R. Readhead
Deputy Chief Constable

Hampshire Constabulary
Police Headquarters
West Hill
WINCHESTER
Hampshire
S022 5DB

Tel: 0845 045 45 45
Fax: 01962 871189

I.R Readhead LL.B
Deputy Chief Constable

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Our Ref: IR/DCC/hjs

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Yours sincerely,

I.R. Readhead
Deputy Chief Constable

Other Document Form

Number D883

Title COPY LETTER FROM MN MACKENZIE TO JCC REDHEAD 19/2/04

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Receiver Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Statement Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

19 February 2004

I R Readhead
Deputy Chief Constable
Hampshire Constabulary
Police Headquarters
West Hill
Winchester
Hampshire SO22 5DB

Dear Mr Readhead,

Thank you for your letter 28 January

I cannot agree that from the onset of the enquiry into the deaths at the Gosport War Memorial Hospital the best officers have been employed for the investigations. You are of course aware of the farcical situation at Gosport C.I.D. when two officers received operational advice, a D.C. and a D.I. despite the fact that more senior officers were involved in the supervision of the investigation. (Supt. Whiting's letter 5 December 2000). A great deal of protection seems to be afforded to senior officers.

It is confirmed in writing that Det. Chief Supt. Watts was the supervisory officer for D.C.I. Burt's investigation when concentration was made on the last week of my mother's life instead of from the arrival at Gosport, for a period of 2 to 4 weeks, virtually pain-free, fully weight bearing and walking with a zimmer.

The next continuing investigation came under Det. Supt. James – who did not query Treasury Counsel's advice and whose behaviour is the subject of complaint. Presumably he too came under the jurisdiction of a senior police officer. I suspect that 'resources' came high on the agenda. A recent item in the Sunday Express gives some comment from Prof. Forrest on this short-sighted approach.

The CHI Report July 2002 produced a Press Statement from HQ but little action for the 11 people who had approached the Hampshire Constabulary April 2001 – February 2002. The meeting with yourself on the 11 September 2002 did little to provide confidence in the Hampshire Constabulary with your statement that there would be no further investigations and your attitude towards me was noted by others. The alleged comments made by Supt. Stevens regarding the recommendations to the PCA in connection with John James gives me the impression that the Professional Standards Dept. (which comes under your jurisdiction) is far from professional. Your personal behaviour towards me at the meeting 11 September 2003 does not give me the impression that professionalism

comes high on the agenda throughout Hampshire Constabulary. Further alleged comments from you on the investigation conveyed to me by A.N. Other instead of to us all, is also a matter of concern when I understood it was Chief Det. Supt. Watts who was in charge of the investigation and all information should come through him. As you have said yourself, you are not a Detective.

Your comment that "Det. Chief Supt. Watts is regarded as a national authority in respect of investigations such as this" is not borne out by the Report No. 2 Shipman enquiry. He may be the first officer to follow recommendations so far advised in the Shipman Report but this does not make him a national authority and obviously there will have to be further improvements covering the needless stress caused to families over the past year. Many have noted the speedy action taken by other constabularies, in similar cases although, in defence of Hampshire, other cases have not involved the same numbers. There is nothing complex in law or medicine relating to my mother's case.

Had communication and confidence been inspired by Police HQ there would have been no need to contact the media who have been instrumental in no small way to getting this investigation ongoing and speeded up.

I have no doubt that in due course there will be a Public Inquiry and I will do my part in revealing the background to the investigations which I feel stem from Police HQ and the part played by very senior officers.

Yours sincerely,

Code A

Other Document Form

Number 1 D855

Title NOTES OF MEETING WITH MATTHEW COHN 23/2/04

(Include source and any document number if relevant)

Receivers instructions urgent action Yes/(No)

Code A

Document registered/indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Statement

Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M | SIO

Further action no(s)

Indexer

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Kenny, Owen

From: Kenny, Owen
Sent: 24 February 2004 13:58
To: Niven, Nigel
Subject: Meeting with Matthew LOHN

Nigel,

I've been through the notes made by me during our meeting with Matthew LOHN yesterday (23/2/04) and below are Actions agreed.

1. Dave Grocott to put together information re case law, CPIA etc.

2. Meeting to be arranged by ML with GMC and will go on record by e-mail whilst arranging. Likely to be at their office in London (Gt Portland Street) Monday 1st or Wednesday 3rd March.

3. Meeting to be arranged with Nursing and Midwifery Council.

4. ML suggested that consideration be given to liaison with Royal Pharmaceutical Society as a pharmacist would have been involved.

5. ML will approach Code A re her availability to lead new clinical team.

6. Enquiry team will commence taking statements from FGMs in category 3.

7. ML will commence work on 2s and will meet in a month or so to discuss findings. During assessment he will pass on any 3s identified.

8. In respect of cases in category 1 where FGMs not content, ML suggested obtaining their concerns in writing for consideration.

9. FGMs in respect of cases identified by Professor BAKER to be visited in due course and Officer Reports to be submitted as previously.

OJK.

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

10.00. 23/2/04. F.F.W.

Code A

- Code A / Agenda.
  Doctors' persp.
  GMC.
  Gosport / Next Move.

Code A. GMC say no info from Police

GMC Need to consider what done at time. re - suspension etc.

Taken to Interim Order Committee failed (Code A

Discussed position with Code A with GMC

re - rule amendments.

Code A - Analysis not evidence [illegible] say.

- Way forward) - Timetable GMC.
  Work on 3's re I/V [illegible] Code A
  Where is detriment to case if we disclose analyses to Code A

Limit

Code A Potentially to Code A detriment.

R v Threlfall.

Code A Extremely helpful.

(A). Code A to put together info re - case law CIPA etc.

35 Vine Street London EC3N 2AA
Tel +44 (0)20 7861 4000 Fax +44 (0)20 7488 0084 e-mail london@thealliancelaw.com

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Code A - offer to GMC to give evidence (Code A) to clarify issues.

Code A meeting around table.

If there is an issue re - Code A or anyone else at site.

Code A - Give GMC numbers in each category - should be sufficient to suspend. I.O.C. require evidence verbatim & cwrty.

Code A. - No 2 GMC. Bor medical discipline

Code A

Code A possibility present.

Code A - [illegible] numbers. if [illegible] 10-15 etc. for example - only I/IV 2-3 at later stage for solicitor may challenge other grants [illegible].

NN - meeting to establish level with GMC. does as concerns. meeting to establish issues [illegible] from Code A

Code A - Pros & Cons re GMC taking Code A to Court

Code A to Code A

[illegible] available 1300 - 1530. 25/2
1500 - onward. 26/2

27/2. Free. with notice.

Mon 1/3 - morning to
2/3 no [illegible]
3/3 morning to [illegible]

35 Vine Street London EC3N 2AA
Tel +44 (0)20 7861 4000 Fax +44 (0)20 7488 0084 e-mail london@thealliancelaw.com

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Code A Nursing & Midwifery Council -- nurses. meeting
Need to take advice -- nurses i.e. [illegible].
(A) - & should they be at same Code A ?
Code A — No. - categorically.

Code A. Ask them what their Code A are.
They will ask what will you give.
They will be dipping within that.

Use Code A as intro meeting (Code A

(A) ML. — Royal Pharmaceutical Society — will be pharmacist

Code A [illegible] CMO

Code A Nothing that will be distributed!

Phase 2.

Code A Need to move quickly on this.
Accepting need to ensure both
a [illegible] [illegible].

Code A Code A - Palliative Care expert.

Code A Other [illegible].
Code A - Take lead from [illegible].

35 Vine Street London EC3N 2AA
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FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Geriatrician + Palliative Care :→

Code A – what do you want from them.

Code A – H P Group. Look at the evidence

Code A – All evidence from GOPS.

Code A – In event of fresh [illegible] allegations. need to do asap

Code A – Toxicology.

(A) Code A will provide [illegible].
Goal to look at 3s.
QA 2s.

Code A – In terms of 3s – [illegible].

Code A – will start 2s.
meeting ~ month or so.
During assessment will pass on any 3s.

2 1s not contact. MC suggest put concerns in writing for consideration.

SFD. [illegible] counsel – Baker case.
OK to be taken.

Code A – Timing crucial. Civil crucial.

35 Vine Street London EC3N 2AA
Tel +44 (0)20 7861 4000 Fax +44 (0)20 7488 0084 e-mail london@thealliancelaw.com

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Discussion re- Press after notification.

Location of next meeting with GMC - at Portland St.

Code A - Go on record by e-mail.

35 Vine Street London EC3N 2AA
Tel +44 (0)20 7861 4000 Fax +44 (0)20 7488 0084 e-mail london@thealliancelaw.com

Other Document Form

Number **Code A**

Title LETTER FROM MR REEVES TO DCC.

(Include source and any document number if relevant)

Receivers instructions urgent action Yes/(No)

Code A

Document registered/indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Statement Code A

Indexed as indicated

( ) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further action no(s)

Indexer

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Mr D.Reeves

Code A

Deputy Chief Constable
Mr I Readhead
12-18 Hulse Road
Southampton
Hants
SO15 2JX

January 29th 2004

Dear Mr Readhead

Thank you for your letter dated the 26th January 2004.

The first paragraph of my letter should have read:
'Thank you for your letter dated 6th January 2004 post dated 9th and received 12th January 2004'. It would be difficult let alone impossible to confirm receipt of a letter so far in the future never the less thank you for pointing that out.

When we had our conversation on September 11th 2003 I was not aware of your position regarding this investigation. Your statement to me regarding that there was not one case to get this into a criminal court did raise concerns and cause considerable distress. I am now more aware of your position regarding this matter and fully understand that you should not have discussed any aspects of the case with me.

It would appear from your correspondence that you think I am trying to back your officers into a corner looking for loop holes in this investigation. You are completely wrong Mr Readhead it was you that created these concerns, I am an honourable man with a great deal of interigity.

Our only interest is for justice to be done and the truth to be ousted; however with this sort of correspondence it does not reassure this family.

Please consider this matter closed.

Yours sincerely

Code A

David Reeves

Have/ Have had
with Nigel Nunn. I do not
intend to write again.

Code A

Copy sent to PSD.

Other Document Form

Number D836

Title LETTER FROM LINDA QUINN GMC 6/2/2004 TO DI NIVEN

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No	Code A
Document registered / indexed as indicated No(s) of actions raised	Code A
Statement readers instructions	Code A
Indexed as indicated No(s) of actions raised	Code A
Examined - further action to be taken	O/M | SIO
Further actions no(s)	Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

In reply please quote Code A

Please address your reply to
Conduct Case Presentation Section, FPD
Fax Code A

6 February 2004

Mr Nigel Niven
Deputy SIO
Western Area Headquarters
12-18 Hulse Road
Southampton
Hampshire
SO15 2JX

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Mr Niven

Dr J Barton

Thank you for your letter of 28 January 2004.

I note your comments regarding the second team of experts, and that it was never your intention for their analysis to have been undertaken by January 2004. You also refer to the minutes of our meeting in September 2003. While you and I both took a note, these notes were never agreed between us as formal minutes and we have not seen each other's notes. It is clear from what you say that I have misunderstood what Mr Watts was expecting to be complete by January 2004. It was my understanding, from what Mr Watts said, that the quality assurance check was to be undertaken in October, and that then a second team would be instructed in respect of certain cases, reporting not before January 2004, at which point the police might wish to interview Dr Barton. I now understand the penultimate paragraph of your letter of 28 January 2004 to be the correct and current position.

Please let me know at any time if you think that a meeting would be of assistance to either of our organisations. For our part, at present, apart from the update you have just supplied, we have no further information beyond that included in my letter of 7 January 2004 and our inquiries are on hold pending conclusion of the police investigations.

Yours sincerely

Code A

Linda Quinn
Conduct Case Presentation Section
Fitness to Practise Directorate
Direct Line: Code A
E-mail address: Code A

Other Document Form

Number 0833

Title COPY LETTER TO MR WILLIAMSON WITH MEDICAL CONSENT RE TENIED

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / (No)	Code A
Document registered / indexed as indicated No(s) of actions raised	Code A
Statement readers instructions	Code A
Indexed as indicated No(s) of actions raised	Code A
Examined - further action to be taken	O/M | SIO
Further actions no(s)	Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Expert Review

Ivy Williamson

No. BJC/53

Date of Birth: Code A

Mrs Williamson was seventy-seven on her admission to Gosport War Memorial Hospital on 3 August 2000.

Mrs Williamson has been admitted to Queen Alexander Hospital in July 2000 after suffering a fall and was found to have large pulmonary metastasis. She was diagnosed as suffering with advanced metastatic malignant melanoma and was informed that her outlook was poor. Since her husband was undergoing bilateral knee amputations at the Royal Haslar Hospital it was decided to transfer them both to the Gosport War Memorial Hospital so they could be together as Mrs Williamson did not have long to live.

Mrs Williamson became breathless towards the end of August 2000 and became pyrexial. She suddenly collapsed on 30 August 2000 and was commenced on small doses of Oramorph. She was prescribed Diamorphine in case she was in pain and distress.

She died on 1 September 2000.

The expert review of this case confirmed that the analgesia, by way of Opioids, together with the sedatives were prescribed in only very small doses and for good indications.

Other Document Form

Number 1832

Title COPY LETTER TO MR WILLIAMSON WITH MEDICAL CONSENT RE RENEW

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / (No)

Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Expert Review

Jack Williamson

No. BJC/54

Date of Birth: Code A

Mr Williamson was aged eighty at the date of his admission to Gosport War Memorial Hospital on 29 August 2000.

His previous history had included ischaemic heart disease and he had suffered for many years with leg ulcers. He had been admitted to hospital on a number of occasions and had had skin grafts taken to improve his legs.

Mr Williamson eventually underwent bilateral below knee amputations on 18 August 2000 following which he was transferred to Gosport War Memorial Hospital for rehabilitation and, moreover, to be with his wife who was there having been diagnosed with cancer.

Prior to his amputation he was on Morphine Sulphate 40mgs twice a day and needing Oramorph 10mgs for breakthrough pain although this was stopped post operatively.

On 31 August 2000 it was noted that his right stump area was sloughing and by 11 September 2000 there was oozing from both stumps. Microbiological testing confirmed MRSA in the wound on 16 September 2000 and consideration was given as to whether to transfer Mr Williamson to the surgical team as Haslar.

On 17 September 2000 Mr Williamson's condition deteriorated and it was considered that he was unlikely to survive much longer. He was commenced on Oramorph 2.5mgs four hourly. Mr Williamson died at 21.55 p.m. on 18 September 2000.

The expert review of this case has confirmed that he was only given very small doses of analgesia appropriately at the correct dose.

Other Document Form

Number D831

COPY LETTER TO HR WALSH WITH MEDICAL CONSENT RE REVIEW

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

	Code A
Document registered / indexed as indicated	Code A
No(s) of actions raised	
Statement readers instructions	Code A
Indexed as indicated	Code A
No(s) of actions raised	
Examined - further action to be taken	O/M / SIO
Further actions no(s)	Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Expert Review

Frank Walsh

No. BJC/50

Date of Birth: Code A

Mr Walsh was eighty-three at the time of his admission to Gosport War Memorial Hospital on 9 June 1994. He was admitted as an emergency from home after deteriorating and suffering from a cerebrovascular accident. On admission Mr Walsh was noted as being vague and slow to respond. He had a poor appetite and needed assistance with his mobility. On 9 June 1994 he was noted as being incontinent of both urine and faeces.

On 13 June 1994, when being taken to the bathroom for a wash, Mr Walsh collapsed before he could be put in to the bath and was returned to his bed. Although he was apyrexial on examination he died the following day.

The expert review of this case noted nothing suspicious and no evidence of misprescribing.

Other Document Form

Number 1830

Title COPY LETTER TO MRS TUFNELL WITH MEDICAL CONSENT RE REVIEW

(Include source and any document number if relevant)

Receivers instructions urgent action Yes (No)

Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Code A

Indexed as indicated

No(s) of actions raised

Indexer

Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Expert Review

Ellen Baker

No. BJC/06

Date of Birth: Code A

Mrs Baker was eighty at the time of her admission to Gosport War Memorial Hospital on 7 November 1990.

She had a previous history of epilepsy, osteoarthritis and ischaemic heart disease.

Mrs Baker was admitted from home under the care of Dr Peters. The referral noted that Mrs Baker had a venous ulcer on her left leg and the nurse was to continue dressings.

On admission she was noted to have three episodes of angina which was reduced by use of GTN.

Mrs Baker continued to deteriorate on 8 November 1990 complaining of chest pain and profuse sweating. She was seen by Dr Peters and prescribed 5mgs of Diamorphine intravenously.

Despite this medication and continued oxygen therapy there was no improvement in her condition and she died the following morning at 10.35 a.m.

The expert opinion is that the death was consistent with acute myocardial infarction which was treated appropriately. Part of that treatment included a small dose of Diamorphine which was therapeutically indicated.

Other Document Form

Number D829

Title COPY LETTER TO MR THOMPSON WITH MEDICAL CONSENT RE REVIEW

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Statement Code A

Indexed as indicated

No(s) of actions raised

Indexer Code A

Examined - further action to be taken	O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Expert Review

Hubert Clarke

No. BJC/10

Date of Birth: Code A

Mr Clarke was ninety-four when he was admitted to Gosport War Memorial Hospital on 5 June 2000.

His previous medical history had included angina and a history of transient ischaemic attacks ("TIA").

Prior to admission Mr Clarke, who was a widower, lived alone; he had two daughters one of whom would help cook and clean. He coped well but was admitted to hospital on 5 June 2000 following a fall at home. At the time of admission he was described as unsteady on his feet and very sleepy.

On 6 June 2000 he was found on the floor in the corridor having attempted to walk unsupervised and a question was raised at the time whether he would need a placement due to the fall.

On 9 June 2000 Mr Clarke became breathless and restless and was diagnosed with pneumonia.

By 12 June 2000 he was deteriorating and was prescribed subcutaneous Diamorphine 5mgs every four hours.

By 15 June 2000 the Diamorphine was being given via a syringe driver at a dose of 5mgs over twenty-four hours.

Mr Clarke died on 17 June 2000.

The expert review of this case confirmed that Mr Clarke was managed with very small doses of drugs including Diamorphine. The prescribing was within fixed doses and demonstrated good management prior to his natural death. In short he was well looked after with good use of medication.

Other Document Form

Number 9828

e COPY LETTER TO MRS RHODES WITH CONSENT FORM RE RENIEW

clude source and any document number if relevant)

eceivers instructions urgent action Yes / No

Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken	O/M	SIO
Further actions no(s)	Indexer	

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Expert Review

Eileen Hillier

No. BJC/25

Date of Birth: Code A

Miss Hillier was admitted to Gosport War Memorial Hospital on 23 May 1995. She was aged seventy-six at the time of admission. She was a retired French teacher and lived in her own home.

She was treated in January 1995 for psychotic depression with electro convulsive therapy and discharged in March 1995.

Her previous medical history included carcinoma of the breast for which she had undergone a mastectomy and radiotherapy. Although she had no recurrence of her carcinoma she had developed post radiation damage to her chest wall with a discharging sinus.

Following admission in May 1995 care plans were commenced for poor diet and food intake, low mood and treatment of the sinus.

During her inpatient stay she had several falls, one of which required sutures to a scalp injury. At this time her mood fluctuated, the clinical notes recording at times that Miss Hillier was quite bright and at others "still low".

On 28 July 1995 there was a significant bleed from the upper sinus on the chest wall during the night. A further dramatic blood loss occurred on 30 July 1995 and at that time a diagnosis was made that the chest wall sinus was eroding into a main blood vessel.

Miss Hillier's clinical condition deteriorated on 31 July 1995 and she was prescribed at that time Diamorphine 10mgs four hourly together with modest doses of Diazepam for agitation.

The expert review of this case noted that Miss Hillier was physically deteriorating and, following the consensus opinion for palliative care, appropriately low doses of opiates were used.

Other Document Form

Number 1827

Title COPY LETTER B MIDFORD MILLERSHIP WITH CONSENT FORM & REVIEW

(Include source and any document number if relevant)

Receivers instructions urgent action Yes (No)	Code A
Document registered / indexed as indicated No(s) of actions raised	Code A
Statement readers instructions	Code A
Indexed as indicated No(s) of actions raised	Code A
Examined - further action to be taken	O/M | SIO
Further actions no(s)	Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Expert Review

Code A

Code A

Date of Birth: **Code A**

Mr Midford-Millership was eighty-two at the date of his admission to Gosport War Memorial Hospital on 8 July 1999.

He had been admitted by his GP to the Royal Haslar Hospital after his wife had been finding it difficult to cope and he was subsequently transferred to Gosport War Memorial Hospital for general nursing care.

Mr Midford-Millership's past medical history included severe chronic obstructive pulmonary disease and congestive cardiac failure.

Whilst being cared for at the hospital he collapsed suddenly on 19 July 1999 by the side of his bed. No injuries were sustained.

On 20 July 1999 he became very breathless and deteriorated suddenly. It was thought that he had suffered either a cerebrovascular accident or a myocardial infarction. He died shortly afterwards.

The expert review of this case has confirmed that there was no evidence of misprescribing to Mr Midford-Millership and, moreover, that he received a reasonable standard of care at Gosport War Memorial Hospital.

Other Document Form

Number D826

Title COPY LETTER TO MRS MATTHEWS WITH MEDICAL CONSENT RE RENEWED

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No	Code A
Document registered / indexed as indicated	Code A
No(s) of actions raised	
Statement readers instructions	Code A
Indexed as indicated	Code A
No(s) of actions raised	
Examined - further action to be taken	O/M / SIO
Further actions no(s)	Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Expert Review

Dorothy Vince

No. BJC/49

Date of Birth: Code A

Mrs Vince was ninety-one at the date of her admission to Gosport War Memorial Hospital on 14 July 1997.

Her past medical history included carcinoma of the uterus, congestive cardiac failure and diverticular disease. She was a non insulin dependent diabetic.

Mrs Vince had been admitted to the Queen Alexander Hospital as an emergency admission, via her GP, suffering from diarrhoea and weight loss. She was transferred to the Gosport War Memorial Hospital for rehabilitation having been diagnosed with diverticular disease following a colonoscopy.

On 18 July 1997 Mrs Vince was reported to be vomiting and complaining of feeling tired and weary. There was a sudden deterioration in her condition and she died at 5.05 a.m.

Although the actual cause of death was not clear at the time she was not being given any analgesia nor was receiving any drugs via a syringe driver.

The expert review of this case did not identify any problems with the management of this case.

Other Document Form

Number 1 9825

Title COPY LETTER TO MRS GRAHAM WITH MEDICAL CONSENT TO BE RENEWED

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Other Document Form

Number D824

Title COPY LETTER TO HRS E/RES WITH MEDICAL CONSENT RE RENEWAL

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No	Code A
Document registered / indexed as indicated	Code A
No(s) of actions raised	
Statement readers instructions	Code A
Indexed as indicated	Code A
(s) of actions raised	
Examined - further action to be taken	O/M | SIO
Further actions no(s)	Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Expert Review

Dorothy Vince

No. BJC/49

Date of Birth: Code A

Mrs Vince was ninety-one at the date of her admission to Gosport War Memorial Hospital on 14 July 1997.

Her past medical history included carcinoma of the uterus, congestive cardiac failure and diverticular disease. She was a non insulin dependent diabetic.

Mrs Vince had been admitted to the Queen Alexander Hospital as an emergency admission, via her GP, suffering from diarrhoea and weight loss. She was transferred to the Gosport War Memorial Hospital for rehabilitation having been diagnosed with diverticular disease following a colonoscopy.

On 18 July 1997 Mrs Vince was reported to be vomiting and complaining of feeling tired and weary. There was a sudden deterioration in her condition and she died at 5.05 a.m.

Although the actual cause of death was not clear at the time she was not being given any analgesia nor was receiving any drugs via a syringe driver.

The expert review of this case did not identify any problems with the management of this case.

Other Document Form

Number J822

Title COPY LETTER TO MR & MRS D ELLIS WITH MEDICAL CONSENT RE REVIEW

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Code A

Indexed as indicated

(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Expert Review

Kathleen Ellis

No. BJC/18

Date of Birth: Code A

Mrs Ellis was transferred to the Gosport War Memorial Hospital on 23 June 1999 from Queen Alexander Hospital where she had initially been admitted on 7 June 1999 as an emergency with acute confusion, cerebrovascular accident and a lower left chest infection.

The transfer to Gosport War Memorial Hospital was for continuing care and assessment.

Mrs Ellis' past medical history included fractures of her fibula and pelvis following falls in 1996 and 1997.

On admission Mrs Ellis was noted as being confused but compliant and, moreover, did not appear to be in any pain.

According to the notes at the time of transfer, Mrs Ellis was immobile, using a hoist for transfers. It was noted that she takes little diet and had a leg wound on her left leg. She was also noted as having dementia, a chest infection and was dehydrated.

Mrs Ellis had severely impaired swallowing and had been deteriorating for several months. With her further chest infection she was unable to swallow antibiotics and was kept on subcutaneous fluids. A nasogastric tube was attempted to be placed unsuccessfully on four occasions.

On 5 July 1999 Mrs Ellis died at 6.15 a.m.

The expert review concluded that she probably died of recurrent aspiration pneumonia. The care provided to Mrs Ellis was of a good standard.

Other Document Form

Number D821

Title COPY LETTER TO M EARL WITH MEDICAL CONSENT RE REVIEW

(Include source and any document number if relevant)

Receivers instructions urgent action Yes (No)

Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Expert Review

Mary German

No. BJC/19

Date of Birth: Code A

Mrs German was admitted to Gosport War Memorial Hospital on 28 November 1998. Mrs German had previously been diagnosed as suffering from carcinoma of the lung and had a secondary deposit in her spine.

At the time of admission she was already receiving Morphine, Diclofenac and Carbamazepine to treat a mixture of lung, bone and neuropathic pain. She had been admitted from St Mary's General Hospital following a course of radiotherapy. She was admitted for palliative care and received a comprehensive nursing assessment.

By 30 November 1998 Mrs German was noted as being confused as well as breathless which continued.

On 2 December 1998 Mrs German became increasingly short of breath although she denied any pain or discomfort. She died on 3 December 1998.

The expert review noted she was described an appropriate dose of Diamorphine having previously received a carefully calibrated dose of Oramorph. Conversion from Oramorph to Diamorphine via a syringe driver was undertaken in an appropriate manner.

Other Document Form

Number 1820

COPY LETTER TO MR CLIFFORD WITH MEDICAL CONSENT RE RENIELD

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Expert Review

Alice Clifford

No. BJC/11

Date of Birth: Code A

Mrs Clifford was ninety-six at the date of her admission to Gosport War Memorial Hospital.

Prior to her admission she was living at Warren Park Rest Home and was fully dependent on nursing care.

She was noted to have Type II diabetes and a catheter in situ.

The reason for admission to hospital on 14 July 1998 was to provide rehabilitation following an arthroscopic washout of septic arthritis. On admission Mrs Clifford was noted to having a necrotic area on her left calf together with necrotic right and left heels. On 15 July 1998 she was noted to be in discomfort when moved and was given Oramorph. By 18 July 1998 Mrs Clifford was recorded as being in increasing pain and was given Diamorphine 20mgs for pain management.

The notes record clear evidence of severe and increasing pain and Mrs Clifford was commenced on a syringe driver with 60mgs of Diamorphine on 20 July 1998.

On 21 July 1998 Mrs Clifford deteriorated rapidly. She was noted as being comfortable and free of pain prior to her death.

The expert review of this case noted that there was clear evidence of increasing doses of rescue analgesia where pain was not being controlled. A sensible and appropriate increase in syringe driver doses of Diamorphine were utilised. In summary this was a natural death which was appropriately managed and good clinical notes were made to record the progress of the treatment given to this patient.

Other Document Form

Number D819

Title COPY LETTER TO M BULBECK WITH MEDICAL CONSENT RE REVIEW

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Expert Review

Dulcie Middleton

No. BJC/33

Date of Birth: Code A

Mrs Middleton was eighty-six at the time of her admission to Gosport War Memorial Hospital on 15 August 2001.

Mrs Middleton died on 2 September 2001 in Petersfield Hospital under the care of Dr Varden.

Her past medical history had included left ventricular failure, angina, together with a dense stroke which required her to be fed through a gastrostomy feeding tube which was inserted on 31 July 2001.

Unfortunately, subsequent to the insertion of the tube, Mrs Middleton developed abdominal pain and vomiting. A possible abdominal obstruction was diagnosed and Mrs Middleton was commenced on Diamorphine which was 2.5-5mgs as required. This dose was increased when the pain was more severe and Midazolam was added when Mrs Middleton became agitated and distressed.

The expert review of this case confirms that Mrs Middleton was very unwell and was made comfortable with small amounts of analgesia which was gradually increased appropriately.

Other Document Form

Number D809

Title LETTER FROM MR READHEAD TO MR REEVES 26/1/04

(Include source and any document number if relevant)

Receivers instructions urgent action Yes/No

Code A

Document registered/indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further action no(s)

Indexer

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Hampshire Constabulary
Police Headquarters
West Hill
WINCHESTER
Hampshire
S022 5DB

Tel: 0845 045 45 45
Fax: 01962 871189

I.R Readhead LL.B
Deputy Chief Constable

Your Ref:
Our Ref: Code A

Date: 26th January, 2004.

Mr. Reeves

Code A

Dear Mr. Reeves,

Thank you for your letter dated 15th January, 2004. So that there is no ambiguity between us, let me make my position very clear to you. For the purposes of this letter, I would hope that we can correct any issues. So if I can start by saying that I assume in your correspondence to me, your first line is incorrect in that the letter that I sent to you on 6th January, 2004 arrived at your home on 12th January and not 12th November as you state.

My memory regarding the conversation with you is very clear and not failing as you suggest. My return call to you on 11th November was made by my PA to your home. The connection to me was on a mobile telephone. I was driving my car at that time from Portsmouth along the M27 and up Portsdown Hill. We had a very lengthy conversation. It does not surprise me that there would have been delays in me responding to some of your questions because I am aware how sensitive a number of the families are to anything that we say in respect of this investigation. Having said this, I do not recall if there was an 8 second delay in response to one of your questions put to me but find it somewhat surprising that you appear to have used a stopwatch during what was a conversation on an extremely complex case. Whatever the issue may have been on the time delay I have never sought to avoid trying to answer the issues that I thought were the priority with you on the day on which you called me. My letter of 20th November is an attempt to summarise what I thought were the key issues, which were about the length of time taken for the investigation and the issue of DVDs. I would also remind you that you spent quite a considerable length of time telling me how ill your wife had been over this matter and the ramifications for all of your family as you approached the Christmas period. It was for that reason that I focused on such issues in my third paragraph to you. Your letter of 10th December, 2003 puts the focus on the issue of statements and also what I had said at the meeting of 11th September, 2003, that 'we did not have one case strong enough to get into a criminal court'. I do not think there is any ambiguity between this statement and what has been said by Detective Chief Superintendent Watts. At the time that the question was asked there was not sufficient evidence to bring any single case to a criminal Court. This does not mean that cases will not be taken to Court in the future, or that they will. It will be a matter for the Crown Prosecution Service to determine when we have all the evidence and it is presented to them if there is sufficient evidence to proceed with a criminal case. At this moment in time we have

not reached such a phase in the investigation. I believe that the latest Newsletter to all relatives fully explains this position.

In order to clarify some other issues, I accept that my last letter to you contained two inaccuracies. Firstly, I had been advised that prior to the telephone conversation that you had with me you had also had a discussion with Detective Inspector Niven. I now understand that this is not correct, but that you spoke to him after you had the discussion with me. It is true, however, to say that you had a conversation with Owen Kenny. During that discussion you raised a number of issues, including why we had not taken any cases to Court, why we were using Field, Fisher Waterhouse, as opposed to the CPS, the role of our Family Liaison Officer, the Haslar notes, keeping family group members advised, and finally the stress that you and your wife were under having been fighting the case for four years and the unhappiness that you had on having to wait so long. My point was that I do not think it is in the interests of the investigation for family group members to keep contacting a number of officers and debating the same issues. It is for that reason that I think it is important for us to have an agreed communication process into the organisation so that you get a consistent picture. Finally, I also accept that I used the word Counsel in my letter to you and by that I meant Field, Fisher Waterhouse who of course are solicitors. I do hope that this sets the record straight. Future correspondence received will be routed to Detective Inspector Niven as discussed above, or to Chief Superintendent Stevens if it involves the complaint issue concerning Chief Superintendent James.

Yours sincerely,

I.R. Readhead
Deputy Chief Constable

Other Document Form

Number 1801

Title UNUSED NOTED DC ROBINSON – MRS MACKENZIE 13/1/04

(Include source and any document number if relevant)

Receivers instructions urgent action Yes (No)

Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Statement Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A 10.06

HAMPSHIRE CONSTABULARY

MG11C

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

RESTRICTED

Page No. :

Continuation of Statement of :
13/1/04

Tuesday 13th 10-00 Mrs M. Forst hasn't seen key
haematoma - how is it dealt with .
evidence - not in file
- not w
- not

Interdisciplinary PHCT - refer haematoma.
How dealt
No evid M/F
family told Haslar
- no evidence looked at
- don't treat with antibiotics
- drain it - under local - crucial part of evidence.
- tell family suspect not aware if natural

Signed : Signature witnessed by :

RESTRICTED

Other Document Form

Number 3800

Title UNUSED NOTES DC ROBINSON - MRS MACKENZIE

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No	Code A
Document registered / indexed as indicated No(s) of actions raised	Code A
Statement readers instructions	Code A
Indexed as indicated No(s) of actions raised	Code A
Examined - further action to be taken	O/M | SIO
Further actions no(s)	Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

16/11/04

11.40

Whole Hole File

Investigation P.A.C.T. Mr. Millet. —

Roy Burt - Diamorphine. - no mention in medical file.
- reiterate previous conversation

18/8/
21/8 - not treated.

Burton:

- 17 > Grant - disc hip

18 - See Philip Beed - relatives
morphine ... pain free death.

agree -

couldn't have ... treated
couldn't have

... are same

Hospital file not there. -

29/7/ - 11/8 August } Details
14/8 - 17/8 August } of

Syringe Driver set up because family ... diamorphine.

Mr. ... - disappointed - ... same are Case 7 Counsel.

Concerns

When interview me. very careful what say.

12-00

-10 Inform Mr Wabby - had spoke to Dr Robson 2 days
- Some concern re Prof Fawcett.
- prepared to go to Meridian - any helpful notes of team

10hrs : Re > Mrs McK. Murder and will get sent down to Council

Shipman report - blame put on DI Shelmerdine Head of department

responsible for team - will defend DC & DI

FLO - not investigate

Other Document Form

Number D779

Title FAX COPY NOTES OF ANNE NAYSMITH - FIRST 62 CASES

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OPERATION ROCHESTER

Report summarising screening assessment of first 61 cases analysed

This report is compiled from the annotations made during the initial screening of each case. No subsequent editing or amendment is included in this report. However, it should be noted that only the first 20 cases were screened truly blind. In assessing the first 20, I applied the same standards as I would to my own practice, ie that of an experienced medical practitioner in the specialty of palliative medicine. It is my personal belief that excellent clinical practice, ie the best possible decision making given the clinical information available and the patient's preferences, should be the same in all settings, whether specialist or generalist.

However, during the conference after the screening of the first 20 cases it was made clear to me that I was setting an unrealistically high standard for practice in a rehabilitation/continuing care setting. My assessments of all subsequent cases were influenced, therefore, by the views of the other members of the clinical team. There will not be complete consistency in my assessments between the first 20 cases and the subsequent ones.

The screening matrix used for scoring in all cases was as follows:

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B				
Unexplained By Illness C				

In each case the screening assessment was made contemporaneously with the study of that case record. It was not made retrospectively at a later date from my handwritten notes, although they informed my judgement by summarising the important points I abstracted when going through each record.

The following table brings together the assessment notes made on each patient and my own screening assessment score, prior to discussion with other members of the clinical team.

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/01A	Abbott, Victor	Very brief admission – admitted one day and died at 0500 hours the next. Admission diagnosis was chest infection and mild heart failure. Noted to be cyanosed by the nursing staff when they put him to bed at 21:20 on the day of admission – and they then administered the Temazepam 10mg apparently written up for him. NO DRUG CHART WITH THE NOTES RECORDED. So unable to comment on whether any drug written up or administered might have contributed to the apparently sudden development of cyanosis and/or subsequent death.	B2
BJC/02	Amey, Denis	Admitted for terminal care (long term) because wife no longer able to cope. Very severe Parkinson's. Had long term catheter. Treated with Septrin for presumed UTI but then developed pyuria and oliguria, succeeded by scrotal gangrene. Surgical opinion requested but in view of very severe Parkinson's surgery not offered (not clear whether thought unsafe or just inappropriate). Managed with opioid pain relief, apparently by diamorphine via syringe driver. At one point from notes was on 120mg diamorphine/day. NO DRUG CHART IN NOTES RECORDED. It is therefore unclear, and cannot be determined from the evidence available to me at this time, whether the doses of diamorphine administered were escalated only in response to uncontrolled pain and indeed what those doses were.	B2
BJC/03	Attree, Lily N168	Although earlier admissions had been to the geriatric wards, the final admission was to Sultan, the GP Unit, and management was shared by a number of the GPs from her own practice. She was terminally ill with an extremely advanced malignancy and difficulty swallowing. The drug chart records that less oral morphine was given than the GP thought had been prescribed (comparing the written notes with the drug chart) and when she became unable to swallow, the conversion to diamorphine was probably to too high a dose. It is possible that this accelerated death by some days, but probably no more, and as the management was shared by several doctors it seems unlikely there was intent to harm – it seems more a matter of being unskilled in the management of pain in advanced cancer in a confused and demented patient whose pain would be very difficult to assess. And there seems to have been a medical expectation that a lady with a tumour of the extent seen on the CT scan would be bound to have pain, and a concern to treat it even if she were unable verbally to report it because of her dementia and primary oral cancer.	A2
BJC/04	Aubrey, Edith N302	End stage dementia, probably vascular, with a previous history of schizophrenia, for which all medication had been stopped because family members were very keen that she not be sedated in any way. Extremely difficult to nurse – agitated and fighting when nurses attempted to give care – described as " a danger to herself and her attendants" (though not clear that she would actually have been strong enough to hurt a nurse other than, possibly, biting). Given transdermal fentanyl explicitly "to calm her" and dose progressively escalated. Also given very small doses, probably inappropriately small, of diazepam.	C3

Exhibit No	Patient Identification	Assessment Note	Assessment score
		Dr Barton the prescriber but notes explicit that "Dr Lord aware". Letter of complaint from one daughter (described as always having been difficult by her siblings). Response from CEO explicitly states that "Dr Lord felt she was in the last days of her life" and "Dr Lord does not practise euthanasia". But I was not clear from the notes that this lady's dementia was end stage, nor that her death was actually from dementia. She had Barthels of 0 and MMTs of 0, but that seemed to be relatively long standing.	
BJC/05	Aubrey, Henry N303	Terminally ill on admission with ca lung. Rattly cough described before leaving Haslar, which is never a good prognostic sign. Breathlessness was main symptom. Had been on low dose opioids in Haslar, apparently with benefit, but these appear not to have been continued to the date of transfer, or at least they are not listed on the transfer letter. Was immediately started on high dose opioid – fentanyl on the day of admission, then high dose diamorphine and midazolam the following morning. Even given that his distress on the morning of 2.6 was agonal, and not related either to opioid toxicity or a reversible chest infection, management was with excessive doses of diamorphine and midazolam. Even had fentanyl 25mcg been an appropriate starting point (which is questionable given his previously low intake) it would have just reached saturation point probably by the following morning and would have remained in his system after removal (assuming it was removed – not mentioned in medical or nursing notes) for 13-17 hours. To change to diamorphine 60mg/24 hours (which is 50% more in equivalent dosage) with no allowance for washout would have meant effectively a higher level of opioid during the day of death. And midazolam 40mg/24 hours is a very high starting dose which, because no loading dose was given, should theoretically have taken about 10 hours to reach steady state. In fact, he was unresponsive in a little more than 2 hours, suggesting these doses were excessive. They may have accelerated death, though probably only by days to a week or two.	B3
BJC/06	Baker, Ellen N161	Frequent episodes of angina. Had acute onset chest pain with breathlessness and wheeze. GP diagnosed LVF secondary to MI and managed it entirely appropriately with IV diamorphine 5mg, oxygen and Nebulised salbutamol, but she died despite his best efforts.	A1
BJC/06A	Batty, Charles N364	On coproxamol regularly for a period of years for generalised pain, not clear where, though recurrent fungal infections of the groins and scrotum appeared to be part of it and also, latterly, had pressure area problems. As soon as he began to complain of generalised pain he was started on Oramorph and the dose escalated, then when he had difficulty swallowing changed to syringe driver with a further dose escalation. Clearly difficult to assess his pain because of his dementia. But it did not appear that his	C2

Exhibit No	Patient Identification	Assessment Note	Assessment score
		condition was deteriorating prior to starting opioids.	
BJC/06B	Brickwood, Dennis N69	Patient was being actively prepared for discharge against his and his family's will (because they did not wish to pay for residential care) when he developed a chest infection which did not respond to antibiotics, despite a change of antibiotic. Opioids not started until he was failing on the second antibiotic. Clear complaints of pain from the patient. Excellent reasons for pain (vertebral fractures and cracked rib). My quibble is with the speed at which the dose of morphine/diamorphine was escalated and the large amount of hyoscine and midazolam added to the syringe driver. But I suspect death was accelerated little if at all – the doses were just a little unnecessary.	A2
BJC/07	Carby, Stanley N209	Patient experienced what was clinically felt to be extension of an already dense CVA. Blood glucose checked and OK. Although syringe driver set up with inappropriately high doses of diamorphine and midazolam (40mg of each) he died 45 minutes later. He therefore could not have received more than 1.25mg of each drug, not enough to have influenced his survival. He might well have received less, since he had a BP of 90/60 and was peripherally cyanosed, slowing the rate of absorption from the subcutaneous route. Although the notes record that Dr Lord recommended a stat of midazolam 2.5mg earlier in the morning, I cannot see evidence in the drug chart that that was actually given. Even if it were, the total midazolam dosage would not have exceeded 3.75mg and it has a short half life, so the earlier 2.5mg, if it were given, would have been metabolised before the syringe driver was set up. This appears to have been an entirely natural death.	A2
BJC/08	Carter, Edwin N319	This man died of progressive cancer of the stomach. He had pain both from this and from Paget's disease of the right hemipelvis. His pain was well and sensibly managed throughout most of his illness, with a syringe driver initially while he was vomiting, then transferred to MST 20mg, subsequently increased to 30mg BD because of incomplete pain control. But he was documented as awake and mobile, within his limits, on these doses and latterly as being well pain controlled. When he deteriorated at the end of his life and could not swallow, he was transferred to a syringe driver for the last 48 hours. But the opioid dose was massively increased at the time of the transfer – it was initially quadrupled, and then, because he was in pain on movement, a further (probably sensible) increase of 25% was made. I cannot see why such doses should have been given except to ease his passing. However, he was already so close to death that I doubt it made a significant difference to the	A4

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		sublingual route would have been available, and small doses could have been titrated to response. I note the coincidence in time between starting the midazolam and the deterioration in her condition which occurred between 13.8.99 and 16.8.99. On the day of her death I can see no indication that she reported pain. I am therefore at a loss as to why diamorphine 20mg, a high dose in a frail, completely opioid naive lady, was started on that date. I suspect that the combined medication may have accelerated her inevitable death.	
BJC/14	Cresdee, Ronald N165	Management in the GP ward by a group of GPs. Patient had pain from advanced ca bronchus and was clearly dying – reviewed by consultant in palliative medicine and felt to have no specialist palliative care needs (recommended nursing home). Initially morphine was progressively increased. Possibly developed morphine toxicity after a dose increase, though still at modest dose level. This possibility seems not to have been considered. Increasing agitation, hallucinations and deterioration then managed with sedation and markedly increased diamorphine. Impossible to tell from the notes whether diamorphine was being used as a sedative, or whether the GPs worried that underlying pain which the semi-conscious patient could no longer report was a cause of the agitation. Inevitable death from advanced cancer may have been marginally accelerated by excessive opioid dosages but hard to tell.	A2
BJC/15	Cunningham, Arthur N4	Steady deterioration in function during his psycho-geriatric admission and between discharge to nursing home and readmission to Dryad. Not likely to have been reversible. He would have died of his disease in a short time. Had an element of dementia, probably Lewy body, and hence very disturbed and challenging behaviour, which nurses found distressing. He clearly had pain when admitted to Dryad. This is likely to be a mixture of bone pain (from his old injuries compounded by stiffness and immobility) and pressure sore. Neither, the latter particularly, is very responsive to opioids. Granted he had a history of renal problems and Myelodysplasia, but he could at least have been given paracetamol. No palliative care advice was sought, given the difficulties of his multiple pathologies. And his pain seemed incompletely controlled on movement at the initial S/D doses. But the doses of diamorphine and midazolam were rapidly and progressively increased to levels which I would consider high, particularly for someone who was essentially opioid naive. And the very high doses of hyoscine hydrobromide given for his bubbly chest might well have produced agitation and hallucinations.	B4

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		I am worried that the dose escalations might have been intended to prevent him from "lingering", although there is nothing in the notes specifically to support that suspicion. And I certainly find it disquieting that, to the family, diamorphine 20mg and midazolam 20mg over 24 hours were described as "small" doses – I would not expect ever to start at that level of midazolam and often never need to use doses as high as that.	
BJC/16	Devine, Elsie N270	This lady had dementia with difficult behaviour, possibly exacerbated by moving from one hospital to another and the absence of her daughter (whose husband was undergoing BMT in London). She was reviewed by a psychogeriatrician who knew her, and who felt her physical condition was unchanged, although her behaviour had deteriorated (note says "again", suggesting it had initially been difficult in the acute setting but had then improved). But on the same day, with no mention of any pain and no clear pathology likely to give pain, she was started on a fentanyl patch 25mcg/hr. I can find no sign in her drug charts she had been having any other analgesia at all. By the following day she had markedly deteriorated and was started on a syringe driver containing diamorphine 40mg and midazolam 40mg. This was continued until she died. I cannot see a reason in the notes for her to be given high dose opioids or benzodiazepines. I am concerned that she did not have a short prognosis from her underlying pathologies – although her creatinine was rising it was only doing so slowly and her peripheral oedema was disabling rather than life-threatening – and that her life seems likely to have been significantly shortened by the administration of these drugs, apparently for the purposes of sedating her.	C4
BJC/17	Dicks, Cyril N308	Appears to have been dying slowly, but in an expected manner, from longstanding dementia complicated by an acute ?cerebrovascular complication in January. He appeared to be in pain, and was certainly agitated, in the later stages and was probably treated with subcutaneous diamorphine and midazolam, according to the nursing note. But no doses are stated (unusually – in other cases the nurses have written the doses in their notes) and at present I cannot trace an administration record in the drug charts to show that the drugs were ever given, or in what dose. I am sure he would have died, no matter how well he was cared for. It is possible that his death was marginally accelerated by sedation, but I cannot at present adduce any hard evidence for that.	A2

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/18	Ellis, Kathleen N252	Advanced dementia with severely impaired swallowing. Had been deteriorating for several months, more so for 6-8 weeks since she fractured her humerus in a fall. Developed further chest infection. Unable to swallow antibiotics, had few doses. Kept on SC fluids. Probably died of recurrent aspiration pneumonia. Had no drugs at all. No evidence of any sub-optimal care.	A1
BJC/19	German, Mary N248	Already on morphine, diclofenac and carbamazepine on admission for a mixture of primary lung, bone and neuropathic pain. Required several rescue doses, especially at night. Deteriorated with increased secretions. S/D translated straight across from oral requirement to diamorphine equivalent, low dose hyoscine added for secretions. No sedation at all because she was not agitated. Died peacefully.	A1
BJC/20	Graham, Leonard N242	Sudden collapse, typical of MI or PE (clinically more like the latter). Had coroner's pm, which did not show either – only some pus in bronchioles and kidneys. Had diamorphine 2.5mg SC stat when he collapsed because he was agitated and distressed, but clearly agonal at that time (no measurable BP, unresponsive, grey). No other opioids or sedatives.	A1
BJC/21	Gregory, Sheila N238	Acute on chronic confusion precipitated by #NOF. Given regular thioridazine, which probably slightly over-sedated her. Then seems to have developed a chest infection, became generally less well, then breathless and distressed. Nausea a problem. Given oramorph for breathlessness (also had variable bits of discomfort from OA and osteoporosis) which worked well, so converted to regular and then diamorphine + cyclizine in S/D. No sedation added. I would quibble with the initial thioridazine dose (15mg BD seems a lot at 91) and with the initial regular oramorph dose (30mg/day probably at least twice as much as she needed). Then syringe driver conversion was done with an increase – from oramorph 30mg/day to diamorphine 20mg/24hours ie the equivalent of oramorph 80mg/day – which does not seem necessary from the nursing notes.	A2
BJC/22	Hadley, Harry N299	Terminally ill with cancer. Wanted to die. Complaining of generalised discomfort. Not clear why Haslar had stopped his MST, on which he was comfortable when assessed by Bee Wee. MST was restarted but only for 48 hours. Not using rescue oramorph to make him comfortable. Appears that because he c/o severe generalised discomfort was started on high dose S/D. Then became clinically opioid toxic, which added to his distress. This was detected by one GP, who dropped the dose and sensibly switched from cyclizine to levomepromazine, but these changes were promptly reversed by a	A2

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		colleague who increased the dose still further. Death may have been marginally hastened by rapid escalation of opioids and certainly made less comfortable by opioid toxicity. Multiple doctors involved. No suggestion at all that there was any intent to hasten death; just inexpert.	
BJC/23	Hall, Charles NJ260	Very frail and terminally ill when transferred to Daedalus. Poor prognosis had already been discussed prior to transfer. Given a single dose of oramorph 10mg. This relieved symptoms and made him comfortable. If he were not in renal failure, the diamorphine equivalent would have been 20mg/24hrs. Since he was, he probably only needed 10mg/24hrs. In fact was given diamorphine 40mg/24hrs as starting dose, and died within 24 hours. Nothing to suggest intent, only that there was a lack of understanding of how to go from oral to SC and how to allow for the effect of his renal failure.	A2
BJC/24	Hall, Nora NJ71	Excellent palliative care throughout. Frequent consultation with Countess Mountbatten House and reviewed by Bee Wee. Cared for by GPs in Sultan Ward throughout.	A1
BJC/25	Hillier, Eileen NJ43	Brief terminal phase so stayed on Mulberry Ward (psychogeriatric). Old ca breast (1962) with massive chest wall damage from RT. Severe haemorrhage recurrently from chronic chest wall sinus ?eroding into main blood vessel. Kept comfortable with modest doses of diamorphine. No syringe driver (though they would – appropriately – have liked to put one up). Modest IM diazepam doses for agitation – had major agitated depression in any case.	A1
BJC/26	Hobday, Alan N366	Written up for diamorphine soon after admission – not clear why, but not needed and not given. Looks as if there were an expectation that he would die, although he seemed to be at least stable, and possibly improving, from his CVA. Extended his CVA on 7.9.98 with fits. Immediately put on a substantial diamorphine dose in S/D. Midazolam also given but that was logical and appropriate because he was having multiple fits, was unable to take an oral anti-epileptic and IV access was not available in GWMH.	A2
BJC/27	Hooper, Albert N335	Very old, frail man with multiple pathologies including recurrent anaemia – felt too ill to go back to QAH for transfusion and had not greatly helped before	A1

Exhibit No	Patient Identification	Assessment Note	Assessment score
		Longstanding COPD requiring oxygen continuously. Developed chest infection. Treated symptomatically only in view of deteriorating general condition, initially with hyoscine only, then as he c/o pain not relieved by paracetamol given diamorphine 10mg + midazolam 10mg. Doses doubled on day of death because not comfortable being suctioned. Very reasonable care under the overall circumstances. Consultant Dr Reid. Locum Staff Physician who wrote excellent clerking and notes.	
BJC/28	Houghton, Clifford N253.	Steadily deteriorating as a result of cerebro-vascular disease. Emergency readmission to GWMH with TIAs. Became dyspnoeic and distressed. Started syringe driver with midazolam 40mg/24hours on the day before death, when he was already in major deterioration. On the day of death added hyoscine and high dose diamorphine but no stat dose, diamorphine increased when effect not immediately apparent. Times approximate, because notes do not state when Dr Peters visited, but probably had diamorphine 5mg before 11am, 5mg stat at 11am and then about another 20mg by the time of death, equivalent to morphine 180mg/24 hours or 30mg 4 hourly as a starting dose. When added to the high dose midazolam (equivalent to about 160mg diazepam/24 hours) this was major sedation. But he was clearly in the terminal phase of his life already.	A2
BJC/29	Jarman, Thomas N147	Terminally ill with hairy cell leukaemia. Already elderly and frail; living in residential care. Had an episode of sepsis with marked fall in BP. Presumably suffered permanent brain damage; hemiparesis resolved but left non-communicative and very confused, with severe functional impairment, which did not improve. Always tended to cry out a lot, especially at night. This was interpreted it seems as distress, initially noted as "distressed at inability to sleep" but then seems to have been interpreted as pain. In fact, seems previously to have had little pain, needing only occasional paracetamol, and probably ill, confused and distressed emotionally rather than in physical pain. But did not settle with high dose midazolam alone (20mg/24 hours) so given high and escalating doses of diamorphine. Then became unresponsive and looked peaceful, so was felt to be pain free. No evidence of any intent other than to make him comfortable in the terminal phase.	A2
BJC/30	Lavender, Elsie	Elderly diabetic, blind but previously independent with minimal community support. Probable brain stem stroke resulting in fall downstairs. Pain in back, shoulders and arms on movement – shoulders and arms.	B3
	N332	Xrayed but not back – NAD for age. While in acute care had virtually no analgesia and was beginning to	

Exhibit No	Patient Identification	Assessment Note	Assessment score
		mobilise with physio, though still needing 2 to transfer. Sent to GWMH for rehab. Eventual destination unclear – residential care considered. Had long standing stress incontinence. This was severe on admission to GWMH and was catheterised on admission for its management – then tested urine and found had a UTI, started Trimethoprim but unlikely to clear in the presence of a catheter. Complaints of pain on movement over the first few days. Prescribed dihydrocodeine 60mg PRN. Seems only to have had about 1 dose a day. Described as ineffectual but the paracetamol also prescribed was never given, and dihydrocodeine never given regularly, so impossible to assess. Likely to have been musculo-skeletal pain. Never seem to have considered regular paracetamol, a trial of ibuprofen, TENS or any alternative measures to opioids for what was likely to be relatively opioid-unresponsive pain. Changed from PRN dihydrocodeine to MST 10mg BD and titrated up to 30mg BD. On at least one occasion was given MST 10mg as rescue analgesia prior to movement, so fundamental failure to appreciate pharmacokinetics of morphine SR. No rescue morphine prescribed. Titration of MST based on patient's continued complaints of pain and use of rescue analgesia – presumably dihydrocodeine – so sensible. Bad night on 4.3.96, so changed to syringe driver. Described as "not eating or drinking" – but having substantial morphine doses so may well have been sedated, nauseated and anorexic! Changed to diamorphine 100mg, ie equivalent to MST 150mg BD! And given midazolam 40mg! No note explaining why sedation was felt necessary, nor why there was such an extreme increase in opioid dose.	
BJC/31	Lee, Catherine N284	Severe dementia. Transferred for rehab after NOF. Had needed no analgesia in 24 hours prior to transfer. Started on oramorph 5mg 4 hourly from day of admission ?why. Increasingly sleepy, agitated and apparently distressed. Ate and drank less and less as became more sedated. Given diazepam as well for 2 days. Also given Fentanyl 25mcg/hour as well for 3 days. Oramorph progressively titrated upwards then changed to syringe driver. Change was actually at equivalent dose (oramorph 60mg/24 hours changed to diamorphine 20mg) but midazolam 40mg added!	B3
BJC/32	Martin, Stanley N328	Very well known to the ward. Admission shortly before death with severe breathing difficulties, probably mixture of CCF and infection. Became anuric. Given single dose of diamorphine 5mg IM to relieve dyspnoea but died 20 minutes later so probably absorbed little if any of it.	A1
BJC/33	Middleton, Dulcie N310	Note this patient died in Petersfield Hospital under Dr Vardon, although she had previously been in	A1

Exhibit No	Patient Identification	Assessment Note	Assessment score
		Daedalus Ward GWMH for rehab post stroke. Had undiagnosed intra-abdominal catastrophe, with pseudo-obstruction, abdominal distension and abdominal pain. Also had angina and LVF. PEG and SC fluids only; oral route not available. Also had aspiration pneumonia with white out of right lung. Very frail; on continuous oxygen. Begun on diamorphine 2.5-5mg PRN; in fact nurses chose to start at 5mg. Had 1 or 2 doses most days, ie 10mg diamorphine. When pain more severe and continuous S/D with diamorphine 20mg very reasonable. Required 5mg breakthrough 3 days later so increased to 30mg diamorphine and midazolam 20mg added because agitated and distressed. High dose of midazolam but no range.	
BJC/34	Packman, Geoffrey N346	Had some form of intra-abdominal lesion which bled while on Clexane and continued to bleed even after it was stopped. Multiple pathology and morbid obesity, would not have been fit for surgery under any circumstances. No very active measures taken to resuscitate him (no blood transfusion etc) but given that the bleeding did not stop even after his BP presumably fell somewhat, blood transfusion would probably have been futile. Poor pre-morbid state, horrible photographs of his pressure sores and ulcerated legs.	A1
BJC/35	Page, Eva A2	Dying of lung cancer. Transferred to GWMH for palliative care. Confused and agitated, frightened and calling out ?cerebral metastases ?exacerbation of pre-existing cerebro-vascular disease as a result of illness ??pre-terminal agitation. Trial of tranquilisers did not produce improvement so used stat doses of diamorphine and a fentanyl patch mainly for sedation – pain does not seem to have been a feature of the illness. Deteriorated rapidly after fentanyl applied and died the next day, about 12 hours after a syringe driver was set up. Not ideal palliative care. Fentanyl 25mcg would have been much too high a dose to be tolerable for a frail old lady with minimal discomfort. However, it was then translated across into diamorphine without any further increase, indeed with if anything a slight decrease (exact equivalence would probably have been 30mg).	A2
BJC/36	Parr, Gwendoline	Clearly very frail when transferred for gentle rehab – comment ?slightly optimistic on admission. But not expected to die.	A2
	N330		

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/43	Ritchie, John N321	Irrelevant record. Not in Gosport War Memorial. Not under geriatricians. Had heart disease and vascular dementia affecting frontal lobes with psychopathic personality. RTA. Plastic surgery. Had cardiac arrest and could not be resuscitated. Never on opioids. Had risperidone 1mg BD and PRN promazine under psychogeriatric supervision	A1
BJC/44	Rogers, Elizabeth N241	Transferred to GWMH for assessment for continuing care. No indication from Dr Lord's assessment letter following ward visit at Haslar that she expected the lady to die. Probably had not had a CVA, just severe infection. GWMH nurses may have been misled by nursing transfer letter which alluded to ?CVA as the cause of acute admission. Following transfer, within 2 days was alleged to have pain requiring substantial morphine doses, which were then alleged not to be lasting 4 hours. In fact, pain likely to be due to stiff joints and flexion contractures, and to pressure areas, none of which would be opioid sensitive. Then set up on high dose syringe driver, quickly increased by 50%, and rapidly died. I feel it is likely that the opioids substantially shortened this lady's life, and may have produced death in a lady who would otherwise have survived for months	B3
BJC/45	Spurgin, Enid N323	Walking a little and using only paracetamol when transferred for rehab after #NOF. But seems to have developed infection in surgical site with increasing pain. Then given rapidly escalating morphine, at one point simultaneously with codydramol, and finally syringe driver, and died. Was given antibiotics. Xrayed but no mention of result. No attempt to refer back to orthopaedic surgeons. Not clear whether the infection was recoverable.	B2
BJC/46	Stevens, Jean N313	Severe IHD and consequent dense left hemiparesis with no recovery. NG feeding; had already survived 1 episode of aspiration pneumonia. Poor prognosis. Admitted to GWMH; only recorded pain in transfer letter was skin discomfort in groin, responding to Sudocreme (pain not mentioned in admission clerking). On admission, begun immediately on morphine 5mg PRN – but given regularly – then changed the next morning to 10mg 4 hourly. Syringe driver set up the same evening, and died the next day. I can see no evidence that local measures or simple analgesia were used to reduce discomfort – cream to skin and regular paracetamol would have been suitable management for this lady. I find it hard to believe other than that the morphine materially hastened her death.	B3

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/47	Taylor, Daphne N333	Irrecoverable CVA. Rattly chest on admission. PEG fed – likely to succumb to aspiration pneumonia at some point, and probably sooner rather than later. Had spastic contracture of arm on hemiparetic side, which gave her pain. No sign of any simple analgesia – discussion of getting a splint but no evidence it ever happened. No muscle relaxants, baclofen etc. Instead, straight on to fentanyl 25mcg, increased after 1 patch to 50mcg and then, after 3 patches, became distressed one night and syringe driver put up at 2am. Ironically, opioid dose decreased in syringe driver – suspect that was inadvertent, because they didn't know how to convert from fentanyl to diamorphine. Quickly died thereafter. Noted to be very drowsy from the time the fentanyl was started. But PEG feeding maintained. Cannot see justification for high dose opioids when her pain was likely to be musculo-skeletal and essentially not morphine sensitive.	B2
BJC/48	Tiller, Sylvia N174	Clearly a dying woman. Given small amounts of oramorph, which is good for heart failure. Only in the last 24 hours set up on a syringe driver with diamorphine, hyoscine and midazolam. Think the dose of diamorphine inappropriately high, but I am sure it made little difference to the outcome. Concerned about the admission plan to GWMH. Had complained of no pain or breathlessness at all, but plan was "make more adequate analgesia available" and diamorphine written up that day ?what was the motivation. Patient had clearly and repeatedly expressed a wish to die.	A2
BJC/49	Vince, Dorothy N150	Investigated acutely in QAH – found to have diverticular disease. May have had occult ca – weight loss, low albumin, GI bleeding – but not seen on colonoscopy. Or possible diverticular abscess. Transferred to GP care in Sultan ward GWMH. Only routine meds – codeine for diarrhoea, metoclopramide for vomiting PRN, occasional paracetamol. Sudden deterioration early hours of day of death, with mild pyrexia, hypotension, vomiting. Sudden collapse and death. Actual cause of death not clear, but no PM. No analgesia/syringe driver at all. Not under care of Dr Lord/Dr Barton once she was transferred to GWMH though under Dr Lord at QAH.	A1
BJC/50	Walsh, Frank N332	Emergency admission to Sultan under GP. Loss of mobility, doubly incontinent. PMH TIAs. On aspirin and senna; receiving physio. Collapsed in early morning while vertical ?another TIA. Given antibiotics for chest infection but died shortly afterwards.	A1
BJC/51	Wellstead, Walter N337	Readmitted to the psychogeriatric ward because of advanced vascular dementia and severe agitated depression with paranoid features and wandering behaviour. Mobility impaired by recent repair of R	A1

Exhibit No	Patient Identification	Assessment Note	Assessment score
		#NOF. Multiple falls during the admission. Noted to be in severe pain when moved and had to be put back to bed. (Repeat Xray of R hip during this admission had shown good position of the DHS but separated trochanter ?new injury.) Had severe flexion contractures of both legs. In pain ++ during any attempt to move him. Started on syringe driver with diamorphine 15mg and haloperidol 20mg (reasonable in view of psychiatric history and recent medication). Only quibble is that he is subsequently described as semi-conscious and comfortable, but 4 days later diamorphine was doubled ?why. He subsequently became agitated (?opioid toxic) and haloperidol removed, midazolam 10mg substituted. Died peacefully with a terminal bronchopneumonia.	
BJC/52	Wilkie, Alice N3	Cannot see in the case record any of the medical notes for the final admission to Daedalus, or the second drug chart which must have existed. In the absence of the notes it is very difficult to make any sensible assessment. She had late stage dementia and had become very dependent following a UTI which required IV antibiotic therapy. She was needing 2 nurses and a hoist for transfers. It is therefore possible that she would have died of her dementia in GWMH whatever management had been carried out. The only relevant drug chart I can find shows that she was treated with a syringe driver containing diamorphine 30mg and midazolam 30mg on 20/8 and 21/8 (the day of death). The nursing notes suggest the syringe driver may have been initiated on 17/8, when permission was given by the son, but there is no other evidence of this. And I have no evidence on which to judge whether the deterioration in her general condition prior to 17/8, alluded to in the nursing note of that date, was due to medical problems or secondary to opioid or other treatment. I judge the treatment to be sub-optimal simply on the basis of the inadequacy of the nursing notes. It may in fact have been medically entirely appropriate, although I would be very surprised if such a frail elderly lady with no malignant disease or fracture required a dose of diamorphine of 30mg/24 hours.	B2
BJC/53	Williamson, Ivy N294	Died of advanced metastatic malignant melanoma. Excellent care. Opioids and sedatives only in very small doses, for good indications, and only gradually increased in response to symptoms.	A1

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/54	Williamson, Jack N243	Had bilateral through knee amputations on a background of known IHD (previous MIs), depression and possible early dementia and polypharmacy. Stumps were oozing when transferred to Daedalus for rehab (and to be with his dying wife, Ivy – BJC/53). Pre-amputation was on MST 40mg BD and needing oramorph 10mg for breakthrough – this was stopped post-op. Stumps got worse. 200mls pus came from R stump and grew MRSA. Deteriorated rapidly, probably mainly MRSA infection exacerbated by worsening CCF and lost will to live after seeing his wife die. Only given tiny doses of analgesia – oramorph 2.5mg once on the afternoon of death, then diamorphine 5mg less than 2 hours before death. Syringe driver set up at that time with diamorphine 10mg, but would have had very little indeed when he died.	A1
BJC/55	Wilson, Robert N5	Unwell with alcohol-related diseases – cardiac failure, liver disease, #humerus, widespread oedema. On Trazodone from psychogeriatricians. Immediately he was admitted to Dryad he was given doses of oramorph 10mg, PRN the first day and regularly for the next 2, by which time he was unresponsive (not surprisingly considering his liver dysfunction). Then transferred to a syringe driver, initially at the correct conversion but diamorphine tipped on the final day. Not at all clear why the morphine was started, why it was given at such a high dose, which he could have been predicted not to tolerate, and why the diamorphine was escalated so rapidly on the final day of life. Rapid deterioration after admission to GWMH seems likely to be related to excessive opioid doses in a man with alcoholic liver disease.	B3
BJC/56	Windsor, Norma N157	One might criticise the GP caring for her in Sultan Ward for not appreciating how ill she was becoming with the nausea and diarrhoea, and not noticing the dehydration developing. One might also criticise him for not treating the first cold, clammy, hypotensive episode, which was probably a first episode of sepsis, more seriously. She had CLL with consequent immunosuppression and had only stopped steroids (for her dermatitis) 3 weeks before – she might well have been hypoadrenal, and this was not addressed seriously at any stage in her hospital stay. Once the GP appreciated she was seriously ill, he arranged transfer to acute medical care and they in turn to ITU, and management was optimal from that point. At no time did she have significant amounts of analgesia in GWMH. Her maximum intake was 7 tablets of coproxamol in one day.	A1
BJC/57	Midford-Millership, Douglas N772	Immaculate care, presumably in Sultan. Doing very well. Sudden collapse ?CVA ?MI and died within 3 hours. Had no opioids or sedatives at all.	A1

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/58	Corke, James N77/	No notes relevant to final admission. Was discharged from Sultan to home on 5.8.89. Died on 14.8.89. Death notification form says under care of GP beds but listing of admission episodes gives no admission later than 5.8.89 and handwritten entry "Died in Haslar 14.8.89" ?died in A&E or after emergency transfer.	B1

Signature: Code A

Date: 9 November 2003

Name: Dr Anne Naysmith FRCP

Other Document Form

Number 1774

MEETING NOTES WITH GMC AT FFW 20/11/02.

(include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Statement Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Meeting note

Name: **Judith Chrystie**	Call type: **Meeting**
Duration:	Date: **20 November 2002**

Barton - Meeting with Hampshire Constabulary

Attendees:

GMC: Michael Keegan - MK

FFW: Judith Chrystie - JZC
John Offord - JHO

Police: DI Nigel Niven - NN
DC Owen Kenny - OK

Meeting

The attendees agreeing that JZC would make a brief minuted note of the meeting for circulation to all parties.

The parties introducing themselves and explaining their involvement in the case.

JZC explaining the situation within the GMC. Advising that the GMC would not proceed if NN indicated that to do so could prejudice any policy enquiry. JZC explaining the difference between running the case as a conviction matter and one in which we had to prove serious professional misconduct. JZC indicating the criminal rules of evidence were applied in GMC proceedings.

MK updating NN and OK as to the current position of the GMC enquiries. Indicating that the matter had both been screened and placed through the PPC.

JZC clarifying that the papers that the screener and the PPC had seen had been provided by Acting Detective Superintendent Burt. Noting that these papers had been forwarded through to the GMC when it appeared that the police were no longer pursuing any criminal investigation. NN advising that when, in 1998/1999 concern was raised by the death of Gladys Richards, an investigation had taken place which the police admitted was not as effective as it should have been. Advising that the CPS had considered the investigation and, in particular, the report prepared by Livesley on the Richard's case and had taken the view that causation could not be made out.

NN explaining that following the CPS's conclusion, the families of the elderly patients stated that they considered the police had been too quick to conclude the matter and that as a consequence four other cases were "dip sampled" by a new investigating officer, Detective Superintendent James. Those other cases were considered by two alternative experts Ford and Munday.

NN indicating that he was concerned about the issue of causation and whether proving causation may be just outside of the Constabulary's reach. Noting, however, that although the file had been prepared again for the CPS (by DI Stickler) and contained information on all five cases, there were a number of other incidents which still required full investigation. NN indicating that on statistical analysis and a similar fact basis it may be possible to establish causation. Noting that there were significant arguments about the appropriateness of the prescribing regime and the instructions left by clinical staff. The attendees noting that this was a particular issue for professional regulation given that it was not necessary to show that causation resulted in death merely of the inappropriateness of the prescribing regime amounted to bad practice.

NN advising that there were 50 other cases that the police may consider. One of the issues that would have to be resolved was whether a policy decision should be made to look at the hundreds of individuals who had died at the Gosport War Memorial Hospital. Noting that from 1994 to the period in which Dr Barton resigned from the hospital, there were thousands of deaths, 600 of which had been certified by Dr Barton. There were further cases in which Dr Barton had provided the care although the death may have been certified by a different practitioner.

Given the number of cases and the provisional views being provided by an alternative expert instructed by NN, Professor Robert Forest, NN stating that he was increasingly moving towards the view that he was entitled to argue that causation could be made out. NN noting, however, the difficulty in showing that death through bronchial illness of pneumonia was a consequence of diamorphine. Although it was noted that excessive diamorphine could cause respiratory difficulties, the victims were elderly patients who were, therefore, vulnerable in any event.

NN commenting that although there was a theme developing through the cases to suggest that Jane Barton had relied on diamorphine and syringe drivers, the police had to investigate the practices of the other practitioners working at Gosport Hospital. The attendees agreed that Jane Barton could not be seen to be persecuted alone.

JZC noting that the environment in which Dr Barton was working in which there were no prescribing policies may have allowed her to operate undetected.

OK identifying the fact that in 1991 concerns had been raised regarding the use of diamorphine by junior nurses. MK and JZC advising OK that these papers had been provided to the GMC but did not take the matter further in terms of the interim procedures. OK advising the circumstances in which the concerns had been made by the junior nurses and the fact that the medical practitioners and senior nurses had been opposed to any questioning of the clinical decision making. Noting that the fact that concerns had been raised some years previously did suggest that there was something amiss with James Barton's practice over a period of years.

NN noting that there appeared to be a lack of motive. OK was continuing to look at this element.

NN advising that Liam Donaldson had asked Professor Baker to consider the issues raised by the cases identified by the police. NN had persuaded Professor Baker to also expand his enquiries into Dr Barton's GP practice. NN noting that Professor Baker's analysis of the statistics would take some time.

JZC advising that the GMC had the power to make an interim order suspending or placing conditions upon a medical practitioner's registration notwithstanding the fact that he or she had not been found guilty of serious professional misconduct. Stating that in this instance the IOC had determined not to place any interim order upon Dr Barton's registration. Noting that this was based on a convincing argument by Dr Barton explaining the lack of resources and supervision and the poor conditions under which she had had to work. Stating that given that the police were suggesting that there was potentially hundreds of deaths caused by Dr Barton and were actively assessing whether a murder charge could be prosecuted, JZC would be concerned to protect the patients and the public interest by presenting new evidence to an IOC Panel.

The parties discussing the disclosure requirements for GMC. Noting that the GMC would be forced to disclose any document which they wished to present to an IOC hearing in reliance of a request for an interim order.

NN appreciating the vulnerability of the GMC to criticism if a patient was killed at the hands of Dr Barton when the GMC could have taken action to prevent her from practising. He was, however, concerned regarding disclosure of material which he would not wish revealed to the doctor at too early a stage. NN stating that it would possible for him to write a letter for the GMC indicating that police investigations were continuing and that there were a minimum of 50 patients whose deaths would be analysed. The letter could also advise that early medical advice suggested that the deaths had been hastened by the prescribing regime provided by Dr Barton. The attendees agreeing that the letter from NN would also formally request that the GMC state their proceedings.

JZC expressing concern that the defence could argue that Dr Barton was no longer working at Gosport War Memorial Hospital and, therefore, patients were not at risk from diamorphine prescriptions or syringe drivers. OK noting in this regard that Dr Barton's private practice would include elderly patients. JZC commenting that although she appreciated that it had not yet been determined whether the criminal enquiry should consider the private/GP practice, it would be helpful if the fact that investigations may be expanded in this direction could be included within the letter to the GMC. NN stating that whilst he would wish to assist the GMC as far as possible, it may be

difficult for him to add this element to any letter. Noting that Professor Baker had agreed to expand his analysis to include Barton's private practise, but this was not part of his specific remit established by Liam Donaldson.

NN advising that the letter to the GMC would also formally establish the Constabulary's commitment to liaise closely with the GMC. The parties agreeing that formal letters would be written outlining information that was possible for the GMC to disclose. There would also be contact through e-mail, telephone and further meetings. JZC advising that she was likely to phone NN on a monthly basis so that she could report back to the GMC in her monthly reports!

The parties noting that Alexander Harris had expressed concern that the individuals involved in the various investigations and enquiries were not liaising. Noting the commitment to liaise closely could be articulated to Ann Alexander at Alexander Harris - it would, however, be necessary to stress the different role that each of the particular stakeholders were bound to adopt. Detail would not be provided about the level of communication or the information being passed between the parties but Alexander Harris should be advised that formal channels of communication had been developed.

In this regard, NN advising that he had met with Ann Alexander last week. The meeting had been productive in that it had been on a non-adversarial basis. Stating that Ann Alexander had used the media to generate publicity for her firm following the meeting, however, formal channels of communication had been established and it had been agreed that the family could raise concerns regarding any police investigation through Alexander Harris. Hampshire Constabulary had also agreed to advise any new individuals that Alexander Harris were acting for relatives; NN stressing that this would not be a referral service but merely informative.

NN stating that an important date was his meeting with the CPS scheduled for 28 November 2002. This meeting would establish the Constabulary's expectations as to the speed with which the CPS should consider the papers. NN advising that if the CPS did not consider the matter should proceed to a prosecution, the case could be considered by Treasury Counsel (an alternative Treasury Counsel from that which considered the initial referral of the Richard's case).

OK querying whether the GMC had any record of Dr Barton's qualifications as he did not have a full history or CV. The GMC would attempt to track down as much information as possible.

The GMC also would pass on any Rule 6 response letter if appropriate. JZC also advising that the GMC had received two other complaints Carby and Batson. NN and OK did not recognise these names as individuals within the 50 cases being investigated by the Constabulary. JZC to pass the documents through to the Constabulary.

There appeared to be a culture of resorting to diamorphine care too quickly (perhaps for a easy life?). The parties identified the fact that there may be problems with other doctors. MK advising NN and OK that the case against Lord had been "screened" within the GMC procedures and a decision taken not to pursue the matter.

As regards disclosure, JZC stating that she would work on the assumption that any documents provided by the police would be undisclosable unless she was specifically advised otherwise in writing. JZC stating that the GMC enquiry, once it was permitted to proceed would, of course, have to disclose any documentation passed through by the police. NN and OK appreciating this fact and noting that at that stage, in any event, the policy enquiry would be concluded. NN stating that once the police enquiry was concluded it would be possible to pass JZC all relevant documentation and, indeed, this was the basis on which the police worked.

JZC explaining that we had received a report from CHI. She explained that we wished to obtain the documents that had been considered by the CHI investigation team and, moreover, visit CHI in order to analyse the witness statements taken. Stating that there would be no intention to interview the witnesses. NN agreeing that this would not prejudice any police investigation and JZC and JHO could proceed with this aspect of the GMC enquiry.

The parties summarising the fact that NN would provide a letter to the GMC which could be used by the GMC in an IOC hearing, which would formally ask the GMC to stay their investigations and which would state that the parties were committed to regular liaison. (JZC and MK noting that it may be difficult to persuade an IOC panel to place an interim order based only on a letter but identifying that this was the best position). NN advising that the police would advise the GMC of any significant event and would release information if it was appropriate for them to do so.

Barton – Meeting with Hampshire Constabulary

Attendees:

GMC: Michael Keegan – MK

FFW: Judith Chrystie – JZC
John Offord – JHO

Police: DI Nigel Niven – NN
DS Owen Kenny – OK

Meeting

The attendees agreeing that JZC would make a brief minuted note of the meeting for circulation to all parties.

The parties introducing themselves and explaining their involvement in the case.

JZC explaining the situation within the GMC. Advising that the GMC would not proceed if NN indicated that to do so could prejudice any Police enquiry. JZC explaining the difference between running the case as a conviction matter and one in which we had to prove serious professional misconduct. JZC indicating the criminal rules of evidence were applied in GMC proceedings.

MK updating NN and OK as to the current position of the GMC enquiries. Indicating that the matter had both been screened and placed through the PPC.

JZC clarifying that the papers that the screener and the PPC had seen had been provided by Acting Detective Superintendent Burt. Noting that these papers had been forwarded through to the GMC when it appeared that the Police were no longer pursuing any criminal investigation. NN advising that when, in 1998/1999 concern was raised by the death of Gladys Richards, an investigation had taken place which the Police admitted was not as effective as it should have been. Advising that the CPS had considered the investigation and, in particular, the report prepared by Livesley on the Richard's case and had taken the view that causation could not be made out.

NN explaining that following the CPS's conclusion, the families of the elderly patients stated that they considered the Police had been too quick to conclude the matter and that as a consequence four other cases were "dip sampled" by a new Investigation Officer, Detective Superteindent James. Those other cases were considered by two alternative experts Ford and Munday.

NN indicating that the issue hinged on whether causation could be made out – and whether proving said causation may be outside of the investigations reach. NN added that a further file had been prepared for the CPS (by Supt. Stickler) and contained information on all five (above) cases. There were now a number of other incidents which still required a fuller investigation. NN indicating that on statistical analysis and a similar fact basis it may be possible to support/establish causation. Noting that there were significant arguments about the appropriateness of the prescribing regime and the instructions left by clinical staff. The

attendees noting that this was a particular issue for professional regulation given that it was not necessary to show that causation resulted in death merely of the inappropriateness of the prescribing regime amounted to bad practice.

NN advising that there were 50 other cases that the Police may consider. One of the issues that would have to be resolved was whether a policy decision should be made to look at the hundreds of individuals who had died at the Gosport War Memorial Hospital. Noting that from 1994 to the period in which Dr Barton resigned from the Hospital, there were around a thousand deaths, 600 of which had been certified by Dr Barton. There were further cases in which Dr Barton had provided the care although the death may have been certified by a different Practitioner.

Given the number of cases and the provisional views being provided by an alternative expert instructed by NN, Professor Robert Forrest, NN stating that he was increasingly moving towards the view to argue that causation could possibly be made out. NN noting, however, the difficulty in showing that death through bronchial illness of pneumonia was a consequence of diamorphine. Although it was noted that excessive diamorphine could cause respiratory difficulties, the victims were elderly patients who were, therefore, consequently vulnerable in any event.

NN emphasised that although there was a theme developing through the cases to suggest that Jane Barton may have relied on diamorphine and syringe drivers, the Police had an open mind as to whether any crime had been committed at all and if so, by whom. The investigation would consider the practices of other Practitioners working at Gosport Hospital. The attendees agreed that Jane Barton could not be the sole subject of any investigation.

JZC noting that the environment in which Dr Barton was working in which there were no prescribing policies may have allowed her to operate undetected.

OK identifying the fact that in 1991 concerns had been raised regarding the use of diamorphine by Junior Nurses NK and JZC advising OK that these papers had been provided to the GMC but did not take the matter further in terms of the interim procedures. OK advising the circumstances in which the concerns had been made by the Junior Nurses and the fact that the Medical Practitioners and Senior Nurses had been opposed to any questioning of the clinical decision making. Noting that the fact that concerns had been raised some years previously did suggest that there was something may be amiss with Jane Barton's Practice over a period of years.

NN noting that there appeared to be a lack of motive. OK was continuing to look at this element.

NN advising that Liam Donaldson had asked Professor Baker to perform a statistical analysis of the GWMH issues. NN had raised the possibility of Professor Bakers work being expanded to enquire into Dr Barton's GP Practice. NN noting that Professor Baker's analysis of the statistics would take some time.

JZC advising that the GMC had the power to make an interim order suspending or placing conditions upon a Medical Practitioner's registration notwithstanding the fact that he or she had not been found guilty of serious professional misconduct. Stating that in this instance the IOC had determined not to place any interim order upon Dr Barton's registration. Noting that

this was based on a convincing argument by Dr Barton explaining the lack of resources and supervision and the poor conditions under which she had had to work. Stating that given that the Police were suggesting that there was potentially hundreds of deaths caused by Dr Barton and were actively assessing whether a murder charge could be prosecuted, JZC would be concerned to protect the patients and the public interest by presenting new evidence to an IOC Panel.

The parties discussing the disclosure requirements for GMC. Noting that the GMC would be forced to disclose any document which they wished to present to an IOC hearing in reliance of a request for an interim order.

NN appreciating the vulnerability of the GMC to criticism if a patient died at the hands of Dr Barton when the GMC could have taken action to prevent her from practising. He was, however, concerned regarding disclosure of material which he would not wish revealed to the Doctor at too early a stage. More importantly, any such action would have to be based on evidence. At this stage there was no new evidence other than the prevailing view as to the lack of causation now being potentially challengable and the numbers of deceased patients being significantly expanded. NN stating that he was due to meet with the CPS to discuss the case, after which he foresaw that it would be possible for him to write a letter for the GMC indicating that Police investigations were continuing and that there were a minimum of 50 patients whose deaths would be analysed. The letter could possibly also advise that early medical advice suggested that the deaths may had been hastened by the prescribing regime provided by Dr Barton. The attendees agreeing that the letter from NN would also formally request that the GMC stay their proceedings.

JZC expressing concern that the defence could argue that Dr Barton was no longer working at Gosport War Memorial Hospital and, therefore, patients were not at risk from diamorphine prescriptions or syringe drivers. OK noting in this regard that Dr Barton's Private Practice would include elderly patients. JZC commenting that although she appreciated that it had not yet been determined whether the criminal enquiry should consider the Private/GP Practice, it would be helpful if the fact that investigations may be expanded in this direction could be included within the letter to the GMC. NN stating that whilst he would wish to assist the GMC as far as possible, it may be difficult for him to add this element to any letter. Noting that, whereas it would no doubt be of interest for Professor Baker to expand his analysis to include Dr Barton's Private Practice, this was not part of his specific remit established by Liam Donaldson. This matter was not yet clear.

NN advising that the letter to the GMC would also formally establish the Constabulary's commitment to liaise closely with the GMC. The parties agreeing that formal letters would be written outlining information that was possible for the GMC to disclose. There would also be contact through email, telephone and further meetings. JZC advising that she was likely to phone NN on a monthly basis so that she could report back to the GMC in her monthly reports.

The parties noting that Alexander Harris had expressed concern that the individuals involved in the various investigations and enquiries were not liaising. Noting the commitment to liaise closely could be articulated to Ann Alexander at Alexander Harris – it would, however, be necessary to stress the different role that each of the particular stakeholders were bound to adopt. Detail would not be provided about the level of communication or the information.

being passed between the parties but Alexander Harris should be advised that formal channels of communication had been developed.

In this regard, NN advising that he had met with Ann Alexander last week. The meeting had been productive in that it had been on a non adversarial basis. Stating that Alexander Harris had used the media to generate publicity for the firm following the meeting. However, formal channels of communication had been established and it had been agreed that the family could raise concerns regarding any Police investigation through Alexander Harris. Hampshire Constabulary had also agreed to advise any new individuals that Alexander Harris were acting for some relatives; NN stressing that this would not be a referral service but merely informative.

NN stating that an important date was his meeting with the CPS scheduled for 28 November 2002. This meeting would establish the Constabulary's expectations as to the speed with which the CPS should consider the papers. NN advising that if the CPS/Police had any doubts about the matter it could be referred to Treasury Counsel. (An alternative Treasury Counsel to that which considered the initial referral of the Richard's case?).

OK querying whether the GMC had any record of Dr Barton's qualifications as he did not have a full history or CV. The GMC would attempt to track down as much information as possible.

The GMC also would pass on any Rule 6 response letter if appropriate. JZC also advising that the GMC had received two other complaints Carby and Batson. NN and OK did not recognise these names as individuals within the 50 cases being investigated by the Constabulary. JZC to pass the documents through to the Constabulary.

There appeared to be a culture of resorting to diamorphine care too quickly (perhaps for a easy life?). The parties identified the fact that there may be problems with other Doctors. MK advising NN and OK that the case against Lord had been "screened" within the GMC procedures and a decision taken not to pursue the matter.

As regards disclosure, JZC stating that she would work on the assumption that any documents provided by the Police would be undisclosable unless she was specifically advised otherwise in writing. JZC stating that the GMC enquiry, once it was permitted to proceed would, of course, have to disclose any documentation passed through by the Police. NN and OK appreciating this fact and noting at that stage, in any event, the Police enquiry would be concluded. NN stating that once the Police enquiry was concluded it would be possible to pass JZC all relevant documentation and, indeed, this was the basis on which the Police worked.

JZC explaining that we had received a report from CHI. She explained that we wished to obtain the documents that had been considered by the CHI investigation team and, moreover, visit CHI in order to analyse the witness statements taken. Stating that there would be no intention to interview the witnesses. NN agreeing that this would not prejudice any Police investigation and JZC and JHO could proceed with this aspect of the GMC enquiry.

The parties summarising the fact that NN would provide a letter to the GMC which could be used by the GMC in an IOC hearing, which would formally ask the GMC to stay their investigations and which would state that the parties were committed to regular liaison. (JZC

and MK noting that it may be difficult to persuade an IOC panel to place an interim order based only on a letter but identifying that this was the best position). NN advising that the Police would advise the GMC of any significant event and would release information if it was appropriate for them to do so.

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Meeting note

Name: Judith Chrystie	Call type: **Meeting**
Duration:	Date: **20 November 2002**

Barton - Meeting with Hampshire Constabulary

Attendees:

GMC: Michael Keegan - MK

FFW: Judith Chrystie - JZC
John Offord - JHO

Police: DI Nigel Niven - NN
~~DC~~ Owen Kenny - OK

Code C

Meeting

The attendees agreeing that JZC would make a brief minuted note of the meeting for circulation to all parties.

The parties introducing themselves and explaining their involvement in the case.

JZC explaining the situation within the GMC. Advising that the GMC would not proceed if NN indicated that to do so could prejudice any policy enquiry. JZC explaining the difference between running the case as a conviction matter and one in which we had to prove serious professional misconduct. JZC indicating the criminal rules of evidence were applied in GMC proceedings.

MK updating NN and OK as to the current position of the GMC enquiries. Indicating that the matter had both been screened and placed through the PPC.

JZC clarifying that the papers that the screener and the PPC had seen had been provided by Acting Detective Superintendent Burt. Noting that these papers had been forwarded through to the GMC when it appeared that the police were no longer pursuing any criminal investigation. NN advising that when, in 1998/1999 concern was raised by the death of Gladys Richards, an investigation had taken place which the police admitted was not as effective as it should have been. Advising that the CPS had considered the investigation and, in particular, the report prepared by Livesley on the Richard's case and had taken the view that causation could not be made out.

NN explaining that following the CPS's conclusion, the families of the elderly patients stated that they considered the police had been too quick to conclude the matter and that as a consequence four other cases were "dip sampled" by a new investigating officer, Detective Superintendent James. Those other cases were considered by two alternative experts Ford and Munday.

NN indicating that he was concerned about the issue of causation and whether proving causation may be just outside of the Cor Code C ry's reach. Noting, however, that although the file had been prepared again for the CPS (by DI Stickler) and contained information on all five cases, there were a number of other incidents which still required full investigation. NN indicating that on statistical analysis and a similar fact basis it may be possible to establish causation. Noting that there were significant arguments about the appropriateness of the prescribing regime and the instructions left by clinical staff. The attendees noting that this was a particular issue for professional regulation given that it was not necessary to show that causation resulted in death merely of the inappropriateness of the prescribing regime amounted to bad practice.

NN advising that there were 50 other cases that the police may consider. One of the issues that would have to be resolved was whether a policy decision should be made to look at the hundreds of individuals who had died at the Gosport War Memorial Hospital. Noting that from 1994 to the period in which Dr Barton resigned from the hospital, there were thousands of deaths, 600 of which had been certified by Dr Barton. There were further cases in which Dr Barton had provided the care although the death may have been certified by a different practitioner.

Given the number of cases and the provisional views being provided by an alternative expert instructed by NN, Professor Robert Forest, NN stating that he was increasingly moving towards the view that he was entitled to argue that causation could be made out. NN noting, however, the difficulty in showing that death through bronchial illness of pneumonia was a consequence of diamorphine. Although it was noted that excessive diamorphine could cause respiratory difficulties, the victims were elderly patients who were, therefore, vulnerable in any event.

NN commenting that although there was a theme developing through the cases to suggest that Jane Barton had relied on diamorphine and syringe drivers, the police had to investigate the practices of the other practitioners working at Gosport Hospital. The attendees agreed that Jane Barton could not be seen to be persecuted alone. IN ISOLATION, JB FOR ONLY MEMBER OF STAFF TO BE INVESTIGATED.

JZC noting that the environment in which Dr Barton was working in which there were no prescribing policies may have allowed her to operate undetected.

OK identifying the fact that in 1991 concerns had been raised regarding the use of diamorphine by junior nurses. MK and JZC advising OK that these papers had been provided to the GMC but did not take the matter further in terms of the interim procedures. OK advising the circumstances in which the concerns had been made by the junior nurses and the fact that the medical practitioners and senior nurses had been opposed to any questioning of the clinical decision making. Noting that the fact that concerns had been raised some years previously did suggest that there was something amiss with James Barton's practice over a period of years.

NN noting that there appeared to be a lack of motive. OK was continuing to look at this element.

NN advising that Liam Donaldson had asked Professor Baker to consider the issues raised by the cases identified by the police. NN had ~~persuaded~~ HAD RAISED ISSUE WITH ICE Professor Baker ~~to also~~ expand his enquiries into Dr Barton's GP practice. NN noting that Professor Baker's analysis of the statistics would take some time.

JZC advising that the GMC had the power to make an interim order suspending or placing conditions upon a medical practitioner's registration notwithstanding the fact that he or she had not been found guilty of serious professional misconduct. Stating that in this instance the IOC had determined not to place any interim order upon Dr Barton's registration. Noting that this was based on a convincing argument by Dr Barton explaining the lack of resources and supervision and the poor conditions under which she had had to work. Stating that given that the police ~~were suggesting that there was~~ COULD NOT EXCLUDE THE POSSIBILITY THAT THERE MAY BE EVENTUALLY FALLING CRIMINAL CHARGE AFTER ENQUIRY potentially hundreds of deaths ~~caused by Dr Barton~~ and were actively assessing whether a murder charge could EVENTUALLY be prosecuted, JZC would be concerned to protect the patients and the public interest by presenting new evidence to an IOC Panel. NN EMPHASISED THAT AT THIS JUNCTURE THERE WAS NO NEW EVIDENCE. ONLY THE POLICE UNDERTAKING THEIR ENQUIRY TO CONSIDER ADDITIONAL DATES

The parties discussing the disclosure requirements for GMC. Noting that the GMC would be forced to disclose any document which they wished to present to an IOC hearing in reliance of a request for an interim order.

NN appreciating the vulnerability of the GMC to criticism if a patient was ~~killed~~ at the hands of Dr Barton when the GMC could have taken action to prevent her from practising. He was, however, concerned regarding disclosure of material which he would not wish revealed to the doctor at too early a stage. NN stating that it would possible for him to write a letter for the GMC indicating that police investigations were continuing and that there were a minimum of 50 patients whose deaths would be analysed. The letter could also advise that early medical advice suggested that the deaths had been hastened by the prescribing regime provided by Dr Barton. The attendees agreeing that the letter from NN would also formally request that the GMC state their proceedings.

~~JZC expressing concern that the defence could argue that Dr Barton was no longer working at Gosport War Memorial Hospital and, therefore, patients were not at risk from diamorphine prescriptions or syringe drivers. OK noting in this regard that Dr Barton's private practice would include elderly patients. JZC commenting that although she appreciated that it had not yet been determined whether the criminal enquiry should consider the private/GP practice, it would be helpful if the fact that investigations may be expanded in this direction could be included within the letter to the GMC. NN stating that whilst he would wish to assist the GMC as far as possible, it may be~~

difficult for him to add this element to any letter. Noting that Professor Baker had agreed to expand his analysis to include Barton's private practise, that this was not part of his specific remit established by Liam Donaldson.

NN advising that the letter to the GMC would also formally establish the Constabulary's commitment to liaise closely with the GMC. The parties agreeing that formal letters would be written outlining information that was possible for the GMC to disclose. There would also be contact through e-mail, telephone and further meetings. JZC advising that she was likely to phone NN on a monthly basis so that she could report back to the GMC in her monthly reports!

The parties noting that Alexander Harris had expressed concern that the individuals involved in the various investigations and enquiries were not liaising. Noting the commitment to liaise closely could be articulated to Ann Alexander at Alexander Harris - it would, however, be necessary to stress the different role that each of the particular stakeholders were bound to adopt. Detail would not be provided about the level of communication or the information being passed between the parties but Alexander Harris should be advised that formal channels of communication had been developed.

In this regard, NN advising that he had met with Ann Alexander last week. The meeting had been productive in that it had been on a non-adversarial basis. Stating that Ann Alexander had used the media to generate publicity for her firm following the meeting. However, formal channels of communication had been established and it had been agreed that the family could raise concerns regarding any police investigation through Alexander Harris. Hampshire Constabulary had also agreed to advise any new individuals that Alexander Harris were acting for relatives; NN stressing that this would not be a referral service but merely informative.

NN stating that an important date was his meeting with the CPS scheduled for 28 November 2002. This meeting would establish the Constabulary's expectations as to the speed with which the CPS should consider the papers. NN advising that if the CPS did not consider the matter should proceed to a prosecution, the case could be considered by Treasury Counsel (an alternative Treasury Counsel from that which considered the initial referral of the Richard's case).

OK querying whether the GMC had any record of Dr Barton's qualifications as he did not have a full history or CV. The GMC would attempt to track down as much information as possible.

The GMC also would pass on any Rule 6 response letter if appropriate. JZC also advising that the GMC had received two other complaints Carby and Batson. NN and OK did not recognise these names as individuals within the 50 cases being investigated by the Constabulary. JZC to pass the documents through to the Constabulary.

There appeared to be a culture of resorting to diamorphine care too quickly (perhaps for a easy life?). The parties identified the fact that there may be problems with other doctors. MK advising NN and OK that the case against Lord had been "screened" within the GMC procedures and a decision taken not to pursue the matter.

As regards disclosure, JZC stating that she would work on the assumption that any documents provided by the police would be undisclosable unless she was specifically advised otherwise in writing. JZC stating that the GMC enquiry, once it was permitted to proceed would, of course, have to disclose any documentation passed through by the police. NN and OK appreciating this fact and noting that at that stage, in any event, the policy enquiry would be concluded. NN stating that once the police enquiry was concluded it would be possible to pass JZC all relevant documentation and, indeed, this was the basis on which the police worked.

JZC explaining that we had received a report from CHI. She explained that we wished to obtain the documents that had been considered by the CHI investigation team and, moreover, visit CHI in order to analyse the witness statements taken. Stating that there would be no intention to interview the witnesses. NN agreeing that this would not prejudice any police investigation and JZC and JHO could proceed with this aspect of the GMC enquiry.

The parties summarising the fact that NN would provide a letter to the GMC which could be used by the GMC in an IOC hearing, which would formally ask the GMC to stay their investigations and which would state that the parties were committed to regular liaison. (JZC and MK noting that it may be difficult to persuade an IOC panel to place an interim order based only on a letter but identifying that this was the best position). NN advising that the police would advise the GMC of any significant event and would release information if it was appropriate for them to do so.

Other Document Form

Number 1766

Title LETTER FROM MR READHEAD TO MR REEVES 6/1/04

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No	Code A
Document registered / indexed as indicated No(s) of actions raised	Code A
Statement readers instructions	Code A
Indexed as indicated No(s) of actions raised	Code A
Examined - further action to be taken	O/M | SIO
Further actions no(s)	Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Hampshire Constabulary
Police Headquarters
West Hill
WINCHESTER
Hampshire
S022 5DB

Tel: 0845 045 45 45
Fax: 01962 871189

I.R Readhead LL.B
Deputy Chief Constable

Your Ref:
Our Ref: IR/DCC/hjs

Date: 6th January, 2004.

Mr. D. Reeves

Code A

Dear Mr. Reeves,

Thank you for your letter dated 10th December, 2003. I apologise for the delay in replying.

I have already had a conversation with Detective Chief Superintendent Watts concerning the discussion that we had, as Alexander Harris, Solicitors, have contacted us on this particular issue. Apparently, according to Alexander Harris, I advised you that we were only looking seriously at 7 cases, that the telephone call was being tape recorded, and that we had possession of information on DVDs.

From my own point of recollection and as you will recall, I was driving a car along a motorway at the time, I have no memory of using the word 7. I do remember saying that we were looking into a large number of cases and that these were divided into 3 key areas. I remember saying that there was a small number that were in the highest league of concern. However, I also made it clear that even this was not relevant until a thorough examination had been conducted by Counsel currently reviewing the recommendations of the three medical experts. For this reason, the small number may change at any stage.

The suggestion that the telephone conversation was being tape recorded is frankly absurd and I have absolutely no idea who suggested such a notion, certainly it was not me.

With regard to the issue of the CD, I think that I fully covered this in my last correspondence to you.

I am sorry that this case has taken so long to investigate, but as has been said to you on frequent occasions, we are adopting the best professional investigative processes in matters of this complexity. I was also disappointed to learn after the telephone conversation you had with me that you had already had a not dissimilar discussion with Detective Inspector Nigel Niven. As you know, I am predominantly responsible for the complaint investigation in this matter and I wonder why you felt it necessary to be advised by one senior police officer and then to contact another. My concern is that inevitably you were trying to look for gaps in the explanation that has been given to you so I intend in the future to make sure that the only briefings being given in relation to crime investigation come through Mr. Niven. I will only respond to matters that involve the complaint.

Finally, you asked me to comment about the issue of our meeting on 11th September, 2003 when I stated that as far as I was aware, Operation Rochester at that time did not have one case strong enough to get into a criminal court. This is wholly consistent with what had been said by Detective

Chief Superintendent Watts. If you recall, the question was that irrespective of the other 61 cases, if we had one case strong enough to go to Court why did we not take that. My response was that, as far as I was aware, we did not have such evidence and in any case the professional advice was to review all the matters at this time because if we failed on that one case, it would be very difficult to bring another.

I do hope that this makes my position clear and again take the opportunity to empathise with the position that you and the rest of the families find yourselves currently in. I continue to give you my assurance that we will try and deal with the matter as quickly as we can.

Yours sincerely,

I.R. Readhead
Deputy Chief Constable

Other Document Form

Number 1761

Title LETTER TO MR WATTS FROM GMC 7/1/02.

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / (No)	Code A
Document registered / indexed as indicated	Code A
s) of actions raised	
Statement readers instructions	Statement Code A
Indexed as indicated	Code A
No(s) of actions raised	
Examined - further action to be taken	O/M / SIO
Further actions no(s)	Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

HAMPSHIRE CONSTABULARY

Code A
Chief Constable

Western Area Headquarters
12-18 Hulse Road
Southampton
Hampshire
SO15 2JX

Our Ref.

Your Ref. Code A

Tel. Code A
Fax.

28th January 2004

Ms Quinn
Conduct Case Presentation Section
FPD
General Medical Council
178 Great Portland Street
London, W1W 5JE

Dear Ms Quinn

Re Gosport War Memorial Hospital – Operation Rochester

Thank you for you letter of the 7th January 2004, addressed to Mr Watts, the content of which I have noted. At the present time Mr Watts is on leave and I have been asked to reply to you on his behalf.

Within your letter you point out that, in essence, the position of the GMC has not changed since October 2003. Likewise, out of necessity, our position also remains fundamentally the same for the reason given in our letter of the 6th October 2003.

In respect of Professor Baker's report, you are correct to point out that reference was made to this document in the same letter. However, I am sure you will understand that distribution of this report is a matter entirely for the office of the Chief Medical Officer.

Having undertaken a process of quality assurance, we are about to commence the process of informing the relatives associated with Operation Rochester with the outcome of the initial analysis of our clinical team. This will be completed by mid February.

In your last paragraph you make reference to our second team of experts and an expectation of a report being ready in January 2004. It is unclear to me why you should think this to be the case. I have read the minutes taken in respect of our meeting held 30th September 2003 and our subsequent correspondence and can find no reference to such a report being

expected by January. It was never our position that we would have such an analysis completed by that time. That said, it is our intention to conduct such an analysis by a second team in respect of certain cases. We will, of course, continue to update you, to the extent we can, as to the progress of our investigation. Indeed, it might be useful to consider meeting in the near future should you think that it would be of some use.

If I can be of further assistance, please do not hesitate to contact me.

Yours sincerely

Nigel Niven
Deputy SIO

Other Document Form

Number 1754

Title 2nd LETTER FROM JUDITH CHRISTIE TO DI NIVEN 23/12/02

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Receiver Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Statement Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Our Ref: JZC/00492-14742/2164803 v1

Strictly Private & Confidential

D.I. N Niven
Major Crime Investigations Team
Hampshire Constabulary
Western Area Headquarters
12-18 Hulse Road
Southampton
Hampshire SO15 2JS

23 December 2002

Second letter

Dear Nigel

General Medical Council - Dr. Jane Barton
Operation Rochester – Gosport War Memorial Hospital

I write separately to my formal letter confirming the GMC's formal instructions to me that disciplinary proceedings will be stayed.

I enclose a copy of the meeting note I made following our productive meeting on 20 November 2002. Should you have any changes you wish incorporate into the note please do not hesitate to contact me following which I shall make the amendments and forward an updated set of minutes to you.

In accordance with your agreement, I confirm that John Offord and I have arranged to review the documentation held by the Commission for Health Improvement on 14-15 January 2003. During our visit we shall analyse the material held by CHI but we do not propose to take any action on it other than requesting copies of relevant material and assessing whether, following the conclusion of the police enquiries, whom of the witnesses interviewed by CHI should be seen by this firm.

Finally, many thanks for your Christmas card – absolutely magnificent!

Code A

Judith Chrystie
Assistant Solicitor
Direct Line: 020 7861 4953
Email: jzc@ffwlaw.com

Other Document Form

Number 1746

Title LETTER 9/1/2004 FROM DINGEN TO ANN REEVES

(Include source and any document number if relevant)

Receivers instructions urgent action Yes (No)

Receiver
Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Statement
Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

HAMPSHIRE CONSTABULARY

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Western Area Headquarters
12-18 Hulse Road
Southampton
Hampshire
SO15 2JX

Tel. 0845 0454545
Fax. 023 80599838

Our Ref. Op Rochester

Your Ref.

9th January 2004

Mrs A Reeves

Code A

Dear Mrs Reeves,

Thank you for your letter of the 2nd of January 2004. Firstly, please let me apologise for not responding sooner to your earlier letter of the 12th November 2003.

In respect of that letter, you raise concerns about the delay in notifying relatives as the outcome of the analysis of the patient records conducted by Professor Forrest and his team. I think you will recall that our policy in respect of this issue has already been explained to you and the other Family Group Members. Once the quality assurance process has been completed we will be in a position to discuss the findings with the relatives.

Additionally, the issue in respect of the recording of statements has also been explained.

With regard to your concerns relating to the patient records. We have taken possession of the medical records in relation to the patients subject to our enquiry and these notes have been analysed. It is a fact that archived notes may be, on some occasions, incomplete but the team conducting the analysis have not indicated that there is anything particularly unusual in that.

It is my intention to write to all the Family Group Members in the near future and provide another bulletin. Within this bulletin I will deal further with some of the issues mentioned above. The reason for providing updates in this fashion is to ensure that all Family Group Members receive the same information at the same time.

Continued/.....

In the mean time, I would like to thank you for bringing your concerns to my attention. If I can assist you any further, please do not hesitate to contact me.

Yours sincerely

Nigel Niven
Detective Inspector

Other Document Form

Number D738

LETTER FROM ANN REEVES TO DI NIVEN 2/1/05

(include source and any document number if relevant)

Receivers instructions urgent action Yes/(No)

Receiver Code A

Document registered/indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Statement Code A

Indexed as indicated

No(s) of actions raised

Code A

hined - further action to be taken

O/M	SIO

Further action no(s)

Indexer

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Mrs A Reeves

Code A

Detective Inspector N Niven
Western Area Headquarters
12-18 Hulse Road
Southampton
Hants
SO15 2JX

2nd January 2004

Dear Mr Niven

I am writing regarding my letter dated 12th November of which you have yet to show me the courtesy of acknowledging. Your lack of response only emphasises the current feelings that me and my family have towards this Police investigation. We are continuously working towards making this investigation thorough and true, without the much needed support from you.

Firstly, please can you answer my concerns as outlined in my previous letter?

Secondly, I would like to outline to you that the medical file of my late Mother, Elsie Devine that was delivered to me by your office is not only illegible in areas, but also and most alarmingly incomplete. If this is how the evidence was presented to the medical experts then I am deeply troubled that they will have been analysing manipulated evidence, which does not allow them to reach a true conclusion of my Mother's care. Following this point it is very questionable that my Mother's medical file is indeed accurate.

Perhaps you can explain to me the purpose of me having these files which has obviously taken a great deal of Police time and expense.

Yours sincerely

Code A

Ann Reeves

cc
Chief Constable P. Kernaghan
Det Superintendent S.Watts
Chief Superintendent D. Stevens

Other Document Form

Number D737

Title LETTER FROM ANN REEVES TO DI Code A 12/11/03

(Include source and any document number if relevant)

Receivers instructions urgent action Yes/(No)

Code A

Document registered/indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further action no(s)

Indexer

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Mrs A Reeves

Code A

Detective Inspector N Niven
Western Area Headquarters
12-18 Hulse Road
Southampton
Hants
SO15 2JX

12th November 2003

Dear Mr Niven

Thank you for your letter dated the 4th November 2003.

Whilst I appreciate your hard work in this investigation, it has become increasingly difficult to understand your procedure in this case. Again I feel it is necessary to voice my concerns due to the conflict of information from the start of the investigations and, the continual irregularities that have caused considerable distress.

When the 62 cases were being presented to the experts, I was told that after each 20 cases we would be informed of the findings. It was later decided that we would have to wait until the analysis of all 62 cases were complete and we all felt that this was probably a fair way of dealing with it.

At the Netley meeting on the 11th September 2003 we were all informed that the 62 cases had been finalised and although there are some cases that have grave concerns others have died of natural causes. It was then stated that those relatives who had died of natural causes, the decision was not to tell the families yet. The reason being was that you wanted to obtain further expert opinion, as you will recall this caused considered distress to some families. After all, we were under the impression that it was imminent that we would hear what had happened to our loved ones. Having looked at Professor Forest's credentials how anybody can doubt his word is very confusing. I would think that if he says someone died of natural causes, providing he had all the information, then this is what happened. However, I still feel that the medical files need to be read in conjunction with all relevant information from the families concerned, as these files are not a true course of events.

I have recently been informed of two cases where Professor Forest did not have all the medical files. One of those would have been in the first 20 and I say this because Mr Rushworth told me my mother was and that you were working alphabetically. When we are informed of such important issues and; the person regarding these cases was not contacted when her case was being looked at by the experts, it gives us no confidence in the eventual findings. It would appear that when we were told that the experts had all finished their analysis, this was not true. How could it be when you are still collecting medical files on some people?

In my experience all police investigations begin with signed statements and having had three visits from your officers to my house to check on the report on my mother, such a statement could have easily been taken. I understand in your letter to me that you are satisfied you have all the information on my mother's stay at the Gosport War Memorial Hospital however, that is in your opinion only. As I am not privileged to read your officer's written report I do not share your confidence. I now understand DC Robinson will be visiting relatives to make sure, yet again, that you have all the details. This is a complete waste of police time and money but if statements were taking and signed in the beginning we would not be going down this route.

In your letter dated 26th September and 4th November 2003 you have stated. "You may well get a visit from DC Kate Robinson". Almost 2 months down the line I am still waiting.

I am now requesting for a signed statement to be taken from me to end any doubt in my mind that you presently have all the details. This is an appalling situation causing considerable distress to my family and I should not have to be writing to you at this late stage on these issues.

Kind Regard

Code A

Ann Reeves

cc
Chief Constable P Kernaghan
Det. Superintendent S Watts
Chief Superintendent D Stevens

Other Document Form

Number D.44E

File of [illegible] GMH

lude source and any document number if relevant)

:eivers instructions urgent action Yes / No	Code A
:ument registered / indexed as indicated	Indexer
(s) of actions raised	Code A
.tement readers instructions	Statement Code A
lexed as indicated	Indexer
(s) actions raised	
amined - further action to be taken	O/M / SIO
irther actions no(s)	Indexer

/hen satisfied all action raised Office Manager to endorse other Document Master Number Form.

I ACKNOWLEDGE RECEIPT OF TWO DVDs CONTAINING THE PATIENT RECORDS THAT WERE SIEZED FROM THE GOSPORT WAR MEMORIAL HOSPITAL.

Code A

.....

Director of Finance

17.3.00

SPOKE TO DR BARTON IN THE TREATMENT ROOM AND SAID COULD I HAVE A WORD. I SAID THAT IF I HAD OFFENDED HER IN ANY WAY THAT I WAS VERY SORRY AND I APOLOGISED.
SHE REPLIED THAT IT WAS NOT THAT BUT THE FACT THAT I HAD DIFFICULTY IN "ACCEPTING WHAT WE DO HERE".SHE SAID SHE WAS ANNOYED THAT MRS ROBINSON HAD SPOKEN TO ME ABOUT IT AND THAT SHE HAD IN FACT CALLED HER THAT DAY TO SAY THAT.
DR BARTON CONTINUED WITH THE FACT THAT SHE THOUGHT I HAD DIFFICULTY "KEEPING ALL THE BALLS IN THE AIR AT THE SAME TIME" AND WOULD THERE BE MUCH DIFFERENCE IN PAY BETWEEN TOP E AND MY PAY WITH THE NEW PAY RISES COMING INTO EFFECT.
I SAID "NO" AND SHE ASKED ME IF I WOULD NOT PREFER TO GO TO QAH AS A TOP E AND NOT HAVE ALL "THE STRESS" OF MY PRESENT ROLE.
I SAID I WOULD ACTUALLY HAVE MORE WORKLOAD AT QAH AS AN E THAN I HAVE IN MY PRESENT POST AS AN F.AND THAT I HAD NO INTENTION TO WORK AT QAH IN THE NEAR FUTURE.

She also said I was not the only one.

* Syringe Divers – De BeeWee.
Not all staff happy with decisions – trained + untrained.

Hill – very defensive.

Difficult @ QAH. – because of G. grade
Called Hill for support – not happy due to attitudes needed to talk.
Told advice given for wrong reasons.

– if this was already in pipeline (Performance Plan) not aware when had PPR – would never have applied for G. ∴ would not have had stress on E. Keen.

Sign – wants my job!

MEETING RE: PERFORMANCE 14.3.00

I MET WITH SISTER HAMBLIN AT HER REQUEST. I SAID TO HER THAT BEFORE SHE STARTED THAT DURING MY ABSENCE FROM THE WARD I HAD TIME TO REFLECT ON MY RELATIONSHIP WITH HER AND THAT I HAD NOT ALWAYS SUPPORTED HER AS I SHOULD HAVE DONE. I HAD ALLOWED MYSELF TO BE USED BY OTHER MEMBERS OF STAFF AND THIS WAS NOT RIGHT AND IT WAS SOMETHING THAT I WAS GOING TO CORRECT.

I FELT I NEEDED TO STAND BACK MORE AND THINK ABOUT MY POSITION BEFORE MAKING DECISIONS AND IF NECESSARY REFER TO SISTER HAMBLIN.

I WAS TOLD THAT I WAS HAVING A PERFORMANCE PLAN THAT HAD BEEN COMPILED WITH THE HELP OF PERSONNEL.

WE DISCUSSED MY INTERVIEW WITH MRS ROBINSON LAST WEEK AND THE FACT THAT SHE HAD RAISED THE SUBJECT OF MY MANNER OF COMMUNICATING IN A POOR WAY WHEN I WAS UNDER STRESS. I WAS NOT AWARE OF THIS. SISTER HAMBLIN SAID SHE WISHED THAT MRS ROBINSON HAD EXPLAINED TO ME WHAT SHE HAD MEANT. I SAID THAT MRS ROBINSON DID SAY THAT SHE HAD NEVER SEEN ME THAT WAY HOWEVER.

SISTER HAMBLIN SAID STAFF OF ALL GRADES HAD COMPLAINED ABOUT THE WAY THAT I SPOKE TO THEM BUT THEY HAVE REFUSED TO PUT IT IN WRITING.

I WAS NOT AWARE OF THIS AND AT NO TIME HAS THIS EVER BEEN DISCUSSED WITH ME ACTUALLY I HAVE HAD VERY GOOD FEEDBACK FROM THE STAFF AND DURING MY ACTING UP PERIOD LAST YEAR I WAS TOLD BY MY MANAGER THAT THE WARD HAD A GOOD ATMOSPHERE.

MRS ROBINSON HAD ALSO SAID THAT DR BARTON HAD REPORTED THAT SHE FOUND ME DIFFICULT TO WORK WITH AND ASKED ME IF I HAD EVER HAD ANY PROBLEMS WITH DOCTORS BEFORE I SAID NO AND I WAS UNAWARE OF ANY DIFFICULTY.

I WAS SHOWN THE PERFORMANCE PLAN AND DID NOT UNDERSTAND IT ALL.

SISTER HAMBLIN SAID SOME OF IT WAS NITPICKING AS ONE ITEM REFERED TO ME PHONING THE WARD AT BREAKFAST TIME I HAD WAITED UNTIL DRS ROUND WAS OVER BUT I SHALL REFRAIN FROM DOING SO IN FUTURE.

"They don't want them there". They have interpreted.

TALKING TO RELATIVES WAS ANOTHER ISSUE RAISED TO MY KNOWLEDGE I HAVE NOT HAD A PROBLEM WITH THIS ONE INCIDENT DISCUSSED WAS WHEN SN SHAW WAS HAVING A DIFFICULT CONVERSATION WITH A RELATIVE IN THE HALLWAY I JOINED HER FOR SUPPORT THIS WAS AT THE END BY PHOENIX DAY HOSPITAL AFTERWARDS SHE COMMENTED THAT I HAD DEALT WITH IT WELL I DO ACCEPT THAT I SHOULD HAVE TAKEN THE RELATIVE TO A ROOM FOR PRIVACY. Jill says Freda 2 paced.

WE AGAIN DISCUSSED MY MOVING TO QAH AND AGAIN I SAID I WAS NOT READY FOR THE MOVE I AM BEGINNING TO FEEL PRESSURIZED.

SISTER HAMBLIN SAID A COMMENT WAS MADE WHO IS IN CHARGE OF THE WARD ME OR HER? ANOTHER UNWRITTEN COMMENT.
I HAVE ALSO BEEN ASKED FOR THE KEYS TO THE DESK THAT MRS ROBINSON GAVE ME AS SHE FELT THAT I SHOULD HAVE ACCESS TO ALL WARD DOCUMENTATION AS DEPUTY CLINICAL MANAGER I NEED A CONFIRMATION OF MY ROLE AND WHAT WARD DECISIONS I CAN MAKE e.g BED MOVES ETC.. AND WHAT I HAVE ACCESS TO AND WHAT NOT.

Different when Jill not on.
Not attended courses.
Body Language – don't mess with me today
Porters & Caterers did I feel I could do better – no
Relatives how did I feel when they are angry – sorry Pat Ken
Ward Clerk – commented on time spent & Barbara.
Teaching not started. – Training & Development?
Stress management – off sick called to cancel.

Pre-Surgery stress.
Advised me to see Barbara / Bill week prior to interview to ask what their plan was for me.
~~with Barb off duty~~.

Tooth + Jacket Potatoe.
Handover – 7.30 – Dr Barton.

Reading Paper.

(1). Relationship & other staff – how I speak to them.
Supporting her with other staff.
Good ideas not followed through.
Getting teaching going.
Not attended training – another letter.

Meetings & Jill have discussed many times her helping me and treating me like an F grade.
No days involves other people.

JUST A PAIR OF HANDS
OFF DUTY GIVEN TO E GRADES
WANTS KEYS BACK
NO DECISION MAKING
NO DEFINITE ROLE CLINICALLY NO DECISIONS
SARCASTIC REMARKS AT DESK TO WHOM
E GRADES INVOLVED MORE IN DECISIONS THAN ME
NO MANAGERIAL INPUT AT ALL SAID SHE WAS IN AT THE DEEP END

ria	Completion Date and Comments

Portsmouth HealthCare NHS Trust
MEMORANDUM

From

Barbara Robinson

BR/lp

To

Shirley Hallman

09 April 1999

RE: APPRAISAL INTERVIEW

Shirley, thank you for meeting with me on Thursday 1st April 1999 for your Appraisal.

It has been a difficult and disappointing year for you where you feel there has been no development in your role and where you had no autonomy. However, you have achieved the implementation of nursing teams and given a greater leadership role to the 'E' grades.

In the last month you have had the opportunity to lead the team in your 'Acting Up' role. You have made significant steps forward in many areas and have excellent plans for developing the staff and helping them to feel valued.

You have agreed to continue to 'Act Up' in the absence of the Clinical Manager and for this I am very grateful. We have discussed your objectives, which focus on good team management and communication. You are also going to develop your own clinical role and hopefully the Ward will pass the Education Audit and have Student Nurses.

Congratulations on your achievements so far and please do not hesitate to use me for advice and support.

Code A

PORTSMOUTH HealthCare NHS TRUST

Year: 1999/2000 **Date of Appraisal: 1st April 1999**

Manager's Name: Barbara Robinson

Team Name: Dryad

Employee Name: Shirley Hallman

Key Objective	Achieve By	Measurement Criteria	Evaluation
1. Business Planning			
1.1 Agree Team Objectives and Training needs.	May 1999	Team Objectives and Training Plan forwarded to Code A	Achieved.
1.2 Ensure all staff have an Appraisal and Personal Development Plan.	May-October 1999	Evidence of completed Appraisals and Reviews	
Review	Nov-March 2000		
1.3 Evaluate all training with staff and form action plans.	Ongoing	Evidence of completed T1 and T2.	
1.4 Ensure all new HCSW's complete NVQ Level 2 in Care.	Within 2 years of appointment	New HCSW's have gained NVQ Level 2.	Ongoing.
2. Communication	Dates by April 1999	Dates are in place for the year.	
2.1 Hold staff meetings	Monthly	Evidence of meetings having taken place.	
2.2 Continue to work in partnership with Social Services.	Ongoing	Meetings with Social Worker based at GWMH. Evidence of shared documentation.	

Employee Name: Code A

Key Objective	Achieve By	Measurement Criteria	Evaluation
2.3 Attend Community Hospital Contract Group Meetings whilst acting up.	Ongoing	Have been able to contribute to service planning Trust wide.	
2.4 Establish a fair system for off duty and A/L	June 1999	Staff are satisfied with the Duty Rotas	
3. Service Development/Clinical Governance			
3.1 Continue to work on projects connected with Health Promoting Hospitals	Ongoing	Evidence of implementation of project	Ongoing
3.2 Introduce Clinical Supervision.	June 1999	A small 'Action Learning' group has been set up	Date to be arranged.
3.3 Monitor service specific and infection control standards.	As per monitoring calendar	Reports from audits.	
3.4 Participate in Consumer Satisfaction Survey	October 1999	Evidence of feedback from consumers	
3.5 Work with Practice Development Facilitators	Ongoing	Attended Away Day 20th May 1999 to discuss way forward.	
3.6 Implement teaching sessions for trained staff	Fortnightly	Trained staff are able to demonstrate development in their practice	ongoing - monthly.
3.7 Support trained staff to increase their autonomy	Ongoing	Trained staff are confident in leading their teams and in taking decisions	
3.8 Update Ward philosophy	June 1999	Ward philosophy is displayed on Ward	
3.9 Prepare for Student Nurses	September 1999	Successful audit completed by Southampton University	
4. Personnel			
4.1 Continue to monitor sickness absence.	Ongoing	Staff are seen on return from sick leave. Long term sickness is managed with Personnel and Occupational Health.	

Employee Name: Code A

Key Objective	Achieve By	Measurement Criteria	Evaluation
4.2 Maximise recruitment	Ongoing	Recruitment is integrated within the Hospital with vacancies/adverts/interviews.	
5. Finance			
5.1 Strive to work within budget.	Ongoing	Budget statements.	
5.2 Alert Service Manager of pressure points.	Immediately	BR/Accountant aware of pressure points.	
6. Millennium			
6.1 Work out staffing for Christmas and the New Year	June 1999	There is an agreed staffing strategy	

Employee Name .....

Key Objective	Achieve By	Measurement Criteria	Evaluation
Appraisal –	March –		
Staff Training.	By May.	Ongoing..	
Moving Handling Booking.			
Fire Lectures			
C.P.R.			
N.V.Q	**Code A**		
Staff meetings –			
S.N.	**Code A**		

Minutes of Ward Meeting, March 9th, 2000.

Present

Lynne Barrett,	Freda Shaw,	Gill Hamblin,	Debbie Barker,
Gill Ryder,	Jeanette Florio,	Pauline Goode,	Denise Lyons,
Liz Bell,	Eileen Harris,	Cheryl Gamblin,	Ruth Linford,
Margaret Wigfall,	Anita Tubbritt,	Pippa Jones,	Jane Basson,
Maria Wordley,	Leonnie Cosgrove.		

Letter of thanks received from Ted Stares, including a £25 donation for staff. It was agreed that this would be added to the tea boat.

All staff who has worked extra hours were thanked for their efforts.

Staff were reminded to ensure that patients are sat up properly, for meals, with correct tables and clothes protectors. It was agreed that as there is a shortage of clothes protectors, if patients are happy, they could wear blue aprons. More clothes protectors to be purchased.

It was suggested that we might like consider our ward being put forward as a 'centre of excellence'. Lynne Barrett to obtain more information before a decision is made.

Staff were reminded that when attending to patients, to check their hands, necks and creases, especially when poorly.

Staff were reminded to ensure that patients have the correct tables, that is, bed tables when in bed and chair tables when in chairs. It was requested for more urine bottle holders to be purchased. Staff were asked to be more careful with metal catheter bag hangers, as they cost £1.16 each to replace!

Off duty and staff rotas were discussed. The option of self-rostering was suggested. This would include staff selecting two early and two late shifts, plus one other. If there were no cover for a shift, Sister or S/N Barrett would organise cover. Other rota systems were suggested and discussed. A two week trial of self-rostering to be commenced.

It was requested that pharmacy receipts and property forms be placed in the correct files, not left on Sister's desk.

Staff were reminded that it was their responsibility to look out for and read course information leaflets, and not to rely on being told.

A book on Ethnic minorities and cultural differences is now available in Sisters office.

After trial, it was agreed that Syringe driver charts were useful, but it was felt that sections for additives and fluid length were required. SS/N Tubbritt will attempt to modify the charts.

Clinical supervision groups are going well – as yet no feedback from either group.

Ward donations discussed.

Nutrition group – patients to be weighed within 48 hours of admission, if appropriate. There has been some discrepancy of weights using chairs. Other uses for 'Thick and Easy' were mentioned to group.

Toileting – Staff were reminded that they cannot legally refuse to toilet anyone at mealtimes. Use common sense and offer toilet prior to meals, or take patients out of the dinning area to toilet if necessary.

Excessive heat problem discussed. Night staff to monitor room air temperature using food probe, and to record daily in the diary. Previous temperature monitoring was not acceptable to the estates department.

Staff were reminded to help patients who have meals and drinks left. Night drinks problem also highlighted. To try for a volunteer to help with morning coffees. Domestic/staff unofficial breaks also discussed.

It was requested that a notice board or book displaying our thankyou cards be placed on view.

Night staff were reminded to ask all patients with dentures if they would like them cleaning/soaking.

S/N Gill Ryder thanked everyone for making her feel so welcome.

Staff were reminded that toiletries soaps etc. should not be wrapped in blue hand towels or contiwipes.

S/N Jane Basson volunteered her services of Aromatherapy and massage for patients. She would like to offer her services free to staff, on a trial basis, for feedback with a view to use on patients, in the future. Contact S/N Basson for further details.

Staff were reminded that all lower leg/foot bandaging should be toe to knee, not, toe to ankle.

Next ward meeting – Tuesday 25th April at 1.45pm.

Report of Investigation into allegations of harassment by Staff Nurse Shirley Hallmann relating to Gill Hamblin , Clinical Manager and Dr Jane Barton, Clinical Assistant.

Purpose of Investigation:

To establish whether there is evidence to support the allegation of harassment and to clarify the following:

1. The issues and events which led to Staff Nurse Hallmann making the allegation.
2. The perspective of these issues and events held by Gill Hamblin and Dr Jane Barton.
3. Background information on events leading to the letter of complaint.

Documentation supporting this report:

1. Correspondence
2. Transcripts of interviews with:
   - Shirley Hallmann and Betty Woodlands
   - Maureen Mills
   - Gill Hamblin
   - Dr Jane Barton
   - Barbara Robinson
   - Rena Pearce - at the request of Shirley Hallmann
3. Additional information submitted by Shirley Hallmann.

1. The issues and events which have led to Staff Nurse Hallmann making this allegation.

1.1 The letter of complaint:

Shirley Hallmann is an F'Grade on Dryad Ward, Gosport War memorial Hospital.
She has been in post for 2 years.
She feels she is being harassed by her line manager, Gill Hamblin to consider moving to an E' grade post at QAH and that this is being reinforced by Dr Jane Barton.
She feels 'not wanted' on Dryad Ward.

1.2 The role of the F' Grade, Deputy Clinical Manager on Dryad Ward:

This was felt by Shirley to be ill-defined and that she had little opportunity to use her initiative or assume responsibility.
She felt bored and sought opportunities to develop her management/leadership skills.
She felt frustrated by Gill Hamblin's directionless leadership style.
She was keen to achieve a G'grade post and had applied for posts.
She had particularly enjoyed the period when she had acted up as the G' grade on Dryad Ward, whilst Gill Hamblin was on long term sick and had received positive feedback from her line manager on her performance. This led to greater frustrations in the F' grade role when Gill Hamblin returned to work.

1.3 The professional relationship between Shirley Hallmann and Gill Hamblin:
This is poor and periods of long term sickness by both individuals has meant that efforts to improve it through the Personnel Department, have been ineffectual.
The relationship was temporarily 'rescued' when the opportunity for Shirley Hallmann to work on Edith Keen Ward arose.
The relationship further deteriorated on her return to Dryad Ward when she was presented with the performance plan.
The unsuccessful application to the G' grade post on Edith Keen Ward, and the lack of F' grade posts at QAH further exacerbated the difficulties in the relationship, particularly when the offer of an E' grade post at QAH was rejected by Shirley Hallmann.

1.4 The changing role of Dryad Ward from continuing care to rehabilitation:
This change had produced a more demanding client group and increased expectations of relatives/carers, which has increased the service pressures of the ward.
It has also increased the training needs of the team.

1.5 The Team Dynamics
Tensions are high amongst the team members and communication poor, with gossip and hearsay rife.
Several staff have complained to Gill Hamblin about Shirley Hillmann's manner, but have not felt able to approach Shirley directly or to put it in writing.
Shirley Hallmann felt marginalised by the team dynamic, particularly the role of the E' grades.

2a. The perspective of these issues from Gill Hamblin:

2a.1 Work opportunities at QAH:
Gill Hamblin felt she had supported Shirley Hillmann's application to the G' grade post on Edith Keen and was aware of her ambition for G' grade posts.
She thought Shirley had wished to extend her experience in an acute setting and had supported her transfer to QAH. She was surprised when Shirley chose to return to Dryad.
She provided almost daily support to Shirley whilst she was working on Edith Keen.

2a.2 The F' Grade Role on Dryad ward:
Gill Hamblin felt this was a difficult role on Dryad ward and had had to be persuaded to make an appointment to it. The previous 2 post holders had had difficulties. The reason for this was unclear, but there was clear support for the division of the team into 3, each led by an E' grade.
Gill Hamblin felt that Shirley lacked insight into how she filled the deputy role and was impatient, wanting to force change rather than negotiate it. She attributed this to inexperience and offered Shirley opportunities for training which for various reasons Shirley was unable to attend.

2a.3 The professional relationship between Shirley Hallmann and Gill Hamblin:

At the time of the investigation, Gill Hamblin was frustrated and angry with Shirley Hallmann and felt manipulated by her. She felt the complaint was unjustified as she had always sought to support Shirley particularly over recent weeks when Shirley had been working at QAH.

Gill Hamblin sited several occasions when Shirley Hallmann had sought her advice, particularly following the unsuccessful interview and the consideration of the E' grade post.

She felt there were performance issues, particularly related to team relationships and Shirley's attitude, which she hoped would be addressed by the performance plan, but admitted some clumsiness in introducing it in the March 14th meeting.

2a.4 The changing role of Dryad Ward:

Gill Hamblin agreed that the work of the ward had changed and wondered whether this had proved too stressful for Shirley, causing her rather aggressive manner.

Patients and relatives seemed to prefer to speak directly to her rather than Shirley and this led to increased tensions between them.

2a.5 The Team Dynamics:

Gill Hamblin described her team as 'great' and that the atmosphere of the ward was harmonious when Shirley was not on duty. Tensions were high when they both worked the same shift.

She felt Shirley could be moody, unpredictable and super sensitive. She also commented on Shirley's high sickness levels since her appointment.

2b. The perspective of these issues from Dr Jane Barton:

2b.1 Work opportunities at QAH:

Jane Barton was emphatic that she had only wanted to support and advise Shirley through her decisions regarding opportunities at QAH. At no time had she wished to put her down.

2b.2 The F' Grade Role on Dryad ward:

As a visitor to the ward Jane Barton did not feel it was her place to comment on such a management issue.

2b.3 The professional relationship between Shirley Hallmann and Gill Hamblin:

Jane Barton described Shirley as tending to 'work to her own agenda' and not being a 'team player'.

She felt that Shirley could be aggressive in manner and was prone to periods of apparent sulking.

She observed that she thought that Shirley tended to prefer 'paper work' to a more clinical role and she described Gill Hamblin as being very much the ' clinical boss' with a competent control of the ward.

2b.4 The changing role of Dryad Ward:
Jane Barton felt Shirley Hallmann had managed tolerably well when she was acting-up, but the ward had been quiet at that time.
She felt the changing role of the ward had impacted on the work of the team, with families being increasingly demanding.

2b.5 The Team Dynamics:
Jane Barton felt unable to comment on this but observed that it was often easier not to disagree with Shirley's opinion rather than upset her.

3. Background information:

3a. Personnel - Maureen Mills:

3a3 The professional relationship between Shirley Hallmann and Gill Hamblin:
The poor professional relationship between Gill Hamblin and Shirley Hallmann had been brought to the attention of personnel up to a year ago, and support and guidance had been given to both individuals during that time.
There were felt to be valid issues on both sides.

3b. Barbara Robinson - Service Manager:

3b.1 Work opportunities at QAH:
She felt that Shirley had performed well in the role of acting clinical manager.
She encouraged her to consider the experience of working at QAH.
In giving feedback following the unsuccessful interview she encouraged Shirley to reflect on her manner and how this might affect a situation, as this had been particularly noticeable in the interview.
The E' grade posts was offered as there were no F' grade posts available at QAH, and Barbara felt this might have been a good way into the Acute service.

3b.2 The F' Grade Role on Dryad ward:
Barbara had encouraged Gill Hamblin to recruit an F' grade has she felt it would provide support to the Clinical Manager and strengthen the leadership of the team.

3a.3 The professional relationship between Shirley Hallmann and Gill Hamblin:
She wondered if Gill Hamblin's obvious clinical expertise and hierarchical manner actually undermined confidence in others.
She had not observed any unprofessional or inappropriate behaviours whilst she was Shirley Hillman's line manager, nor had anyone approached her with concerns about Shirley's competence.

3b.4 The changing role of Dryad Ward:
She noted that this had changed.

3b.5 The Team Dynamics:
Barbara Robinson felt that Shirley Hallmann had managed very well when she was acting clinical manager. Several changes had been implemented and hierarchical

structures removed which had enabled healthcare support workers to be particularly valued. Team objectives had been introduced for the first time and appraisals organised. The team had appeared happy.

3c. Rene Pearce

3c.3 The professional relationship between Rena Pearce and Gill Hamblin:

Rena Pearce had difficulties in her professional relationship with Gill Hamblin.
She had felt ostracised by the team and unsupported by Gill Hamblin.
She felt her confidence was continually undermined.
She became very scared and felt hurt, sad and depressed.
This was resolved when she left the ward. for another position.

3d. 19.04.00 Incident reported to me by Shirley Hallmann as an example of the poor working relationship between herself and Gill Hamblin.

A difference of professional opinion concerning discharge produced an angry response from Gill Hamblin at the team handover and apparently inappropriate behaviours towards a patient.

Investigator's Observations:

1 Work opportunities at QAH:

Shirley Hallmann would appear to rely quite heavily on the advice of others, when making decisions relating to her career.
She is keen to gain a G' grade post, particularly as she had enjoyed the acting-up role.
She appears ambivalent as to whether she wishes to work in the Acute service, but whether this was related to the grade of post on offer or the type of work was difficult to determine.
Both Gill Hamblin and Dr Jane Barton had sought to be supportive whilst she was making these choices.

2 The F' Grade Role on Dryad ward:

There do appear to be some doubts expressed as to whether this post is tenable on Dryad Ward.
This ambivalence may have encouraged the team 'splitting' evident in this investigation

3 The professional relationship between Shirley Hallmann and Gill Hamblin:

The emotional content of this investigation was extremely high and was particularly evident in the interviews of the key parties. This emotion was partially triggered by the letter of complaint, but was also evident in descriptions of the working relationship of Gill Hamblin and Shirley Hallmann and is clearly in my opinion very deep-seated.
Professional rivalry and leadership competitiveness are evident, not helped by the fact long term sickness has enabled each to enjoy the role unchallenged by the other.

4 The changing role of Dryad Ward:

The three key players all appeared stretched and this investigation added to this. They attributed this to the increased work pressures due to the changing role of the ward.

5 The Team Dynamics:

The leadership issue is potentially quite destructive to the team of Dryad Ward and there is evidence of this already occurring and potentially affecting patient care.
During the weeks of the investigation I was made aware of an exacerbation in the poor working relationship between Shirley Hallmann and Gill Hamblin, which may cause further difficulties when seeking a resolution to this issue.

Conclusion:

Mis-interpretation, fuelled by poor communication, differences in perceptions, professional rivalry and unsubstantiated expectations seems to be the theme of the investigation, rather than a calculated and malicious attempt to drive Shirley Hallmann from the ward. In fact, both defendants appear to have played quite supportive roles when asked for advice by Shirley Hallmann, in the past.

Rosemary Salmond, Investigating Officer.

Notes of the Meeting held between Shirley Hallman, Betty Woodland and Rosemary Salmond on Thursday 30 March 2000 at 9.00am. in the Potteries.

This meeting was arranged as part of the formal investigation into a harassment claim brought by Shirley Hallmanounder the umbrella of the Trust Policy 'Harassment - policy for the prevention of'.

The meeting began with Shirley recounting the reasons why she had needed to have an extended period of sick leave between the beginning of November 1999 and the January 2000. This had included gynaecological surgery and a tooth extraction, following several weeks of pain. Shirley had found this time very traumatic, particularly as she has 'difficult memories' to manage during the Christmas period.

Shirley returned to work on January 24 2000.

Shirley had an IPR review with Gill Hamblin in February. Shirley has not yet received a report from this review. At the time of the original IPR, Shirley was in an acting-up capacity as Gill Hamblin was on long term sick. A copy of the original IPR carried out by Barbara Robinson on 1st April 1999 and a memo written by Barbara Robinson on April 9th 1999 are attached to these notes.

Shirley described how during the IPR review she had discussed with Gill Hamblin, her frustrations of her current role in the team. She felt her role as deputy was ill-defined, with little responsibility and opportunity to use her initiative. She felt bored and asked for opportunities to develop her management/leadership skills. She recognised that their working relationship was strained and sought ways to improve this. She would like to be able to support Gill more, " to be leaned on".

Shirley emphasised that she had been feeling like this about her job prior to her sick leave and had resolved on returning to work that she would try to sort it out. She was feeling so much better and she did not wish work stresses to cause further illness.

As part of this resolve she had applied for an G-grade post at Queen Alexander's Hospital.(QAH)

Shirley described how an opportunity had arisen for some of the Gosport Team to go and work at QAH for one month to assist with a vacancy problem. Gill Hamblin encouraged her to consider this and so she went to work on Edith Keen Ward which coincidentally was the ward where the post she had applied for was. A member of the Edith Keen staff had also applied for it and Shirley was conscious of the tensions associated with this. She described how she had sought support for this from Gill Hamblin and had frequently phoned her.

Shirley was interviewed for the G-grade post but was not successful. She received interview feed back from Barbara Robinson, who previously had always been very supportive, but was surprised at some of the content. She was told that she had a reputation of having an 'attitude problem'and that Dr Barton found her challenging to work with. She was told that there were no F-grade vacancies at QAH but there were E-grade posts which she might wish to apply for. Shirley stated that she did not like the fast track nature of the acute service work and decided to return, with some apprehension, to her post on Dryad Ward at Gosport.

On March 10th Shirley received a phone call from Gill informing her that she was to work a "straight shift" on the Sunday and that she wished to meet with her on the following Tuesday, March 14th.

Shirley described this meeting on March 14th in great detail and frequently referred to notes she had made straight afterwards. She described how she began the meeting with apologies for not supporting Gill in the way she could expect from her deputy. She was then told by Gill that following consultation with Maureen Mills, Senior Personnel Manager, a performance plan had been drawn up.

Shirley said that she was told that this plan had been produced because she had a poor "communication manner, when under stress" and that "all grades of staff including Porters and Caterers" had complained about this. Shirley was shocked as she was not aware of this and it had never been discussed with her before. In fact during her period of acting-up, she had received very good feedback from the staff and had been complimented on the good atmosphere of the ward.

In describing the performance plan, Shirley felt that little account had been taken of her IPR objectives, that she was a challenge to Gill's leadership and as a consequence responsibility and initiative were being further removed from her role. She did not feel that she her role as deputy clinical manager was being acknowledged. She felt "she was just another pair of hands"

The meeting on the 14th.March continued with more encouragement from Gill Hamblin for Shirley to consider the E-grade post at QAH. Shirley felt pressurised by this, in the light of the content of the rest of the meeting.

In discussing the provocation for the letter Shirley had written on 24th March formally requesting this investigation, Shirley described Gill Hamlin's leadership style as one of mixed messages, innuendo, no action, directionless, nothing was ever recorded and that there was a lot of exaggeration. She felt Gill was challenged by anybody with knowledge or new ideas and controlled her team by encouraging passivity. She emphasised that these feelings were based on her experiences over the 24 months she had been in post on the ward.

When asked what resolution she sought to this investigation, Shirley replied that she would like to be helped to develop a better working relationship with Gill Hamlin, based on openness, clear strategy, innovation and mutual respect.

Signed: Shirley Hallman Code A

Rosemary Salmond Code A

Notes of the meeting held between Maureen Mills, Personnel Manager, and Rosemary Salmond, Investigating Officer, on Tuesday April 4th 2000

This meeting was convened, as part on the investigation triggered by a formal complaint of harassment by Shirley Hallman implicating Gill Hamblin and Dr Jane Barton.

Maureen described how she had given a lot of individual time to both Gill Hamblin and Shirley Hallman over the last year or so. These meetings were often triggered by the poor working relationship between the two and tended to have more of a 'salvage' result rather than produce lasting change. She felt that there were issues on both sides.

Maureen stated that she had one formal dealing with Gill Hamblin. She described her as 'pressured when the ward was full', good with practical issues and very good with relatives.

However, personnel had had more knowledge of Shirley Hallman. An exit interview undertaken by Melanie Kyme was shared with Gill Hamblin as it referred to Shirley's manner towards staff. Gill Hamblin had frequently stated that several staff had complained to her about Shirley but despite encouragement nothing had been put in writing. Shirley had frequently not attended courses she had been booked on and tended to be 'initially enthusiastic but not so good on implementation.'

Maureen described how she had been approached by Gill for help in working with Shirley on her return to the ward, to address some of these issues. Gill had said that she had spoken to Shirley previously about her manner with other staff and so Maureen sent Gill a draft format anticipating that it would be used in discussion.

Code A

Maureen Mills

Rosemary Salmond

Notes of the meeting held on Thursday April 6th 2000, between Gill Hamblin, Ward Manager of Dryad Ward, and Rosemary Salmond, Investigating Officer.

This meeting was convened as part of the investigation into the formal complaint of harassment brought by Shirley Hallman against Gill Hamblin and Dr Jane Barton.

Gill Hamblin stated that she had been the Ward Manager of Dryad Ward for 10 years. She described her team as 'great' and the atmosphere of the ward to be harmonious particularly when Shirley Hallman was not on duty. Whilst there were still 2 members of the original team, Gill Hamblin felt that staff turnover was high, particularly since Shirley's appointment.

In discussion of the role of the 'F' grade nurse on Dryad, Gill Hamblin felt it was a very difficult role within the team. She described how she had had 3 F' grade nurses during this time and none of them had been successful appointments. She described how the team was divided into three, with each division led by a E' grade staff nurse. She described how she had had to be persuaded to appoint to the F' grade.

In describing her leadership style, Gill Hamblin preferred to 'lead by example', where possible she liked there to be 'consensus decision making,' but recognised that 'policies had to be adhered to.' She felt her role was to support and advise team members.

In describing Shirley Hallman's manner, she felt she could be 'formidable and intimidating' and quick to 'put people down.' She stated that this was Shirley's first appointment as an F' grade and that she had wanted to 'change things' and that she tended to 'lay down the law' rather than 'negotiate solutions.' She felt Shirley could be 'moody'. She tended to 'stew on things', was 'unpredictable' and often responded without thought. She would 'read things into things' and was 'super sensitive.' She was also 'status orientated,' liked to do everything and wanted a G' grade post. Shirley had had frequent periods of sickness probably amounting to 6 months in all, since her appointment 2 years ago.

In considering the events leading up to this investigation, Gill Hamblin expressed her anger. She felt 'set-up' and that Shirley Hallman had 'come back to cause trouble'.

In discussion about Shirley Hallman's transfer to QAH, Gill Hamblin recalled how Barbara Robinson had sought permission from her to send Shirley to QAH for one month and how Shirley had been ambivalent about going and had approached her for advice. Whilst working in QAH, Gill Hamblin recalled how she had received almost daily phone calls from Shirley, complaining about the work and seeking support.

Gill Hamblin stated that she was aware that Shirley Hallman had been actively looking for a G grade post for some time and she had supported Shirley Hallman's application for the post at QAH. Shirley Hallman had sought her advice following the unsuccessful interview and particularly about considering an E grade post.

Whilst Shirley Hallman was working at QAH, Gill Hamblin reiterated how well the ward had been functioning and the good atmosphere that had prevailed.

Gill Hamblin admitted to feelings of irritation concerning the regular phone calls and this together with unsubstantiated complaints about Shirley Hallmann's manner from the team, led her to consult with Maureen Mills. She was keen to 'sort things out.'

In describing the meeting with Shirley Hallmann, on Tuesday 14th March, Gill Hamblin expressed surprise at the apologies initiated by Shirley. She wondered at their sincerity and felt manipulated. Gill Hamblin then told Shirley of the complaints about her manner and drew her attention to a performance plan, drafted by Maureen Mills. Gill Hamblin described how she was anxious to get it agreed as she was aware that Maureen Mills was shortly to go on leave. Gill Hamblin stated that Shirley had been very shocked to receive the feedback about her manner as she had never been complained about before.

Gill Hamblin felt that Shirley had noted what had been discussed and feedback from the team 'queried why Shirley Hallmann was being so nice to them.'

Gill Hamblin described how the work of the ward had changed and wondered whether Shirley Hallman's clinical competence was adequate to meeting the new demands. She felt this might explain why teaching sessions that Shirley Hallmann had been responsible for organising had not happened. In house training had been made available to Shirley but she had not always been able to attend them.

Finally Gill Hamblin commented that patients and their relatives seemed to prefer to speak directly to her rather than to Shirley Hallmann.

Signed: Gill Hamblin

Code A

Rosemary Salmond

Code A

Notes of the meeting between Dr Jane Barton and Rosemary Salmond, Investigating Officer, on Friday 7th April.

This meeting was convened as part of the investigation of a complaint of harassment brought by Shirley Hallman against Dr Jane Barton and Gill Hamblin.

Dr Barton stated that she had worked on Dryad Ward for 12 years, giving 5 sessions a week, and that she felt she knew Gill Hamblin and the team well. As a visitor to the ward she stated that she did not feel it was appropriate for her to be involved with management issues.

In describing Shirley ~~Hall~~ Hallmann's manner Dr Barton felt that she could be aggressive in manner and would also have periods of apparent sulking. It was often easier not to disagree with Shirley's opinion rather than upset her. In consequence changes to treatment routines particularly relating to opiate administration would happen on shifts that Shirley was not working. She described Shirley as 'working to her own agenda' and not really a 'team player.'

When asked how Shirley had managed when she acted up for Gill Hamblin during an extended period of sick leave, Dr Barton felt she had managed tolerably well, but the ward had not been busy as at that time the Consultant had not been admitting. Dr Barton observed that she felt Shirley appeared to enjoy 'paper work' in preference to a more clinical role.

Dr Barton described how she had only wanted to give advice and support to Shirley Hallman and had never 'put her down or been beastly to her'. She described how Shirley had asked for her advice before applying for the G grade post at QAH and how she had photo-copied some articles for her.

Dr Barton described a discussion between herself and Shirley, initiated by Shirley following her return to Dryad. Shirley had asked if there was a problem between them, to which she had replied 'no'. Dr Barton then asked Shirley how she was getting on with the job opportunities at QAH, assuming Shirley was still wanting to do acute work. 'If I had known she did not want to work there I never would have inquired .... I bitterly regret offering support'.

She described how the work on the ward had changed. There had been limited consultant cover. Families were increasingly demanding, with unrealistic expectations and one or two had been particularly difficult.

When asked how she viewed Gill Hamblin's professional role, Dr Barton described her as the 'Clinical Boss' and with a competent control of the ward. She was consistent in her approach to all staff.

Code A

Rosemary Salmond

Code A

Dr Jane Barton note.)

Rosemary Salmond

Code A

Dr.JA Barton

Code A

1st May 2000

Dear Rosemary

Notes of Meeting on Friday 7th April

Thank you for sending me a copy of your notes taken at the above meeting.
I have reservations about the paragraph concerning Barbara Robinson and her part in the problems on Dryad Ward.

It is not my intention to give the impression that Barbara set out to cause trouble between my self and Shirley. I am sure she only intended to give her a fair debrief and interpretation of how her job interview had gone. Could you please delete that paragraph.

Otherwise I have no difficulty with your interpretation of what was said.

Yours Sincerely

Code A

Jane Barton

Meeting between Barbara Robinson and Rosemary Salmond, Investigating Officer, held on Tuesday 13 April.

This meeting was held as part of the investigation into the formal complaint of harassment brought by Shirley Hallman against Gill Hamblin and Dr Jane Barton.

The issues considered at this meeting were:

a senior manager's perspective of the parties involved
a perspective of events immediately prior to the complaint.

Barbara Robinson described how well Shirley Hallman had managed during the time when she had been acting-up as Clinical Manager. She had appeared to really enjoy the management role and had worked proactively to support the application for IiP status. The team had appeared happy and hierarchical structures removed which enabled the health care support workers particularly to be valued. Team objectives were introduced for the first time and appraisals organised. However Barbara added that she felt the work of the ward had changed from continuing care to rehabilitation, particularly when Dr Ian Read took over from Dr Lord.

In describing Shirley Hallman, Barbara Robinson said she had no reason to question her competence and had not been approached by anyone on this issue. She had not observed any unprofessional or inappropriate behaviours whilst she was Shirley Hallman's line manager.

In describing Gill Hamblin, Barbara Robinson felt that she was firstly a clinician and tolerated the management role. She wondered if Gill Hamblin's obvious clinical expertise and hierarchical manner actually undermined the confidence of others.

In discussing the F' Grade position on Dryad ward, Barbara Robinson expressed doubts as to its viability, and acknowledged that she had encouraged Gill Hamblin to recruit to it as she felt this would provide support to Gill and strengthen the leadership of the team.

Barbara Robinson stated that she had offered Shirley Hallman the opportunity to gain different professional experience at QAH through Gill Hamblin. Shirley had agreed to this.

Barbara Robinson stated that during the interview for the G' grade post on Edith Keen, Shirley Hallman had presented quite negatively and been particularly critical of the ward she would be managing. During the interview feedback session, Shirley Hallman had asked what she needed to do to help herself in applications for G' grade posts. Barbara Robinson responded by encouraging Shirley to reflect on her manner and how this could affect a situation, using comments from Jane Barton as an example.

Also during the interview feedback session, Barbara Robinson stated that Shirley Hallman had been adamant she did not wish to return to GWMH. In consequence

Barbara Robinson had suggested she might like to consider an E' grade post as a way in to a career in the Acute Sector. It was left that Shirley Hallmann would think about this and let Barbara Robinson know her decision later. Half an hour after the feedback session, Shirley had rung to say she 'wasn't sure'. Barbara Robinson was surprised to hear 3 days later that Shirley Hallmann had returned to GWMH.

Code A

Barbara Robinson

Rosemary Salmond Code A

Meeting between Reena Pearce and Rosemary Salmond, Investigating Officer, on Tuesday April 19th at 1.30pm

This meeting was arranged at the request of Shirley Hallmann, as part of the investigation into the formal complaint of harassment brought by Shirley Hallmann against Gill Hamblin and Dr Jane Barton.

Reena Pearce expressed some concerns as to whether she wished to allow this interview to be included in the investigation. It was agreed that she would make a decision when she had seen this transcript.

Reena Pearce explained that she had been appointed to the D' grade post on Dryad Ward in February 1994. The team led by Gill Hamblin had recently moved there from Redcliffe Annex. She was thrilled with this appointment a she had particularly wanted to return to NHS Nursing after a prolonged spell in the private sector.

Reena Pearce described her interest in wound care and her keenness to extend her knowledge. With the benefit of hindsight she now feels that she may have been 'too enthusiastic' and that this had been perceived as a threat to the designated link nurse in the team.

Reena Pearce went on to describe how she had felt increasingly ostracised by the team and felt unsupported by Gill Hamblin as the team leader.She felt her professional confidence was continually undermined. She became very 'scared' of Gill Hamblin, cried a lot on the ward ("I've never done this before") and felt very hurt, sad and depressed.

This issue came to a head when a formal (subsequently unsubstantiated) complaint was made by an auxiliary nurse concerning Reena Pearce's clinical practice. Reena said she was devastated by this. She felt there had been collusion between the Nursing Auxiliary and Gill Hamblin. She was particularly disappointed that Gill Hamblin had never discussed this complaint with her personally.

At this point a D' grade post came vacant on Daedalus Ward and Reena Pearce left Dryad Ward. "It was the best decision I have ever made".

When asked what she now thought of Gill Hamblin, Reena Pearce stated that she was a good nurse but that her leadership was not very fair and she had 'favourites'.

When asked how well she knew Shirley Hamblin, Reena Pearce replied that she had never worked with her and as her opinion would be based on hearsay it was not given.

Reena Pearce

Code A

Rosemary Salmond

Code A

1/5/00

Dear Mrs Salmond,

I am enclosing a copy of an incident that occurred recently on Dryad. I have given a copy to Mrs Peach and discussed it with her but feel it gives an excellent example of the sorts of difficulties I experience at work. If you feel appropriate please attach it to my documents.

The situation between Sister Hamblin and myself has deteriorated even further since I met with you. She has established a close working relationship with Staff nurse Barrett which has resulted in my being excluded even further from all work related matters.

This has resulted in comments being made to me from various staff members about Sister Hamblins working relationship with Staff nurse Barrett and myself.

My exclusion is noticeable to all concerned.

Yours sincerely

Code A

Shirley Hallmann.

INCIDENT RE; PATIENT DISCHARGE 19/4/00

During the morning Mrs Rabbitt showed me her left knee which had become very swollen overnight. I told her that I would get the physio to have a look at it as the doctor had already left.
Mrs Rabbit suffers from a degenerative condition and had a planned discharge date 20/4/00, she and her husband had seen Dr Reid 18/4/00 when he had said she could go but the ward was to hold the bed for seven days due to the patients poor health and possibility of failure to manage at home.

During the course of her stay the staff had numerous discussions with her and her husband about help but they had constantly refused. The only aid was a stair lift and Mr Rabbit sole carer.
Shirley Dunleavy (physio) saw Mrs Rabbitt and told me that in her opinion she would not be safe for discharge she offered to speak to Dr Reid but he was unobtainable therefore I telephoned Dr Peters who was duty Dr for advice. He said, as he did not know the patient and we were unhappy about her safety at home to delay discharge and telephone Dr Reid the following morning.
Shirley said she would give some treatment using megapulse then and the following morning and would review again discuss with Dr Reid.
Sr Hamblin was a day off but came to the ward prior to a meeting I mentioned Mrs Rabbitts knee but she said she was for discharge as Dr Reid had said the day before I explained that her condition had changed as the knee was really enlarged and told her the opinion of the physio she still maintained that Mrs Rabbitt was for discharge.
Sr Hamlin later returned to the ward and came into handover and it was obvious to everyone that she was angry when she asked me about the cancelled discharge I again explained that the physio and myself did not agree that she was ready for discharge.
Sr Hamblin left in a very angry manner and I felt everyone was acutely embarrassed.
I received a telephone call later from Sr Hamblin saying she had referred Mrs Rabbitt to the occupational therapist that he would deal with it and would be contacting either S/N Shaw or S/N Ryder.
I later met Shirley (physio) and asked her what was happening as by this time I felt at sea with this she said it was a lie that the O/T was dealing with it as she had been there when he saw Sr Hamblin and he would not have time before Easter to sort anything out. She continued to say that the patient appeared "aghast" when Sr Hamblin appeared in her room and told her she would be going home as planned. She was shocked at Srs manner as she had held her in high regard and stated that if she were discharged the next day she wanted a letter from Sr Hamblin to state the reason for discharge in case she fell at home.
Shirley had said Sr Hamblin was so angry when she spoke to her that she "looked like she was going to explode " but that it didn't wash with her as they were used to it and sometimes felt like wearing a crash helmet before coming to the ward.
I was upset by this whole episode and took advise from Mrs Howes who told me to proceed with the clinical plan as it was clinically sound and she thought I already knew that.
To discuss the issue of Sr Hamblin with Mrs Peach in the morning which I will do.

Code A

Mrs G Hamblin

Code A

FC/WJJ

24 May 2000

Dear Gill

Thank you for attending the meeting with myself and Jane Parvin on 23 May 2000. The purpose of the meeting was to discuss the findings of the investigation undertaken by Rosemary Salmond into allegations from Shirley Hallmann that you had harassed her. As stated in my letter of 16 May 2000 I explained that the conclusion of the report indicates that misinterpretation, poor communication, differing perceptions, professional rivalry and unsubstantiated expectations are at the root of the issue investigated. As a consequence the investigator has concluded that there was no intended harassment on your part.

I explained that Jane and I had met with Shirley who had accepted the outcome of the report but remained very distressed and concerned for the future with regards to your working relationship and her relationship with the rest of the team. Your response to this was that you felt that there had been no justification on Shirley's part to make the allegation and that you found it very difficult to accept that you had behaved in a way that had contributed to the current situation. I advised you that although the original allegation of harassment had not been substantiated the issues needed to be tackled.

We discussed the issues in some detail and you agreed that as the Team Leader you were responsible for ensuring the overall effective performance of the team and the individual performance of team members. You admitted that you did experience difficulties in effectively undertaking this element of your role. This factor had been highlighted in the report and was reinforced in that the team had experienced similar issues with previous staff nurses.

You also accepted that your relationship with Shirley had broken down to the extent that it was affecting team performance and thus patient care and that this was no longer tenable. As a result you agreed that you and Shirley needed to talk to find a way forward.

The key issues were broadly as follows:-

- A breakdown in the professional working relationship between yourself and Shirley.
- Concerns regarding Shirley's performance particularly with regards to her management style.
- Shirley's isolation from the rest of the team.
- Your own skills and knowledge with regards to effective performance management.
- Support for you, Shirley and the rest of the team.

The following action was agreed:-

- A series of meetings between yourself and Shirley to be facilitated by Ann Dalby. Shirley has already agreed to this proposal. The purpose of the meetings will be to develop an effective and professional working relationship and to identify a plan to assist Shirley to improve her performance and relationships with the team.
- You will receive support and advice from Jan Peach at your monthly support meetings, specifically with regards to this issue and more generally concerning effective performance management. I would urge you to consider your own training and development needs.
- You will continue to receive support and advice from Maureen Mills.
- You will, in conjunction with Jan and Jane, identify what support is necessary for both Shirley and the rest of the team in planning Shirley's return to work from sick leave.

I appreciate that this is a difficult and stressful time for you and would urge you to seek all the support, advice, training and development opportunities that are available to you.

Yours sincerely

Fiona Cameron
Divisional General Manager
Fareham & Gosport

Mrs S Hallmann

Code A

FC/WJJ

30 May 2000

Dear Shirley

Thank you for attending the meeting with myself and Jane Parvin on 16 May 2000, also present at this meeting Betty Woodland RCN representative.

The purpose of the meeting was to discuss the findings of the investigation undertaken by Rosemary Salmond into allegations you had made against Gill Hamblin that she had harassed you. As I stated in my letter to you of 11 May 2000 the conclusion of the report indicated that misinterpretation, poor communication, differing perceptions, professional rivalry and unsubstantiated expectations were at the root of the issue investigated. As a consequence the investigator has concluded that there was no intended harassment of you.

I asked you how you felt about the outcome of the investigation and you indicated your disappointment but accepted some responsibility for areas of communication which you felt you could address in the future. You were very clear that you wanted to continue working on Dryad Ward and that your sole reasons for having brought the matter to my attention was to find a way forward. To this end you were satisfied with the conclusion of the report. The proposed means of moving this issue on was to first of all share the results of the investigation and your response with Gill.

The second element of the proposal was that both you and Gill participated in some facilitated time out with Code A to attempt to resolve the relationship issue highlighted in the report. You will continue to receive support and advice from Betty Woodland and of course may contact any member of the Personnel team for support and advice as well.

Longer term it is envisaged that you, Gill, Jane and Maureen will work with the team to progress its development.

I appreciate that this has been a difficult and stressful time for you and would urge you to continue seeking support and advice from Betty and Maureen Mills as you require it.

Yours sincerely

Fiona Cameron
Divisional General Manager
Fareham & Gosport

Copy: Betty Woodland RCN representative

Mrs S Hallmann

Code A

FC/WJJ

11 May 2000

Dear Mrs Hallmann

Thank you for your letter of 24 March 2000 which as you know initiated an investigation into the issues you raised. That investigation report is now complete and a copy is attached for you.

The conclusion of the report indicates that misinterpretation, poor communication, differing perceptions, professional rivalry and unsubstantiated expectations are at the root of the issue investigated. As a consequence the investigator has indicated that there was no intended harassment of yourself. Given the seriousness of the initial complaint and the results of the subsequent investigation I would appreciate the opportunity to discuss the report with you and the possibilities for taking things forward.

To this end I am proposing a meeting to take place on 16 May at 12.30 pm here at the Potteries (opposite St Christopher's Hospital). A copy of this letter and report will also be sent to your union representative who you may of course bring with you to the meeting. Also present at this meeting will be Jane Parvin from Personnel. Please let me know if the date and time and unsuitable and I will reorganise, if however the date and time are suitable I look forward to seeing you on 16 May at 12.30 pm.

Thank you for your patience in waiting for the result of this report.

Yours sincerely

Fiona Cameron
Divisional General Manager
Fareham & Gosport
Copies: Jane Parvin, Senior Personnel Manager, Betty Woodland RCN representative

Mrs G Hamblin

Code A

FC/WJJ

16 May 2000

Dear Gill

Please find enclosed a copy of the investigation report produced by Rosemary Salmond into allegations of harassment made by Staff Nurse Shirley Hallmann against yourself.

The conclusion of the report indicates that misinterpretation, poor communication, differing perceptions, professional rivalry and unsubstantiated expectations are at the root of the issue investigated. As a consequence the investigator has indicated that there was no intended harassment. Given the seriousness of the initial complaint and the results of the subsequent investigation I would appreciate the opportunity to discuss the report with you and the possibilities for taking things forward.

To this end I would be grateful if you could attend a meeting with Jane Parvin and myself on Tuesday 23 May at 1.00 pm at the Potteries.

You may be accompanied if you wish.

Please confirm that you are able to attend.

Yours sincerely

Fiona Cameron
Divisional General Manager
Fareham & Gosport

Private & Confidential

FC/LD

Dr J Barton
Dr Knapman & Partners
The Surgery
148 Forton Road
GOSPORT
PO12 3HH

25 May 2000

214

Dear Jane

Please find enclosed a copy of the investigation report produced by Rosemary Salmond into allegations of harassment made by Staff Nurse Shirley Hallmann.

The conclusion of the report indicates that misinterpretation, poor communication, differing perceptions, professional rivalry and unsubstantiated expectations are the root cause of the breakdown in communications between Shirley and Gill.

As a consequence, the investigator has concluded that there was no intended harassment by either yourself or Gill Hamblin.

Thank you for your co-operation in this difficult issue.

Yours sincerely

Fiona Cameron
Divisional General Manager

Report of Investigation into allegations of harassment by Staff Nurse Shirley Hallmann relating to Gill Hamblin , Clinical Manager and Dr Jane Barton, Clinical Assistant.

Purpose of Investigation:

To establish whether there is evidence to support the allegation of harassment and to clarify the following:

1. The issues and events which led to Staff Nurse Hallmann making the allegation.
2. The perspective of these issues and events held by Gill Hamblin and Dr Jane Barton.
3. Background information on events leading to the letter of complaint.

Documentation supporting this report:

1. Correspondence
2. Transcripts of interviews with:
   - Shirley Hallmann and Betty Woodlands
   - Maureen Mills
   - Gill Hamblin
   - Dr Jane Barton
   - Barbara Robinson
   - Rena Pearce - at the request of Shirley Hallmann
3. Additional information submitted by Shirley Hallmann.

1. The issues and events which have led to Staff Nurse Hallmann making this allegation.

1.1 The letter of complaint:

Shirley Hallmann is an F'Grade on Dryad Ward, Gosport War memorial Hospital.
She has been in post for 2 years.
She feels she is being harassed by her line manager, Gill Hamblin to consider moving to an E' grade post at QAH and that this is being reinforced by Dr Jane Barton.
She feels 'not wanted' on Dryad Ward.

1.2 The role of the F' Grade, Deputy Clinical Manager on Dryad Ward:

This was felt by Shirley to be ill-defined and that she had little opportunity to use her initiative or assume responsibility.
She felt bored and sought opportunities to develop her management/leadership skills.
She felt frustrated by Gill Hamblin's directionless leadership style.
She was keen to achieve a G'grade post and had applied for posts.
She had particularly enjoyed the period when she had acted up as the G' grade on Dryad Ward, whilst Gill Hamblin was on long term sick and had received positive feedback from her line manager on her performance. This led to greater frustrations in the F' grade role when Gill Hamblin returned to work.

1.3 The professional relationship between Shirley Hallmann and Gill Hamblin:

This is poor and periods of long term sickness by both individuals has meant that efforts to improve it through the Personnel Department, have been ineffectual.

The relationship was temporarily 'rescued' when the opportunity for Shirley Hallmann to work on Edith Keen Ward arose.

The relationship further deteriorated on her return to Dryad Ward when she was presented with the performance plan.

The unsuccessful application to the G' grade post on Edith Keen Ward, and the lack of F' grade posts at QAH further exacerbated the difficulties in the relationship, particularly when the offer of an E' grade post at QAH was rejected by Shirley Hallmann.

1.4 The changing role of Dryad Ward from continuing care to rehabilitation:

This change had produced a more demanding client group and increased expectations of relatives/carers, which has increased the service pressures of the ward.

It has also increased the training needs of the team.

1.5 The Team Dynamics

Tensions are high amongst the team members and communication poor, with gossip and hearsay rife.

Several staff have complained to Gill Hamblin about Shirley Hillmann's manner, but have not felt able to approach Shirley directly or to put it in writing.

Shirley Hallmann felt marginalised by the team dynamic, particularly the role of the E' grades.

2a. The perspective of these issues from Gill Hamblin:

2a.1 Work opportunities at QAH:

Gill Hamblin felt she had supported Shirley Hillmann's application to the G' grade post on Edith Keen and was aware of her ambition for G' grade posts.

She thought Shirley had wished to extend her experience in an acute setting and had supported her transfer to QAH. She was surprised when Shirley chose to return to Dryad.

She provided almost daily support to Shirley whilst she was working on Edith Keen.

2a.2 The F' Grade Role on Dryad ward:

Gill Hamblin felt this was a difficult role on Dryad ward and had had to be persuaded to make an appointment to it. The previous 2 post holders had had difficulties. The reason for this was unclear, but there was clear support for the division of the team into 3, each led by an E' grade.

Gill Hamblin felt that Shirley lacked insight into how she filled the deputy role and was impatient, wanting to force change rather than negotiate it. She attributed this to inexperience and offered Shirley opportunities for training which for various reasons Shirley was unable to attend.

2a.3 The professional relationship between Shirley Hallmann and Gill Hamblin:

At the time of the investigation, Gill Hamblin was frustrated and angry with Shirley Hallmann and felt manipulated by her. She felt the complaint was unjustified as she had always sought to support Shirley particularly over recent weeks when Shirley had been working at QAH.

Gill Hamblin sited several occasions when Shirley Hallmann had sought her advice, particularly following the unsuccessful interview and the consideration of the E' grade post.

She felt there were performance issues, particularly related to team relationships and Shirley's attitude, which she hoped would be addressed by the performance plan, but admitted some clumsiness in introducing it in the March 14th meeting.

2a.4 The changing role of Dryad Ward:

Gill Hamblin agreed that the work of the ward had changed and wondered whether this had proved too stressful for Shirley, causing her rather aggressive manner.

Patients and relatives seemed to prefer to speak directly to her rather than Shirley and this led to increased tensions between them.

2a.5 The Team Dynamics:

Gill Hamblin described her team as 'great' and that the atmosphere of the ward was harmonious when Shirley was not on duty. Tensions were high when they both worked the same shift.

She felt Shirley could be moody, unpredictable and super sensitive. She also commented on Shirley's high sickness levels since her appointment.

2b. The perspective of these issues from Dr Jane Barton:

2b.1 Work opportunities at QAH:

Jane Barton was emphatic that she had only wanted to support and advise Shirley through her decisions regarding opportunities at QAH. At no time had she wished to put her down.

2b.2 The F' Grade Role on Dryad ward:

As a visitor to the ward Jane Barton did not feel it was her place to comment on such a management issue.

2b.3 The professional relationship between Shirley Hallmann and Gill Hamblin:

Jane Barton described Shirley as tending to 'work to her own agenda' and not being a 'team player'.

She felt that Shirley could be aggressive in manner and was prone to periods of apparent sulking.

She observed that she thought that Shirley tended to prefer 'paper work' to a more clinical role and she described Gill Hamblin as being very much the ' clinical boss' with a competent control of the ward.

2b.4 The changing role of Dryad Ward:
Jane Barton felt Shirley Hallmann had managed tolerably well when she was acting-up, but the ward had been quiet at that time.
She felt the changing role of the ward had impacted on the work of the team, with families being increasingly demanding.

2b.5 The Team Dynamics:
Jane Barton felt unable to comment on this but observed that it was often easier not to disagree with Shirley's opinion rather than upset her.

3. Background information:

3a. Personnel - Maureen Mills:

3a3 The professional relationship between Shirley Hallmann and Gill Hamblin:
The poor professional relationship between Gill Hamblin and Shirley Hallmann had been brought to the attention of personnel up to a year ago, and support and guidance had been given to both individuals during that time.
There were felt to be valid issues on both sides.

3b. Barbara Robinson - Service Manager:

3b.1 Work opportunities at QAH:
She felt that Shirley had performed well in the role of acting clinical manager.
She encouraged her to consider the experience of working at QAH.
In giving feedback following the unsuccessful interview she encouraged Shirley to reflect on her manner and how this might affect a situation, as this had been particularly noticeable in the interview.
The E' grade posts was offered as there were no F' grade posts available at QAH, and Barbara felt this might have been a good way into the Acute service.

3b.2 The F' Grade Role on Dryad ward:
Barbara had encouraged Gill Hamblin to recruit an F' grade has she felt it would provide support to the Clinical Manager and strengthen the leadership of the team.

3a.3 The professional relationship between Shirley Hallmann and Gill Hamblin:
She wondered if Gill Hamblin's obvious clinical expertise and hierarchical manner actually undermined confidence in others.
She had not observed any unprofessional or inappropriate behaviours whilst she was Shirley Hillman's line manager, nor had anyone approached her with concerns about Shirley's competence.

3b.4 The changing role of Dryad Ward:
She noted that this had changed.

3b.5 The Team Dynamics:
Barbara Robinson felt that Shirley Hallmann had managed very well when she was acting clinical manager. Several changes had been implemented and hierarchical

structures removed which had enabled healthcare support workers to be particularly valued. Team objectives had been introduced for the first time and appraisals organised. The team had appeared happy.

3c. Rene Pearce

3c.3 The professional relationship between Rena Pearce and Gill Hamblin:

Rena Pearce had difficulties in her professional relationship with Gill Hamblin.
She had felt ostracised by the team and unsupported by Gill Hamblin.
She felt her confidence was continually undermined.
She became very scared and felt hurt, sad and depressed.
This was resolved when she left the ward. for another position.

3d. 19.04.00 Incident reported to me by Shirley Hallmann as an example of the poor working relationship between herself and Gill Hamblin.

A difference of professional opinion concerning discharge produced an angry response from Gill Hamblin at the team handover and apparently inappropriate behaviours towards a patient.

Investigator's Observations:

1 Work opportunities at QAH:

Shirley Hallmann would appear to rely quite heavily on the advice of others, when making decisions relating to her career.
She is keen to gain a G' grade post, particularly as she had enjoyed the acting-up role.
She appears ambivalent as to whether she wishes to work in the Acute service, but whether this was related to the grade of post on offer or the type of work was difficult to determine.
Both Gill Hamblin and Dr Jane Barton had sought to be supportive whilst she was making these choices.

2 The F' Grade Role on Dryad ward:

There do appear to be some doubts expressed as to whether this post is tenable on Dryad Ward.
This ambivalence may have encouraged the team 'splitting' evident in this investigation

3 The professional relationship between Shirley Hallmann and Gill Hamblin:

The emotional content of this investigation was extremely high and was particularly evident in the interviews of the key parties. This emotion was partially triggered by the letter of complaint, but was also evident in descriptions of the working relationship of Gill Hamblin and Shirley Hallmann and is clearly in my opinion very deep-seated.
Professional rivalry and leadership competitiveness are evident, not helped by the fact long term sickness has enabled each to enjoy the role unchallenged by the other.

4 The changing role of Dryad Ward:

The three key players all appeared stretched and this investigation added to this. They attributed this to the increased work pressures due to the changing role of the ward.

5 The Team Dynamics:

The leadership issue is potentially quite destructive to the team of Dryad Ward and there is evidence of this already occurring and potentially affecting patient care.
During the weeks of the investigation I was made aware of an exacerbation in the poor working relationship between Shirley Hallmann and Gill Hamblin, which may cause further difficulties when seeking a resolution to this issue.

Conclusion:

Mis-interpretation, fuelled by poor communication, differences in perceptions, professional rivalry and unsubstantiated expectations seems to be the theme of the investigation, rather than a calculated and malicious attempt to drive Shirley Hallmann from the ward. In fact, both defendants appear to have played quite supportive roles when asked for advice by Shirley Hallmann, in the past.

Rosemary Salmond, Investigating Officer.

Notes of the Meeting held between Shirley Hallman, Betty Woodland and Rosemary Salmond on Thursday 30 March 2000 at 9.00am. in the Potteries.

This meeting was arranged as part of the formal investigation into a harassment claim brought by Shirley Hallmanunder the umbrella of the Trust Policy 'Harassment - policy for the prevention of'.

The meeting began with Shirley recounting the reasons why she had needed to have an extended period of sick leave between the beginning of November 1999 and the January 2000. This had included gynaecological surgery and a tooth extraction, following several weeks of pain. Shirley had found this time very traumatic, particularly as she has 'difficult memories' to manage during the Christmas period.

Shirley returned to work on January 24 2000.

Shirley had an IPR review with Gill Hamblin in February. Shirley has not yet received a report from this review. At the time of the original IPR, Shirley was in an acting-up capacity as Gill Hamblin was on long term sick. A copy of the original IPR carried out by Barbara Robinson on 1st April 1999 and a memo written by Barbara Robinson on April 9th 1999 are attached to these notes.

Shirley described how during the IPR review she had discussed with Gill Hamblin, her frustrations of her current role in the team. She felt her role as deputy was ill-defined, with little responsibility and opportunity to use her initiative. She felt bored and asked for opportunities to develop her management/leadership skills. She recognised that their working relationship was strained and sought ways to improve this. She would like to be able to support Gill more, " to be leaned on".

Shirley emphasised that she had been feeling like this about her job prior to her sick leave and had resolved on returning to work that she would try to sort it out. She was feeling so much better and she did not wish work stresses to cause further illness.

As part of this resolve she had applied for an G-grade post at Queen Alexander's Hospital.(QAH)

Shirley described how an opportunity had arisen for some of the Gosport Team to go and work at QAH for one month to assist with a vacancy problem. Gill Hamblin encouraged her to consider this and so she went to work on Edith Keen Ward which coincidentally was the ward where the post she had applied for was. A member of the Edith Keen staff had also applied for it and Shirley was conscious of the tensions associated with this. She described how she had sought support for this from Gill Hamblin and had frequently phoned her.

Shirley was interviewed for the G-grade post but was not successful. She received interview feed back from Barbara Robinson, who previously had always been very supportive, but was surprised at some of the content. She was told that she had a reputation of having an 'attitude problem'and that Dr Barton found her challenging to work with. She was told that there were no F-grade vacancies at QAH but there were E-grade posts which she might wish to apply for. Shirley stated that she did not like the fast track nature of the acute service work and decided to return, with some apprehension, to her post on Dryad Ward at Gosport.

On March 10th Shirley received a phone call from Gill informing her that she was to work a "straight shift" on the Sunday and that she wished to meet with her on the following Tuesday, March 14th.

Shirley described this meeting on March 14th in great detail and frequently referred to notes she had made straight afterwards. She described how she began the meeting with apologies for not supporting Gill in the way she could expect from her deputy. She was then told by Gill that following consultation with Maureen Mills, Senior Personnel Manager, a performance plan had been drawn up.

Shirley said that she was told that this plan had been produced because she had a poor "communication manner, when under stress" and that "all grades of staff including Porters and Caterers" had complained about this. Shirley was shocked as she was not aware of this and it had never been discussed with her before. In fact during her period of acting-up, she had received very good feedback from the staff and had been complimented on the good atmosphere of the ward.

In describing the performance plan, Shirley felt that little account had been taken of her IPR objectives, that she was a challenge to Gill's leadership and as a consequence responsibility and initiative were being further removed from her role. She did not feel that she her role as deputy clinical manager was being acknowledged. She felt "she was just another pair of hands"

The meeting on the 14th.March continued with more encouragement from Gill Hamblin for Shirley to consider the E-grade post at QAH. Shirley felt pressurised by this, in the light of the content of the rest of the meeting.

In discussing the provocation for the letter Shirley had written on 24th March formally requesting this investigation, Shirley described Gill Hamlin's leadership style as one of mixed messages, innuendo, no action, directionless, nothing was ever recorded and that there was a lot of exaggeration. She felt Gill was challenged by anybody with knowledge or new ideas and controlled her team by encouraging passivity. She emphasised that these feelings were based on her experiences over the 24 months she had been in post on the ward.

When asked what resolution she sought to this investigation, Shirley replied that she would like to be helped to develop a better working relationship with Gill Hamlin, based on openness, clear strategy, innovation and mutual respect.

Signed: Shirley Hallman

Code A

Rosemary Salmond

Notes of the meeting held between Maureen Mills, Personnel Manager, and Rosemary Salmond, Investigating Officer, on Tuesday April 4th 2000

This meeting was convened, as part on the investigation triggered by a formal complaint of harassment by Shirley Hallman implicating Gill Hamblin and Dr Jane Barton.

Maureen described how she had given a lot of individual time to both Gill Hamblin and Shirley Hallman over the last year or so. These meetings were often triggered by the poor working relationship between the two and tended to have more of a 'salvage' result rather than produce lasting change. She felt that there were issues on both sides.

Maureen stated that she had one formal dealing with Gill Hamblin. She described her as 'pressured when the ward was full', good with practical issues and very good with relatives.

However, personnel had had more knowledge of Shirley Hallman. An exit interview undertaken by Melanie Kyme was shared with Gill Hamblin as it referred to Shirley's manner towards staff. Gill Hamblin had frequently stated that several staff had complained to her about Shirley but despite encouragement nothing had been put in writing. Shirley had frequently not attended courses she had been booked on and tended to be 'initially enthusiastic but not so good on implementation.'

Maureen described how she had been approached by Gill for help in working with Shirley on her return to the ward, to address some of these issues. Gill had said that she had spoken to Shirley previously about her manner with other staff and so Maureen sent Gill a draft format anticipating that it would be used in discussion.

Code A

Maureen Mills

Rosemary Salmond

Notes of the meeting held on Thursday April 6th 2000, between Gill Hamblin, Ward Manager of Dryad Ward, and Rosemary Salmond, Investigating Officer.

This meeting was convened as part of the investigation into the formal complaint of harassment brought by Shirley Hallman against Gill Hamblin and Dr Jane Barton.

Gill Hamblin stated that she had been the Ward Manager of Dryad Ward for 10 years. She described her team as 'great' and the atmosphere of the ward to be harmonious particularly when Shirley Hallman was not on duty. Whilst there were still 2 members of the original team, Gill Hamblin felt that staff turnover was high, particularly since Shirley's appointment.

In discussion of the role of the 'F' grade nurse on Dryad, Gill Hamblin felt it was a very difficult role within the team. She described how she had had 3 F' grade nurses during this time and none of them had been successful appointments. She described how the team was divided into three, with each division led by a E' grade staff nurse. She described how she had had to be persuaded to appoint to the F' grade.

In describing her leadership style, Gill Hamblin preferred to 'lead by example', where possible she liked there to be 'consensus decision making,' but recognised that 'policies had to be adhered to.' She felt her role was to support and advise team members.

In describing Shirley Hallman's manner, she felt she could be 'formidable and intimidating' and quick to 'put people down.' She stated that this was Shirley's first appointment as an F' grade and that she had wanted to 'change things' and that she tended to 'lay down the law' rather than 'negotiate solutions.' She felt Shirley could be 'moody'. She tended to 'stew on things', was 'unpredictable' and often responded without thought. She would 'read things into things' and was 'super sensitive.' She was also 'status orientated,' liked to do everything and wanted a G' grade post. Shirley had had frequent periods of sickness probably amounting to 6 months in all, since her appointment 2 years ago.

In considering the events leading up to this investigation, Gill Hamblin expressed her anger. She felt 'set-up' and that Shirley Hallman had 'come back to cause trouble'.

In discussion about Shirley Hallman's transfer to QAH, Gill Hamblin recalled how Barbara Robinson had sought permission from her to send Shirley to QAH for one month and how Shirley had been ambivalent about going and had approached her for advice. Whilst working in QAH, Gill Hamblin recalled how she had received almost daily phone calls from Shirley, complaining about the work and seeking support.

Gill Hamblin stated that she was aware that Shirley Hallman had been actively looking for a G grade post for some time and she had supported Shirley Hallman's application for the post at QAH. Shirley Hallman had sought her advice following the unsuccessful interview and particularly about considering an E grade post.

Whilst Shirley Hallman was working at QAH, Gill Hamblin reiterated how well the ward had been functioning and the good atmosphere that had prevailed.

Gill Hamblin admitted to feelings of irritation concerning the regular phone calls and this together with unsubstantiated complaints about Shirley Hallmann's manner from the team, led her to consult with Maureen Mills. She was keen to 'sort things out.'

In describing the meeting with Shirley Hallmann, on Tuesday 14th March, Gill Hamblin expressed surprise at the apologies initiated by Shirley. She wondered at their sincerity and felt manipulated. Gill Hamblin then told Shirley of the complaints about her manner and drew her attention to a performance plan, drafted by Maureen Mills. Gill Hamblin described how she was anxious to get it agreed as she was aware that Maureen Mills was shortly to go on leave. Gill Hamblin stated that Shirley had been very shocked to receive the feedback about her manner as she had never been complained about before.

Gill Hamblin felt that Shirley had noted what had been discussed and feedback from the team 'queried why Shirley Hallmann was being so nice to them.'

Gill Hamblin described how the work of the ward had changed and wondered whether Shirley Hallman's clinical competence was adequate to meeting the new demands. She felt this might explain why teaching sessions that Shirley Hallmann had been responsible for organising had not happened. In house training had been made available to Shirley but she had not always been able to attend them.

Finally Gill Hamblin commented that patients and their relatives seemed to prefer to speak directly to her rather than to Shirley Hallmann.

Signed: Gill Hamblin

Code A

Rosemary Salmond Code A

Notes of the meeting between Dr Jane Barton and Rosemary Salmond, Investigating Officer, on Friday 7th April.

This meeting was convened as part of the investigation of a complaint of harassment brought by Shirley Hallman against Dr Jane Barton and Gill Hamblin.

Dr Barton stated that she had worked on Dryad Ward for 12 years, giving 5 sessions a week, and that she felt she knew Gill Hamblin and the team well. As a visitor to the ward she stated that she did not feel it was appropriate for her to be involved with management issues.

In describing Shirley ~~Hall~~ Hallmann's manner Dr Barton felt that she could be aggressive in manner and would also have periods of apparent sulking. It was often easier not to disagree with Shirley's opinion rather than upset her. In consequence changes to treatment routines particularly relating to opiate administration would happen on shifts that Shirley was not working. She described Shirley as 'working to her own agenda' and not really a 'team player.'

When asked how Shirley had managed when she acted up for Gill Hamblin during an extended period of sick leave, Dr Barton felt she had managed tolerably well, but the ward had not been busy as at that time the Consultant had not been admitting. Dr Barton observed that she felt Shirley appeared to enjoy 'paper work' in preference to a more clinical role.

Dr Barton described how she had only wanted to give advice and support to Shirley Hallman and had never 'put her down or been beastly to her'. She described how Shirley had asked for her advice before applying for the G grade post at QAH and how she had photo-copied some articles for her.

Dr Barton described a discussion between herself and Shirley, initiated by Shirley following her return to Dryad. Shirley had asked if there was a problem between them, to which she had replied 'no'. Dr Barton then asked Shirley how she was getting on with the job opportunities at QAH, assuming Shirley was still wanting to do acute work. 'If I had known she did not want to work there I never would have inquired .... I bitterly regret offering support'.

She described how the work on the ward had changed. There had been limited consultant cover. Families were increasingly demanding, with unrealistic expectations and one or two had been particularly difficult.

When asked how she viewed Gill Hamblin's professional role, Dr Barton described her as the 'Clinical Boss' and with a competent control of the ward. She was consistent in her approach to all staff.

Code A

Rosemary Salmond

Code A

Dr Jane Barton note.)

Rosemary Salmond
The Potteries
St Christophers
Fareham

Dr.JA Barton
148, Forton Road
Gosport
Code A

1st May 2000

Dear Rosemary

Notes of Meeting on Friday 7th April

Thank you for sending me a copy of your notes taken at the above meeting.
I have reservations about the paragraph concerning Barbara Robinson and her part in the problems on Dryad Ward.

It is not my intention to give the impression that Barbara set out to cause trouble between my self and Shirley. I am sure she only intended to give her a fair debrief and interpretation of how her job interview had gone. Could you please delete that paragraph.

Otherwise I have no difficulty with your interpretation of what was said.

Yours Sincerely

Code A

Jane Barton

Meeting between Barbara Robinson and Rosemary Salmond, Investigating Officer, held on Tuesday 13 April.

This meeting was held as part of the investigation into the formal complaint of harassment brought by Shirley Hallman against Gill Hamblin and Dr Jane Barton.

The issues considered at this meeting were:

a senior manager's perspective of the parties involved
a perspective of events immediately prior to the complaint.

Barbara Robinson described how well Shirley Hallman had managed during the time when she had been acting-up as Clinical Manager. She had appeared to really enjoy the management role and had worked proactively to support the application for IiP status. The team had appeared happy and hierarchical structures removed which enabled the health care support workers particularly to be valued. Team objectives were introduced for the first time and appraisals organised. However Barbara added that she felt the work of the ward had changed from continuing care to rehabilitation, particularly when Dr Ian Read took over from Dr Lord.

In describing Shirley Hallman, Barbara Robinson said she had no reason to question her competence and had not been approached by anyone on this issue. She had not observed any unprofessional or inappropriate behaviours whilst she was Shirley Hallman's line manager.

In describing Gill Hamblin, Barbara Robinson felt that she was firstly a clinician and tolerated the management role. She wondered if Gill Hamblin's obvious clinical expertise and hierarchical manner actually undermined the confidence of others.

In discussing the F' Grade position on Dryad ward, Barbara Robinson expressed doubts as to its viability, and acknowledged that she had encouraged Gill Hamblin to recruit to it as she felt this would provide support to Gill and strengthen the leadership of the team.

Barbara Robinson stated that she had offered Shirley Hallman the opportunity to gain different professional experience at QAH through Gill Hamblin. Shirley had agreed to this.

Barbara Robinson stated that during the interview for the G' grade post on Edith Keen, Shirley Hallman had presented quite negatively and been particularly critical of the ward she would be managing. During the interview feedback session, Shirley Hallman had asked what she needed to do to help herself in applications for G' grade posts. Barbara Robinson responded by encouraging Shirley to reflect on her manner and how this could affect a situation, using comments from Jane Barton as an example.

Also during the interview feedback session, Barbara Robinson stated that Shirley Hallman had been adamant she did not wish to return to GWMH. In consequence

Barbara Robinson had suggested she might like to consider an E' grade post as a way in to a career in the Acute Sector. It was left that Shirley Hallmann would think about this and let Barbara Robinson know her decision later. Half an hour after the feedback session, Shirley had rung to say she 'wasn't sure'. Barbara Robinson was surprised to hear 3 days later that Shirley Hallmann had returned to GWMH.

Code A

Barbara Robinson

Rosemary Salmond Code A

Meeting between Reena Pearce and Rosemary Salmond, Investigating Officer, on Tuesday April 19th at 1.30pm

This meeting was arranged at the request of Shirley Hallmann, as part of the investigation into the formal complaint of harassment brought by Shirley Hallmann against Gill Hamblin and Dr Jane Barton.

Reena Pearce expressed some concerns as to whether she wished to allow this interview to be included in the investigation. It was agreed that she would make a decision when she had seen this transcript.

Reena Pearce explained that she had been appointed to the D' grade post on Dryad Ward in February 1994. The team led by Gill Hamblin had recently moved there from Redcliffe Annex. She was thrilled with this appointment a she had particularly wanted to return to NHS Nursing after a prolonged spell in the private sector.

Reena Pearce described her interest in wound care and her keenness to extend her knowledge. With the benefit of hindsight she now feels that she may have been 'too enthusiastic' and that this had been perceived as a threat to the designated link nurse in the team.

Reena Pearce went on to describe how she had felt increasingly ostracised by the team and felt unsupported by Gill Hamblin as the team leader.She felt her professional confidence was continually undermined. She became very 'scared' of Gill Hamblin, cried a lot on the ward ("I've never done this before") and felt very hurt, sad and depressed.

This issue came to a head when a formal (subsequently unsubstantiated) complaint was made by an auxiliary nurse concerning Reena Pearce's clinical practice. Reena said she was devastated by this. She felt there had been collusion between the Nursing Auxiliary and Gill Hamblin. She was particularly disappointed that Gill Hamblin had never discussed this complaint with her personally.

At this point a D' grade post came vacant on Daedalus Ward and Reena Pearce left Dryad Ward. "It was the best decision I have ever made".

When asked what she now thought of Gill Hamblin, Reena Pearce stated that she was a good nurse but that her leadership was not very fair and she had 'favourites'.

When asked how well she knew Shirley Hamblin, Reena Pearce replied that she had never worked with her and as her opinion would be based on hearsay it was not given.

Reena Pearce

Code A

Rosemary Salmond

Code A

1/5/00

Dear Mrs Salmond,

I am enclosing a copy of an incident that occurred recently on Dryad. I have given a copy to Mrs Peach and discussed it with her but feel it gives an excellent example of the sorts of difficulties I experience at work. If you feel appropriate please attach it to my documents.

The situation between Sister Hamblin and myself has deteriorated even further since I met with you. She has established a close working relationship with Staff nurse Barrett which has resulted in my being excluded even further from all work related matters.

This has resulted in comments being made to me from various staff members about Sister Hamblins working relationship with Staff nurse Barrett and myself.

My exclusion is noticeable to all concerned.

Yours sincerely

Code A

Shirley Hallmann.

INCIDENT RE; PATIENT DISCHARGE 19/4/00

During the morning Mrs Rabbitt showed me her left knee which had become very swollen overnight. I told her that I would get the physio to have a look at it as the doctor had already left.
Mrs Rabbit suffers from a degenerative condition and had a planned discharge date 20/4/00, she and her husband had seen Dr Reid 18/4/00 when he had said she could go but the ward was to hold the bed for seven days due to the patients poor health and possibility of failure to manage at home.

During the course of her stay the staff had numerous discussions with her and her husband about help but they had constantly refused. The only aid was a stair lift and Mr Rabbit sole carer.
Shirley Dunleavy (physio) saw Mrs Rabbitt and told me that in her opinion she would not be safe for discharge she offered to speak to Dr Reid but he was unobtainable therefore I telephoned Dr Peters who was duty Dr for advice. He said, as he did not know the patient and we were unhappy about her safety at home to delay discharge and telephone Dr Reid the following morning.
Shirley said she would give some treatment using megapulse then and the following morning and would review again discuss with Dr Reid.
Sr Hamblin was a day off but came to the ward prior to a meeting I mentioned Mrs Rabbitts knee but she said she was for discharge as Dr Reid had said the day before I explained that her condition had changed as the knee was really enlarged and told her the opinion of the physio she still maintained that Mrs Rabbitt was for discharge.
Sr Hamlin later returned to the ward and came into handover and it was obvious to everyone that she was angry when she asked me about the cancelled discharge I again explained that the physio and myself did not agree that she was ready for discharge.
Sr Hamblin left in a very angry manner and I felt everyone was acutely embarrassed.
I received a telephone call later from Sr Hamblin saying she had referred Mrs Rabbitt to the occupational therapist that he would deal with it and would be contacting either S/N Shaw or S/N Ryder.
I later met Shirley (physio) and asked her what was happening as by this time I felt at sea with this she said it was a lie that the O/T was dealing with it as she had been there when he saw Sr Hamblin and he would not have time before Easter to sort anything out. She continued to say that the patient appeared "aghast" when Sr Hamblin appeared in her room and told her she would be going home as planned. She was shocked at Srs manner as she had held her in high regard and stated that if she were discharged the next day she wanted a letter from Sr Hamblin to state the reason for discharge in case she fell at home.
Shirley had said Sr Hamblin was so angry when she spoke to her that she "looked like she was going to explode " but that it didn't wash with her as they were used to it and sometimes felt like wearing a crash helmet before coming to the ward.
I was upset by this whole episode and took advise from Mrs Howes who told me to proceed with the clinical plan as it was clinically sound and she thought I already knew that.
To discuss the issue of Sr Hamblin with Mrs Peach in the morning which I will do.

Code A

PORTSMOUTH
HealthCare
NHS
TRUST

Mrs Shirley Hall

Code A

Our ref
rs/sh

Your ref

Date
12 April 2000

Ext
217

Dear Shirley,

Please find enclosed a copy of the notes that I made following our meeting on Thursday March 30 2000.

I hope they are accurate reflection of what we talked about, but if you would like to make any changes please let me know.

On the other hand, if you are happy with them, please could you sign the bottom of the second page and return one copy to me in the enclosed envelope.

The investigation is nearly complete and I hope to submit my report to Fiona Cameron next week.

Yours sincerely,

Code A

Rosemary Salmond

FAREHAM AND GOSPORT DIVISIONAL OFFICE

'The Potteries'
St. Christopher's Hospital, Wickham Road, Fareham, Hants, PO16 7JD
Tel: 01329 822269 Fax: 01329 822094

PORTSMOUTH
HealthCare
NHS
TRUST

Mrs Betty Woodland

Code A

Our ref
Code A

Your ref

Date
12 April 2000

Ext
217

Dear Betty,

Please find enclosed a copy of the notes that I made following our meeting on Thursday March 30 2000.

I hope they are accurate reflection of what we talked about, but if you would like to make any changes please let me know.

On the other hand, if you are happy with them, please could you sign the bottom of the second page and return one copy to me in the enclosed envelope.

The investigation is nearly complete and I hope to submit my report to Fiona Cameron next week.

Yours sincerely,

Code A

Rosemary Salmond

FAREHAM AND GOSPORT DIVISIONAL OFFICE

'The Potteries'
St. Christopher's Hospital, Wickham Road, Fareham, Hants, PO16 7JD
Tel: 01329 822269 Fax: 01329 822094

Dr Jane Barton
The Surgery
148 Forton Road
Gosport
PO12 3HH

rs/jb

13 April 2000

217

Dear Dr Barton,

Please find enclosed a copy of the notes that I made following our meeting on Friday April 7 2000.

I hope they are accurate reflection of what we talked about, but if you would like to make any changes please let me know.

On the other hand, if you are happy with them, please could you sign the bottom of the page and return one copy to me in the enclosed envelope.

The investigation is nearly complete and I hope to submit my report to Fiona Cameron next week.

Yours sincerely,

Rosemary Salmond

M/s Gill Hamblin
Clinical Manager
Dryad Ward
Gosport War Memorial Hospital
Gosport
PO12 3PW

Code A

17 April 2000

217

Dear Gill

Please find enclosed a copy of the notes that I made following our meeting on Thursday April 6 2000.

I hope they are accurate reflection of what we talked about, but if you would like to make any changes please let me know.

On the other hand, if you are happy with them, please could you sign the bottom of the page and return one copy to me in the enclosed envelope.

The investigation is nearly complete and I hope to submit my report to Fiona Cameron next week.

Yours sincerely,

Rosemary Salmond

Mrs Barbara Robiinson
Asst General Manager
Elderly Medicine
South Block
Queen Alexandra's Hospital
Southwick Hill
Cosham
PO6 3LY

rs/br

27 April 2000

217

Dear Barbara,

Please find enclosed a copy of the notes that I made following our meeting on Tuesday April 13th 2000.

I hope they are accurate reflection of what we talked about, but if you would like to make any changes please let me know.

On the other hand, if you are happy with them, please could you sign the bottom of the second page and return one copy to me in the enclosed envelope.

The investigation is nearly complete and I hope to submit my report to Fiona Cameron next week.

Yours sincerely,

Rosemary Salmond

M/s Reena Pearce

Code A

rs/rp

27 April 2000

217

Dear Reena

Please find enclosed a copy of the notes that I made following our meeting on Tuesday April 19th 2000.

I hope they are accurate reflection of what we talked about, but if you would like to make any changes please let me know.

On the other hand, if you are happy with them, please could you sign the bottom of the page and return one copy to me in the enclosed envelope.

The investigation is nearly complete and I hope to submit my report to Fiona Cameron next week.

Yours sincerely,

Rosemary Salmond

Shirley Hallman

Code A

27 April, 2000

212

Dear Shirley

Please find enclosed an amended report, which if now meets with your agreement, you could sign and return one copy to me, using the stamped addressed envelope.

Yours sincerely

Rosemary Salmond
District Occupational Therapy Advisor

enc.

Rosemary Salmond Spec. Ser. Mg

From: Fiona Cameron-Hosp Manager
To: Rosemary Salmond Spec. Ser. Mg
Subject: INVESTIGATION
Date: 27 March 2000 12:04

Re - Investigation into allegations of Harassment by Staff Nurse S. Hallmann relating to Gill Hamblin, Clinical Manager and Dr Jane Barton, Clinical Assistant.

Thank you for agreeing to undertake the investigation outlined above. The complaint has been made under the umbrella of the Trust Policy ' Harassment - policy for the prevention of'. I am sending a copy of this along with the letter of complaint, under separate cover.

The purpose of the investigation is to establish whether there is evidence to support the allegation of harassment. I belive therefore that the investigation needs to clarify;

1. The issues and events which have led to Staff Nurse Hallmann making the allegation.

2. The perspective of these issues and events held by Gill Hamblin and Dr Jane Barton.

3. Background information on events leading to the letter of complaint.

Suggested list of initial interviews;

Shirley Hallmann - SN Dryad Ward
Gill Hamblin - CM Dryad Ward
Jane Barton - Clinical Assistant, Dryad Ward
Maureen Mills - Personnel Manager

As the investigation progresses you may wish to interview other members of staff if they appear to be material to the question of harassment.

OTHER INFO

Shirley Hallmann is being represented by Betty Woodland (RCN) based in the MIU GWMH.

Gill Hamblin is on leave for 1 week commencing the 27th Mar.

Given the serious nature of the allegations made I would be grateful to have your estimation of a report date as soon as you are able to approximate it. Please let me know if there is any further information you require.

FIONA

PORTSMOUTH
HealthCare
NHS
TRUST

Code A

Our ref

Your ref

Date 24.3.00.

Ext

Dear Mrs F Cameron,

I write to complain about the way I am being harrassed at work almost to the point of leaving my job and the trust.

I wish to evoke the Trusts harassment policy and I know that things have gone so far that the informal stage would be of no use, so I wish to go to formal stage immediately.

I work on Dryad ward at GWMH as the F grade and I've been in post for two years.

I am constantly being harrassed by my line manager Jill Hamblin to consider moving to QAH as an E grade.

Recently I have received similar letters from Dr I Barton. It is obvious to anyone listening that I am not wanted on Dryad ward and this is causing me great distress and stress. I have no wish at the moment to leave Dryad under this cloud, and want the Status Quo to apply.

I realize that things are going to be uncomfortable but I have reached the end of my tether and know that what is happening is not right.

Yours Sincerely

Code A

COMMUNITY HEALTH SERVICES

Gosport War Memorial Hospital
Bury Road, Gosport, Hampshire PO12 3PW
Tel: 023 92524611 Fax: 023 92580360

12 16/3/00.

Fiona Cameron-Hosp Manager

From: Fiona Cameron-Hosp Manager
To: Rosemary Salmond Spec. Ser. Mg
Subject: INVESTIGATION
Date: 27 March 2000 12:04

Re - Investigation into allegations of Harassment by Staff Nurse S. Hallmann relating to Gill Hamblin, Clinical Manager and Dr Jane Barton, Clinical Assistant.

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Gill Hamblin - CM Dryad Ward
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FIONA

PORTSMOUTH
HealthCare
NHS
TRUST

Code A

Our ref

Your ref

Date 24.3.00.

Ext

Dear Mrs F Cameron,

I write to complain about the way I am being harassed at work almost to the point of leaving my job and the trust.

I wish to evoke the Trusts harassment policy and I know that things have gone so far that the informal stage would be of no use, so I wish to go to formal stage immediately.

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I realize that things are going to be uncomfortable but I have reached the end of my tether and know that what is happening is not right.

yours sincerely

Code A

COMMUNITY HEALTH SERVICES

Gosport War Memorial Hospital
Bury Road, Gosport, Hampshire PO12 3PW
Tel: 023 92524611 Fax: 023 92580360

POLICY NO: Code A

PORTSMOUTH HEALTHCARE NHS TRUST

PERSONNEL POLICY

HARASSMENT - POLICY FOR THE PREVENTION OF

1. STATEMENT OF INTENT

The Trust recognises that harassment and bullying against any employee, for whatever reason but in particular against women, people from ethnic minorities, or towards people because of their age, sexual orientation, religion, physical or mental disability is totally unacceptable. Such harassment causes great distress for the individual and may damage the working environment creating poor morale, loss of efficiency, absence and labour turnover and in some instances may contravene the Sex Discrimination and Race Relations Acts. This policy aims to ensure that all staff are treated with dignity and respect and work in an environment free from harassment and bullying. All staff will be made aware of this policy which is intended to complement the Trust's other 'family friendly' policies. All staff will be expected to comply with this policy, if an employee has an accusation of harassment against him/her substantiated they will be treated in accordance with the Trust's disciplinary procedure.

2. DEFINITION AND EXAMPLES

Harassment can be defined as any unwanted, unappreciated and unwelcome behaviour which is offensive to the person involved and causes that person to feel threatened, humiliated or embarrassed. A wide range of behaviour can be identified as harassment. The following are examples, but the list is by no means exhaustive: leering, ridicule, embarrassing remarks or jokes, unwelcome comments about dress or appearance, offensive use of pin-ups or pornographic pictures, verbal abuse and repeated and/or unwanted physical contact, demands for sexual favours or physical assault.

3. RESPONSIBILITIES

3.1 Management

Managers have a positive responsibility to discourage and prevent harassment from taking place and to ensure that all incidents are dealt with promptly and in the strictest confidence. This includes harassment that may occur from clients or members of the public.

3.2 Individual

The individual has a responsibility for ensuring that their own behaviour does not result in allegations of harassment or bullying being made against them.

4. COMPLAINTS PROCEDURE

By its nature harassment may make the normal channel of complaints (i.e. the organisations grievance and disputes procedures) difficult to use because of embarrassment, fears of reprisal or the complaint may be against the line manager. In such cases the individual may wish to consider informal action. All investigation of complaints will be handled with sensitivity and with due respect for the rights of both parties.

4.1 Informal Procedure

4.1.1 What is perceived as harassment can vary from individual to individual, so in the first instance the alleged harasser should be made aware ideally by the complainant that their behaviour is unwelcome and should be asked to stop.

4.1.2 The complainant may seek informal advice, and support from a Personnel Manager without any obligation to take a complaint further. The role of the Personnel Manager will be to:-

- Offer guidance on resolving harassment problems.
- Assist in submitting a grievance if the employee wishes to complain.

- Assist the complainant in making the manager of the alleged harasser aware of the problem.

Additionally staff may wish to access confidential support/counselling through EAR..

4.2 **Formal Complaints Procedure**

4.2.1 If the informal procedure does not result in the harassing behaviour ceasing, the employee may bring a formal complaint using the Trust's grievance and disputes procedure.

4.2.2 In some instances, it may not be appropriate to raise the grievance with the line manager. In this case the employee should seek advice from a personnel manager who should arrange for the grievance to be raised with a more senior manager.

4.2.2 The manager with whom the grievance is raised should arrange for an investigation to take place. The complaint should normally be investigated by the manager (or nominated representative) of the alleged harasser.

4.2.4 Throughout the procedure the complainant and alleged harasser have the right to be represented by a person of their choice.

4.2.5 If the investigation reveals that the complaint is valid, prompt action designed to stop the harassment and prevent its reoccurrence will be taken. In such circumstance, if relocation proves necessary, the alleged harasser and not the victim will be relocated, unless the complainant requests otherwise.

4.2.6 Where disciplinary action is considered necessary this will be in accordance with the Trust's disciplinary procedure.

5. **Training**

Training will be included in the Trust's training arrangements and communication for managers and supervisors to ensure that this policy is effectively implemented. The existence of this policy and its provision will be brought to the attention of staff through information exchange, Communicate, induction programmes and any other relevant method.

Policy produced by: Code A Personnel Director
Policy adopted: December 1994
Reviewed: April 1999

Approved by: Trust Board/Operational Management Group October 1999
To be reviewed: October 2000

g:\trust_hq\secretar\policies\pers\harss.doc\25 October, 1999

Other Document Form

Number 1482

UNUSED 2d 1/V ANNETTE FARRELL.

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Code A

Document registered / indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Code A

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Operation ROCHESTER

Aide-memoire for interviews with staff at GWMH 1988-2002

Name: Annette Farrell

Post held: Snr. Staff Nurse Btn dates: October 1998 March 2000.

Responsibilities Supervision Night Duty.

Ward(s) Deedelus Ward

1. General patient care
   Very Good
2. Use of syringe drivers (including any concerns etc)
   Syringe Drivers were used But in my opinion Correctly.
3. Use of Diamorphine (including any concerns etc)
   Diamorphine was used – No Concerns
4. Training in syringe drivers
   Received training as part of General Nursing training
5. Knowledge of any matters connected with the Police investigations
   Only from Media
6. Knowledge of any matters connected with internal investigations
   Only from Media
7. Rumours/any other information
   Nil
8. Details of medical staff you know of, including visiting GPs.
   Dr. Barton } Same Practice
   Dr Briggs }
   Dr Lloyd (Consultant)
   Philip Beadle (SE Charge Nurse)
   Pat ? (Snr Staff Nurse – Days)
   Mary ? (Staff Nurse – Days)
   Lynne Bagnall (Staff Nurse Nights)
   Sue ? (— — —)

Other Document Form

Number Code A

Title UNUSED NO 1/V ANNE DEAN

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / (No)

Receiver Code A

Document registered / indexed as indicated

No(s) of actions raised

Indexer Code A

Statement readers instructions

Statement Code A

Indexed as indicated

No(s) of actions raised

Indexer Code A

mined - further action to be taken

Code A

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Operation ROCHESTER

Aide-memoire for interviews with staff at GWMH 1988-2002

Name: Code A

Post held: Staff Nurse (on BANK) Btn dates: 1993 - July 1994

Responsibilities General Nursing

Ward(s) Deedalus + possibly others

1. **General patient care**
   Very impressed – Excellent.

2. **Use of syringe drivers (including any concerns etc)**
   To her recollection did not remember seeing one used while at Gosport War Memorial Hospital.

3. **Use of Diamorphine (including any concerns etc)**
   Has no recollection of Diamorphine being used in excess in any way whatsoever.

4. **Training in syringe drivers**
   Had received training in late 70's – Early 80's while ward sister in Glasgow.

5. **Knowledge of any matters connected with the Police investigations**
   NO

6. **Knowledge of any matters connected with internal investigations**
   NO

7. **Rumours/any other information**
   NO. — Now works as practice Nurse at Forton Road surgery with Dr. BARTON.

8. **Details of medical staff you know of, including visiting GPs.**
   Cannot remember any names. only worked 5 nights at GWMH over the period of 1 year

HAMPSHIRE Constabulary

Chief Constable Code A QPM LL.B MA DPM MCIPD

PRIVATE

Our Ref. Operation Rochester
Your Ref.

Western Divisional Headquarters
12-18 Hulse Road
Southampton
Hampshire
SO15 2JX

Tel: 0845 045 45 45
Direct Dial: Code A
Fax:
Email: Code A

09 April 2003

Dear Code A

I have been given your details in connection with an investigation that is currently being undertaken by the Hampshire Constabulary with regard to the Gosport War Memorial Hospital. I am informed by staff records that you worked in one capacity or another at the hospital during the relevant period. The Police intention is to see everybody who worked at the Hospital. This is to ensure a fair and proper investigation. It maybe that you had no concerns about medical care at the Hospital, it is as important for the Police to establish this, as it is, if there are areas that have caused you concern.

Due to the large numbers of people that have to be seen I would be most grateful if you could contact me on the direct line above during office hours. This will assist me in contacting as many people as possible over a short time frame.

Yours sincerely

Chris Yates
Detective Constable 2479
Major Crime Investigations.

PRIVATE

Other Document Form

Number Code A

Title Unused R/V 1/V Code A

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Receiver Code A

Document registered / indexed as indicated

No(s) of actions raised Code A

Statement readers instructions

Statement Code A

Indexed as indicated

Indexer Code A

(s) of actions raised

Examined - further action to be taken

M SIO

Code A

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Operation ROCHESTER

Aide-memoire for interviews with staff at GWMH 1988-2002

Name: Code A

Post held: Staff nurse. Btn dates: June 1999 - Jan 2002.

Responsibilities Second in charge of ward.

Ward(s) Oriel.

1. General patient care

   Fine.

2. Use of syringe drivers (concerns etc)

   Concern about labels on drivers, but no concerns about the actual one.

3. Use of Diamorphine (concerns etc)

   NO.

4. Training in syringe drivers

   Prior to GWMH had a 2-3 day CSE.

5. Knowledge of Police investigations

   NO.

6. Knowledge of internal investigations

   NO.

7. Rumours/any other information

   Prem.

8. Details of medical staff you know of, including visiting GPs.

   Staff Nic Smith, Townsend.

Other Document Form

Number D 453.

Title Unused — 1/1 **Code A**

(Include source and any document number if relevant)

Receivers instructions urgent action (Yes) / No T1/T3T NAMES AS Q8.

Receiver **Code A**

Document registered / indexed as indicated

No(s) of actions raised

Indexer **Code A**

Statement readers instructions

Statement Reader

Indexed as indicated

No(s) of actions raised

Indexer **Code A**

Examined - further action to be taken

Code A

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Operation ROCHESTER

Aide-memoire for interviews with staff at GWMH 1988-2002

Name: Code A

Post held: Registered General Nurse (RGN). Btn dates: 01.02.99 to 05.10.99.

Responsibilities In charge of Nights nursing staff

Ward(s) Deedes Ward.

1. General patient care
Excellent general patient care. N.I untoward seen.

2. Use of syringe drivers (including any concerns etc)
Always set up by two qualified nurses (For G Grade). Would be responsible for checking every hour or so. Only used on patients with severe pain or terminal. No concerns re use.

3. Use of Diamorphine (including any concerns etc)
No concerns. Did not see anything on patients chart that looked incorrect.

4. Training in syringe drivers
Cannot remember doing a syringe driver specific course. Received "in house training."

5. Knowledge of any matters connected with the Police investigations
N.I other than on media

6. Knowledge of any matters connected with internal investigations
No.

7. Rumours/any other information
N.I.

8. Details of medical staff you know of, including visiting GPs.

Code A

Philip Beede A22

Code A

Other Document Form

Number **Code A**

Title Wkly 26 1/V **Code A**

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No T1/R8T wanted as Q8.

Receiver **Code A**

Document registered / indexed as indicated

Indexer **Code A**

No(s) of actions raised A16(Y20) A498 A355 A365(S.60) A494 A495 A497

Statement readers instructions A477 A478 A479 A480 A481 A482 A341 A376 A377 A84 (Y17) A126 (S.50) A586

Statement Reader **Code A**

Indexed as indicated

Indexer **Code A**

No(s) of actions raised

Examined - further action to be taken **Code A**

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Operation ROCHESTER

Aide-memoire for interviews with staff at GWMH 1988-2002

Name: Code A

Post held: Nursing auxillary Btn dates: 1976 - 1994.

Responsibilities General care - washing, feeding, lifting etc.

Ward(s) Radcliffe Annexe — Pallictive Care.

1. **General patient care**
Washing, feeding & general care of patients / Hair Responsibility
No medical/clinical responsibilities
General patient care on Ward was excellent

2. **Use of syringe drivers (including any concerns etc)**
Started using in late 80's. Only staff nurse or Sister would set them up Hrd. No concerns about their use at the Annexe. Only used when patients were very ill to stop constant injections. Families always consulted first

3. **Use of Diamorphine (including any concerns etc)**
No Concerns, other pain killers were used first. often for weeks + only when patient was ~~closest~~ in terrible pain would diamorphine be used again after consultation with families

4. **Training in syringe drivers**
Received no personal training as only staff Nurse & or Sisters would set them up.

5. **Knowledge of any matters connected with the Police investigations**
Retired in 1994 and only knows what was in papers. (Portsmouth Evening News) & television

6. **Knowledge of any matters connected with internal investigations**
As at 5.

7. **Rumours/any other information**
Nil.

8. **Details of medical staff you know of, including visiting GPs.**
N/A Code A
S/N Code A
Sisters Code A, Green, Marjorum. Jill Hambrid
Dr. Grunstone (Geriatrician from Q.A)
Asian female Dr. (Geriatrician)
Dr. Barton.

Other Document Form

Number Code A

Title COPY LETTER ~~from~~ TO MR REEVES ~~To~~ FROM DCC 20/11/07

(Include source and any document number if relevant)

Receivers instructions urgent action Yes (No)

Receiver Code A

Document registered/indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Statement Code A

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further action no(s)

Indexer

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Hampshire Constabulary
Police Headquarters
West Hill
WINCHESTER
Hampshire
S022 5DB

Tel: 0845 045 45 45
Fax: 01962 871189

Copy to:
DS O. Kenny

I.R Readhead LL.B
Deputy Chief Constable

Your Ref:
Our Ref: Code A

Date: 20th November, 2003.

Mr. Reeves

Code A

Dear Mr. Reeves,

Operation Rochester

Thank you for your telephone call on Tuesday, 11th November, 2003 concerning in particular the length of time that will have elapsed prior to you being informed of the outcome of our investigation and secondly, whether you could obtain the DVDs which were used by the clinical team.

The latter question is the easier to answer. I have been advised that the DVDs contain the records of all 62 cases and therefore it was never the intention of the Constabulary to supply Alexander Harris Solicitors with copies as they do not represent all of the families. To-date Alexander Harris have not requested copies of the notes. We are in possession of hard copy prints of the notes and it is our intention to provide copies of relevant notes to families who would like them.

As I explained to you, there is great sympathy for families regarding the length of time that is elapsing for us to be able to come to some final conclusions. We wholly recognise the significant pain that this must cause to all of those involved, especially during this time of the year. We are determined to conclude a thoroughly professional piece of work in an extremely complex investigative process where so much will depend upon the expert evidence provided by medical practitioners. If there were a quicker way to proceed, which did not prejudice such a professional outcome, then I would have no hesitation in ensuring that it was taken. However, on the basis of all the advice I have received, I am assured that the route we are taking is wholly consistent with best practice.

I have included in my correspondence a copy of the Operation Rochester family group updated bulletin dated 2nd November, 2003 which covers some of the aspects mentioned in this letter. I also understand that you spoke to DS Owen Kenny on 10th November, 2003 concerning a number of issues. I do hope that he has now given you enough information to allay your concerns as to the processes we are following. If not, then please feel welcome to come back to us so as to gain reassurance. Can I end again on

a note to say how much we appreciate the support that families are giving us at a time when as a process we recognise the significant concern and trauma that this must be causing you.

Yours sincerely,

Code A

I.R. Readhead
Deputy Chief Constable

Other Document Form

Number **Code A**

Title NOTES OF MEETING WITH ANN ALEXANDER 19/11/03

(Include source and any document number if relevant)

Receivers instructions urgent action Yes/No

Code A

Document registered/indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Code A

Indexed as indicated

No(s) of actions raised

Indexer **Code A**

Examined - further action to be taken

O/M	SIO

Further action no(s)

Indexer

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Notes of meeting, at offices of ALEXANDER HARRIS in Manchester, with Ann ALEXANDER 19th November 2003.

Present; Nigel Niven
Owen Kenny
Ann Alexander
Lisa Alkins

AA referred to a letter from Mr READHEAD which had been sent to one of her clients by her MP. Letter had almost got her sacked. Letter stated that Alexander Harris are supportive of the Police enquiry. Mr READHEAD has no idea whether or not happy. He has no knowledge as to whether Alexander Harris supportive. AA is not wholly happy with the Police enquiry but is supportive in some areas. AA remains concerned about enquiry.

AA has concerns about the outcome of the enquiry. The best case senario is that there is a full prosecution in respect of all cases. Next best is a handful of prosecutions. However that may not happen if there is no evidence and we will be left with a bunch of families unhappy.

AA stated that there is inconsistence of information despite the fact that we (the Police) said that we would try and ensure consistency. AA referred to a recent conversation between Mr READHEAD and David REEVES during which Mr READHEAD said that there are 7 cases worthy of prosecution. This information was not given to other persons. Mr READHEAD told Mr REEVES that the conversation was being tape recorded.

NN stated that there is a demarcation between AA's clients. There are still ongoing PSD matters which we have no involvement in. Clients must accept the demarcation with the DCC's comments. NN stated that he is reluctant to comment on the situation.

AA stated her intention to write to Mr READHEAD.

Issues raised during meeting of 30th September discussed. AA content that issues dealt with but is still aghast that the Police didn't appear to understand conflict within Law firms. The issue of conflict was further discussed and *NN stated that we didn't feel that there would be what we understand as conflict.*

AA is unhappy that after the 30th September the Police responded to some of the issues raised directly to the clients in a letter with the Bulletin before she had a chance to contact her clients. This resulted in a flood of calls from her clients. *NN responded with an apology for not sending AA c copy of the bulletin in advance and explained why this had occurred.*

AA felt that the Police should not have provided a buffet at the FGM meeting at Netley as it was a waste of tax payers money.

AA still has grave concerns regarding the taking of statements. She feels that the Police should take statements in each and every case and doesn't understand why they are not being taken. She stated that because she doesn't understand why they are not being taken she is not in a position to justify her concerns!. *NN explained that the issue of statements has been considered at length and statements will not be taken at this stage.*

The issue of material being supplied to the clinical team was discussed. *NN assured AA that the clinical team have been supplied with and will continue to be supplied with all relevant material.*

Issue of CPS discussed. AA is concerned that the CPS have not been taken on board to assist with a strategy. This was the impression she came away with from the meeting with Mr WATTS. *NN explained that it normal for the Police to investigate and the CPS are independent, however, we will and do take advice from the CPS. NN stated that there was a meeting with CPS in December last year during which a strategy was agreed and that strategy is being followed.*

Issue of Medical records discussed. *NN exlained the copying, printing etc. and our intention to supply FGM with copies.* AA stated that she cannot understand why we are not going through the medical records with the families. She is concerned that the longer we leave it the more memories will fade and people may die. *NN stressed our intention to have the medical records analysed before troubling families unnecessarily.*

AA questioned how can medical experts be sure without contemporaneous views from the families. *NN explained that the stage we are at is still the first analysis.*

AA raised the issue of GP notes and stated that in her 25 years practice GP notes are often more telling and the answer is frequently found in the notes.

AA asked if we have all of the records and if we have the FGMs are not correct. *NN explained the situation regarding the feeder notes of 2 cases identified by the clinical team.*

AA gave an example of a case she dealt with involving a child who had been brain damaged and stated that unless there is an exercise where the FGMs go through the notes the same thing will happen and afterwards others will say I knew he/she was murdered.

AA stated that the majority of the FGMs are happy with the time but are concerned about the stages taken in between. *NN stated that he is content that the FGMs will be content with the stages we are going through. NN went on to explain the various stages of the enquiry.*

NN explained the purpose of Kates visits.

AA wished to know timescale for Kate to visit FGMs. *NN stated he would write to AA with timescale.*

AA Stressed that having heard what's being said she still can't understand why we are not taking statements. FGM's would be made to feel that they were being taken seriously if statements were taken.

AA asked what is the position regarding exhumations, are they being considered.
NN stated that he could not comment on that issue.
AA stated that she would like to be informed before any FGM if there were going to be any exhumations.

Other Document Form

Number D. 415

Title LETTER FIELD FISHER WATERHOUSE TO DI NIVEN 7-10-03

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No	Receiver Code A
Document registered / indexed as indicated	Indexer Code A
No(s) of actions raised	
Statement readers instructions	Code A
xed as indicated	Code A
No(s) of actions raised	
Examined - further action to be taken	O/M | SIO
Further actions no(s)	Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form...

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Our ref: MSL/2515880 v1

letter sent to AH date 16/10/03

Strictly Private & Confidential

Detective Inspector Nigel Niven
Hampshire Constabulary
Western Area Headquarters
12-18 Hulse Road
Southampton
Hampshire S015 2JX

7 October 2003

Dear Nigel

Operation Rochester

I write to confirm the substance of our recent conversation, and our meeting today, concerning conflicts of interest and set out my view on this matter now I have had the opportunity to review the position.

I understand that an issue has been raised with you as to the propriety of the involvement of Field Fisher Waterhouse in Operation Rochester. It has been noted that as a firm we have been acting both for the General Medical Council in their now dormant investigation into Dr Barton and for Hampshire Police supporting your investigation.

We have of course considered the issue as to whether a conflict issue would arise as a routine matter as we would with all our instructions. We are content that no conflict of interest has arisen in our work thus far. This situation is not unique; for example we have previously advised a Health Authority on the investigation of a doctor locally whilst simultaneously advising the General Medical Council on bringing proceedings.

That being said I am mindful of the importance to Hampshire Constabulary of this investigation and the need for it to withstand external scrutiny and maintain public confidence. In such circumstances and in order to remove any contention in the matter of our instruction, I have informed the General Medical Council that I will no longer act for them in respect of the case of Dr Barton. This action should not be viewed as a corrective measure but one where we are proceeding with excessive caution in view of the sensitive nature of the case.

I hope this resolves the issue substantively.

Yours sincerely

Code A

Matthew Lohn
Partner
Direct Line: Code A
Mobile:
Email: Code A

Other Document Form

Number D 411

FGM Bulletin 2/11/03

(Include source and any document number if relevant)

Receivers instructions urgent action Yes/(No)

Document registered/indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further action no(s)

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Receiver	
Code A	
Statement	
Code A	
Indexer	
Code A	
O/M	SIO
Indexer	

Operation ROCHESTER

Family Group Members Investigation Update Bulletin No. 3 dated 2nd November 2003

Family Group Meeting 11th September 2003.

The Family Group meeting took place at Netley as per our last bulletin. In the main the feedback was positive. It is possible that we will hold another similar meeting again although not in the immediate future. Any intended meeting will be mentioned in good time in later bulletins.

Investigation Team

I announced at the Family Group Meeting that Detective Constable Kate Robinson is now our Family Liaison Officer. DC Robinson will be contacting all you in the near future in order to personally introduce herself. Additionally, she will discuss with you three particular subjects.

Clinical Team Findings – At the meeting in September, Detective Chief Superintendent Watts mentioned that consideration will be given as to the most appropriate method of informing you of the Clinical Team findings. We feel that it is vitally important to include your views in this process. I will be writing to you in due course with some suggested options for how we can best do this. In the first instance, however, DC Robinson will discuss the subject with you in person. Please feel free to inform her of any early thoughts you have on how this can best be achieved.

Identified concerns - At the beginning of our investigation many of you identified to members of my team what your specific concerns were in respect of the treatment your relatives received at the Gosport War Memorial Hospital. DC Robinson has been specifically asked to discuss this matter with you during her visit. So far the analysis by the Clinical Team has focused upon the information contained within the patient records. Before any decisions are made in respect of any case, account will need to taken of the information and concerns provided by yourselves. We therefore want to ensure that we have a comprehensive and up-to-date record of your concerns. This information will then be taken into account within the decision making process.

Copy patient records - We are aware that some of you have based some of your concerns upon copies of your relatives patient records you have obtained from the hospital authorities. Not all of you have had sight of these records. We believe that you should all have this opportunity. That way, we feel, you will be able to give the fullest consideration to the above matter in respect of identifying your current concerns. To that end, we are arranging to provide you with a copy of your patient records. We fully understand that for some this process will be too distressing and that you will not want sight of your relatives patient records. Consequently, I have enclosed a reply note with this bulletin giving you a choice. I would be grateful if you could endorse this reply note as to whether or not you wish to receive a copy of your relatives patient records. Also enclosed is a Free Post envelope. Please give this

matter some consideration and send your reply back in the envelope provided. As you would expect, providing such records is a costly affair. Consequently, I only intend to provide one set of patient records per relatives family. I would therefore be grateful if you could also indicate on the above mentioned reply slip which family member should be sent the patient records on behalf the family. If there is a reason why you feel more than one copy should be provided please indicate why in the 'Comments' box on the reply slip. (Please note that the postage has been prepaid and no stamp is needed)

Victim Support

Some of you may recall that at the Family Group Meeting on 5th February at the Solent Hotel, we arranged for members of Victim Support Services to be present. Some of you spoke to them and some were given leaflets. We now feel that it is appropriate to remind you that the Victim Support Services are available to you and we encourage you to consider their use. We have arranged for Judith Cousins of the Gosport VSS to act as a central contact point and she can be contacted on Code A Code A Alternatively you can ring the Hampshire VSS HQ at Eastleigh on Code A I have enclosed a VSS leaflet which outlines the services they provide which you may find interesting.

Conclusion

The work of the investigation and clinical team is ongoing. Please be assured that the consultative process we have engaged with you is not any anyway delaying the core investigation. The work of gathering analysing information continues. It has always been our goal, however, to work with you, the relatives. We are committed to involving you in the process wherever appropriate and shall continue to keep you up to date of developments. We shall continue to liase with Alexander Harris who represents some of you. Indeed, a number of the above subjects arose out of a meeting held with Ann Alexander in Southampton on the 30th September 2003.

Lastly, I would like to raise an issue in respect of the media. Notwithstanding what I have just indicted above, what we do share with you is intended to be confidential. Both Ann Alexander and I have previously explained the impact reporting could have on the outcome of our investigation. We ourselves have a strict policy in respect of the media and this investigation. I would like to take this opportunity to convey my thanks for the discretion exercised thus far. Clearly, our ability to share information with you will depend on that information being treated in confidence.

In the event of any query, please do not hesitate to contact us at our incident room at Park gate police station.

Nigel Niven
Detective Inspector
Major Crime Department

Other Document Form

Number D706

Title LETTER FROM ANDREWS TO MR WATTS 16/9/97

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Code A

Document registered / indexed as indicated

No(s) of actions raised

Indexer Code A

Statement readers instructions

Code A

Indexed as indicated

No(s) of actions raised

Indexer Code A

Examined - further action to be taken

O/M	SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Mrs A Reeves
'Bromfield'
119A The Avenue
Fareham
Hants
PO14 3DP

Detective Inspector N Niven
Western Area Headquarters
12-18 Hulse Road
Southampton
Hants
SO15 2JX

16th September 2003

Dear Mr Niven

Thank you for inviting me for the meeting at Netley Headquarter to update us on Operation Rochester's investigation.

Whilst I fully appreciate the sensitivity of this case and what you can and cannot discuss, I was still completely shattered regarding the decisions made and the context of the meeting. There appeared to be little thought or consideration for those involved and the effect it was going to have on people and in particular, the lack of professional support at hand.

At the last meeting we had with you, it was explained that the experts would be looking at the cases alphabetically and after every 20 cases you would be updated. It has been a very stressful time waiting for your decision and we have been patiently awaiting an answer regarding the events that surrounded the death of our loved ones.

What I cannot understand is the procedure you are taking regarding the officer's reports that you have taken from the families, as I understand you will not be taking these onto the experts at Field Fisher and Waterhouse.

Listening to families that evening regarding the reports taken, it would appear that there was no consistency regarding detail. This might not seem important to you but this is an aspect that I have not been comfortable with for sometime. After Mr Owen Kenny visited me I did have concerns especially as is was the first time an officer had come to hear my complaint so I am now putting those concerns to you writing.

In December 2002 Mr Kenny came to my home regarding the death of my mother at the Gosport War Memorial he did not take any notes. However, at the end of his two an half hour visit I mentioned to him about Mrs Dorie Graham, who had been in touch with me regarding the death of her late husband. I explained to him that she had previously spoken to Mr Ray Bert with her concerns and was anxious to be heard, this was the only time Mr Kenny put pen to paper saying that he would make sure someone went to see her and an officer did so in February 2003. I did not think too much about Mr Kenny not taking notes at the time however, as time passed I was hearing different stories from other people how their interviews were conducted and being concerned I emailed Peter Rushworth. Mr Kenny replied and explained the procedure as in part 4 of his email which I have enclosed.

Following this Mr Peter Rushworth came to visit me and said he would like to make another report, I told him firstly I wanted to know what was already in the report from Mr.Owen Kenny. He returned a few days later and had to tell me that there was very little in the report, only regarding the high levels of diamorphine. I was extremely unhappy to hear this because what was the point of Mr Kenny's two and half-hour visit?

In light of Mr Kenny's email and the conversations I have had with Mr Peter Rushworth the last being on the 11th July 2003 when he informed me that he would be the one coming to inform me of your decision. I question him about this comment with a follow up phone call and asked him how he knew he would be the one to visit me. He told me that he would be visiting everyone which I replied to as being a very long wait for some people. It now appears that policies have changed again and goal posts moved.

During our meeting with Deputy Chief Constable Readhead with regard to Supt John James, I expressed my concerns regarding the length of time this investigation is taking. This was in regard to one of the reasons that Supt.John James gave for not taking this case forward. 'The length of time it would take to get this into court and that the evidence would be too long in the public domain, thus damaging the prospect of a conviction'.

I am sure you have very good reasons for taking the path you are taking however, I do think it insensitive to mention at the meeting that there are cases where patients died of natural causes but you will not be informing the family members yet. It would have been more appropriate to have said nothing.

In closing and on reflection of the meeting on the 11th September 2003, I am assuming that the route you are now taking is because there is no concrete evidence in any one case that the experts have looked at. However, perhaps the missing link maybe found in the various families' evidence.

Thank you for taking the time to read my letter. I hope you can appreciate that this is my last chance of finding out why my mother died at the Gosport War Memorial Hospital and having been down this route before I want to be sure this time no stones go unturned.

I look forward to hearing from you.

Kind Regards

Code A

Ann Reeves

Cc Detective Superintendent S Watts

Subj: **RE: GWMH**
Date: 03/17/2003 12:41:08 PM GMT Standard Time
From: owen.kenny Code A
To: **Code A**
CC: Code A
Sent from the Internet (Details)

Dear Ann

It is regarding your e-mail to Peter on 14th March, which I read today. I thought it would be better for me to clarify the issues by telephone or in person. I am happy to speak to you or visit you to answer any queries which Peter is not in a position to answer.

I am sorry if I mislead you in any way regarding the taking of a statement. When I spoke to you, we (the investigation team), were in the process of visiting all relatives in order to explain our investigation process and to give reassurance that all cases will be reviewed. Statements were not to be taken at that stage but the relatives concerns were recorded on Officers reports.

The hospital medical records of 62 patients have been copied to DVD and provided to a team of 5 medical experts. Each expert is required to read all entries in relation to all 62 so it is difficult for them to estimate how long this will take. It is not practical at this stage to provide any further information to the experts. I recall that when we met we discussed the fact that not all cases were likely to be of concern, so the first task of the medical experts is to screen out those which do not fulfil certain criteria and concentrate on those which do.

The next stage is to provide the experts with further material, including the Officers reports, in relation to the cases of concern. We are weeks, probably several months away from that stage. However in the meantime we will continue to gather information but we will not be taking statements until we know which cases, if any, are likely to result in a prosecution.

It is extremely unlikely that the case of your mother would be screened out in the first instance. I am very much aware of your concerns and the existence of further information in possession of yourself and Ann Alexander. It has always been my intention, in due course, to obtain the further information from you. I have, today, discussed this with Peter Rushworth and instructed him to visit you and obtain all information that you feel may be of assistance to the enquiry.
If you have made a written record of your concerns, as we discussed, that would be very helpful but it is not necessary at this stage to put that in statement form.

I hope the above answers some of your concerns. Once again, I apologise for not making myself clear when we met.

Regards,

Owen.

-----Original Message-----
From: **Code A**
Sent: 17 March 2003 11:29
To: Kenny, Owen
Subject: Re: GWMH

Dear Owen

Thank you for your email.

If this is in respose to my query to Peter Rushworth please email me.

Other Document Form

Number D.705

LETTER TO ANN REEVES FROM DI NIVEN 3/11/03

(Include source and any document number if relevant)

Receivers instructions urgent action Yes/No

Code A

Document registered/indexed as indicated

No(s) of actions raised

Indexer Code A

Statement readers instructions

Code A

Indexed as indicated

No(s) of actions raised

Code A

mined - further action to be taken

O/M	SIO

Further action no(s)

Indexer

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

HAMPSHIRE Constabulary

Chief Constable Paul R. Kernaghan QPM LL.B MA DPM MCIPD

Our Ref. :

Your Ref. :

Western Divisional
Headquarters
12-18 Hulse Road
Southampton
Hampshire
SO15 2JX

Tel: 0845 045 45 45
Direct Dial:
Fax: 023 8067 4057
Email:

03 November 2003

Dear Mrs Reeves

Re: Operation Rochester – Bulletin No.3

The purpose of my letter is twofold. Firstly to provide you with the next Operation Rochester bulletin and secondly to address points raised within your letter of 16th September 2003.

The enclosed bulletin is the third we have prepared. In general the feedback has been positive. For us it is a useful way to keep our Family Group Members updated and also deal with specific concerns raised by individuals - where sharing the issue could assist others within the group.

In respect of your letter, you will recall that I responded on the 29th of September 2003 indicating that I would write further in due course providing a more detailed response. I had intended to do it before now but regrettably, I have been overrun by events. For that I apologize.

In dealing with the points you raised, I intend to adopt an somewhat unusual position and address the point raised last in your letter, first.

You make reference to wanting to know why your mother died and 'want to be sure no stones go unturned'. The investigation being conducted by the operation Rochester team is being carried out professionally, with integrity and with open minds. All the necessary information will be gathered and decisions made on the basis of the facts of any particular case. This has been our position from the onset.

In the first instant a team of experts was identified and provided with all the patient records which had been placed onto DVD's. Their analysis was focused upon those patient records. They were asked to consider the cases alphabetically in batches of 20.

HAMPSHIRE Constabulary

As you know that process has now been completed and our position in respect of quality assurance was explained at the Family Group Meeting on the 11th September.

The thrust of your letter appears to me to relate to your concerns as to whether we have an adequate note of your concerns and information you have in respect of your mothers treatment and, additionally, whether those concerns and information will be taken account of by clinical experts when the decision making process is being conducted.

Firstly, I am satisfied that the information we have in respect of your mothers treatment is full and that we are aware what you specific concerns are. Secondly, I am able to assure you that all the information will be studied by appropriate experts in order for the decision making process to be completed.

However, as you will see from the attached bulletin, that process is being reinforced. DC Kate Robinson has been asked to visit all of our relatives and ensure that we have comprehensive and up-to-date record of relatives concerns and information. To ensure that this process is maximized we intend to provide an copy of the patient notes to relatives to enable them to comment upon them, should they wish. This information will then be taken account along with the Clinical Team findings in the decision making process.

You will also note within the bulletin that we want to consult the relatives as to the preferred way of notifying them of any decisions made. This will help us arrive at the best way to share important news with relatives and deal with a potentially distressing occurrence.

Mention is also made within the bulletin to the services of the Victim Support Scheme. We would encourage any Family Group who feels that might benefit from VSS help to make contact with Judith Cousins of the Gosport office for further advice.

I do not intend to make any comment in respect of the points you raise in respect of Superintendent James and Deputy Chief Constable Readhead. I have, however, forwarded a copy of your letter and my reply to the Professional Standards Department for their attention.

Similarly, it would be inappropriate for me to comment on your closing paragraph in respect of your assumptions or their validity.

I do hope that this letter and enclosed bulletin has provided you with some useful information and reassurance. I am satisfied that the course we are following does deal with your specific concerns. If I can assist you any further please do not hesitate to contact me again

Your sincerely

Nigel Niven
Detective Inspector
Operation Rochester

Other Document Form

Number D702

Title CORRUS BTN DEF CH/EXPT UNITS & GMC DECISION 2003

(Include source and any document number if relevant)

Receivers instructions urgent action Yes/No

Document registered/indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

ed as indicated

No(s) of actions raised

Statement

Code A

Examined - further action to be taken

Further action no(s)

O/M | SIO

Indexer

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Hampshire Constabulary
Police Headquarters
West Hill
WINCHESTER
Hampshire
SO22 5DB

Tel: 01962 871404
Fax: 01962 871130
Telex: 47361 HANPOL

S Watts MSc DPM MIMgt
Detective Chief Superintendent
Head of CID

email: s Code A

Your ref:

Our ref: SW/chm

6th October 2003

Ms L Quinn
General Medical Council
178 Great Portland Street
London W1W 5JE

Dear Ms Quinn

Re: Gosport War Memorial Hospital - Operation Rochester

Thank you for your letter dated 2 October 2003, following our meeting on 30 September 2003 regarding the above matter.

I note your comments, in particular the processes by which the GMC may consider the matter of registration.

The summary which we provided you in respect of our investigation, indicated that a team of clinical experts had examined hospital records in respect of 62 patients at Gosport War Memorial Hospital, under the care of Dr Barton. In a significant number of those cases, the experts take the view that there was negligent care and that the causation of death is unclear. As my colleague DI Niven and I explained, much further work needs to be done to validate and develop these very provisional findings. We took the view, however that the GMC and the relevant Strategic Health Authority should be appraised of this information.

As we explained to you, our primary concern always is the safety of the public. That said, we are also expected to investigate serious allegation such those involved here in a professional and ethical manner. We therefore have to strike a balance between conducting our investigation in the appropriate fashion whilst realistically assessing the risk to the public. Put simply, our ability to disclose information would need to be based on an assessment of the risk that was presented now by Dr Barton.

Our investigation has only considered cases up to 1998 and all relate to the treatment of patients at the Gosport War Memorial Hospital. All the cases of concern raise issues in respect of the use of opiates. My understanding at the present time is that Dr Barton is not allowed to work at the Gosport War Memorial Hospital, and is not authorized to prescribe opiates.

On the basis of the above, I think more assessment needs to be conducted to quantify and clarify the risk that Dr Barton continuing to practice currently presents to the public safety. I would emphasize that our investigation has only concerned itself with issues within the Gosport War Memorial Hospital and not in any other area of practice by any medical staff. You will be aware that Professor Richard Baker was tasked with conducting some analysis by the Chief Medical Officer. His remit would have been wider than ours and although I do not know the outcome of his research, I would imagine any conclusions he has reached might assist you in your deliberations.

It is probable that we will need to interview Dr Barton at length. The interview process is predicated upon a detailed strategy which will include a careful consideration of the information supplied to Dr Barton prior to interview. I note that your letter indicates that any information supplied to the GMC will in its totality be supplied to Dr Barton. Any uncontrolled disclosure to Dr Barton has the potential to detrimentally impact upon the investigation, and I therefore would be reluctant to disclose further information until the above issue of risk has been given thorough consideration.

If I were reassured that material would not be passed to Dr Barton or her representatives, I would be willing to consider, at a future time, providing a more detailed disclosure of information to the GMC. We would be more than happy to discuss with the GMC 'Screener' how we may best achieve the maximum disclosure without a detrimental impact upon the investigation.

Finally, in answer to your question, I can confirm that the patients that you name in the second page of your letter of 30 September were included in those reviewed by the team of clinical experts.

I look forward to hearing from you so that we may progress this matter together.

Yours sincerely

Steve Watts
Detective Chief Superintendent
Head of CID

In reply please quote **FPD/LQ/2000/2047**

Please address your reply to
Conduct Case Presentation Section, FPD
Fax 020 7915 3696

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

2 October 2003

Detective Chief Superintendent Steve Watts
Police Headquarters
Hampshire Constabulary
West Hill
Winchester
Hampshire
SO22 5DB

Dear Mr Watts

Dr J A Barton

I refer to our meeting on 30 September 2003 when you informed me of the stage reached in the Hampshire Constabulary's investigations in this case. I have now had an opportunity to discuss that information within the GMC.

In order for Dr Barton's case to be referred to the Interim Orders Committee (IOC), prima facie evidence is required which is cogent and credible and raises a question as to whether Dr Barton should have a restriction placed on her registration. This information would then be considered by a medical member of the GMC (the screener) with regard to a referral to the IOC. For example, if there is evidence that Dr Barton has been prescribing in an inappropriate and irresponsible manner, and the screener refers this to the IOC, it would be open to the IOC to place a condition on her registration restricting her prescribing. The Committee also has the power to suspend a doctor's registration.

The IOC may make an order when it determines that it is necessary for the protection of members of the public or is otherwise in the public interest or the interests of the doctor. As well as protection of the public, the public interest includes preserving public confidence in the medical profession and maintaining good standards of conduct and performance.

From the information that you provided on 30 September 2003, we consider that it is likely to be in the public interest that the matter is screened. However, we cannot give a final decision without further information.

Therefore could you please supply us with a detailed written summary of the evidence you have in this case to date, including any report prepared by the team of experts. The decision on referral of the information to IOC rests with the screener. If the information supplied is very brief, while it is likely that it would be passed to the screener, there is a possibility that the screener would not refer it to the IOC.

As we discussed on 30 September 2003, if Dr Barton's case is referred to the IOC, the documentation you provide will be disclosed to her and her legal representatives.

Could you please confirm whether the 62 individual cases scrutinised by your team of experts include the five which are already known to the GMC, as follows:

- Gladys Richards;
- Arthur Cunningham;
- Alice Wilkie;
- Robert Wilson;
- Eva Page.

We are grateful to you for keeping us informed of the progress of your investigation, and would ask that you continue to do so.

Please let me know if you require any further information from me before responding to this letter.

Yours sincerely

Code A

Linda Quinn
Conduct Case Presentation Section
Fitness to Practise Directorate

Direct Line: **Code A**
Fax: Code A
E-mail address: **Code A**

Other Document Form

Number **Code A**

MINUTES OF MEETING WITH GMC 30/9/03

(include source and any document number if relevant)

Receivers instructions urgent action Yes/(No)

Document registered/indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

[illegible]ined - further action to be taken

Further action no(s)

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Receiver **Code A**

Statement **Code A**

O/M	SIO

Indexer

Notes of meeting held at the offices of the General Medical Council, 178 Great Portland Street, London. 0930 30/9/03.

Present

Linda Quinn (LQ) - GMC
Steve Watts (SW)
Nigel Niven (NN)

SW commenced the meeting by providing a general background to our investigation. He put in context the case of Gladys Richards and made reference to the work of Liversly, Munday and Ford, the random sample of 4 additional cases. He mentioned the handing in of the 1991 papers. SW further explained that the investigation related to 62 cases. This were brought to police attention as a result of the publicity created when the matter of the 1991 papers was made public in conjunction with the tasking of Professor Baker by the CMO. SW explained the methodology of the Clinical team, their respective disciplines and the creation of the DVD's. The CT assessment ended some weeks ago and the FGM were updated 11/9/03. SW explained our relationship with Alexander Harris and that Ian Barker of the MDU was also spoken to and informed that it was likely that we would need to interview Dr Barton at some point in the future but it would not be for some time yet.

SW explained that we were due to visit the Strategic Health Authority on Friday 3/10/03 to inform them also of where our investigation has reached. The rational for the meetings was to provide the information to the extent we could and scope the way ahead.

LQ asked whether Disclosure was a problem

SW said that it was and explained why

NN asked about Dr Barton's present position

LQ made reference to PPH and PPC (full title mentioned but not recorded). LQ explained that Dr Barton still practices but not within the GWMH. and then discussed issues and procedures.

SW then explained the system used by our CT and definitions as per our result chart. After stating that the percentages were proximate and no intended to be exact said that there were roughly 25% where the care was optimal, 50% where the care was sub-optimal and 25% where the care cause grave concern. SW explained he was seeking the GMC's view as to the way ahead taking into account the circumstances. SW emphasised that we where discharging our duty to inform the GMC and other partners. The public safety was our paramount concern.

LQ explained that the GMC would need more information than just provided if they were to go to a IOC.

NN explained process in terms of any interviews later held and that disclosure by others outside of interview structure may well have negative impact on the interview progression.

LQ then summarised the discussion and asked whether the GMC would be provided with further information in detail.

SW said in may be possible and any request would be given consideration. He then explained the limitations that we were expected to work within. He raised the issue of how information provided would be dealt with and asked made reference to a generalised summary, or SW / NN being able to give verbal evidence.

LQ acknowledged the difficulties involved and explained how GMC hearing run.

SW emphasised that we would always act in a manner that showed fairness to all and summarised our open and transparent investigation. He again emphasised our duty to place the safety of the public first.

NN explained that a balance needed to be struck between protecting the public and ensuring that any investigation is conducted professionally and in an unhindered fashion. Our ability to disclose information would need to be based of an assessment of the risk that was presented now by Dr Barton. At the moment our results are raw and are to be subject to quality assurance by FWW and other experts. Any request for formal disclosure would need to be put into writing with an assessment as to risk included so the fullest consideration can be given to the matter. The point was made that the results only relate to the GWMH. Dr Barton is no longer allowed to practice there and appears only to be working within her general practice.

LQ then asked about the role of Judith Chrystie and Mathew Lohn role with the matter.

SW explained the roles of Lohn and the wholly separate role between him and his employment by the police and that of Chrystie for the GMC.

LQ explained that she would need to speak with her senior whose office we were in at that time.

SW explained again that the meeting was intended to raise awareness at this early stage and to allow for consideration to the way ahead.

Business cards were handed over and the meeting concluded at 1015.

Other Document Form

Number 1698

Title MINUTES OF MEETING WITH SHA 3/10/03

(Include source and any document number if relevant)

Receivers instructions urgent action Yes/(No)

Document registered/indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Indexed as indicated

1 of actions raised

Statement

Code A

Examined - further action to be taken

O/M	SIO

Further action no(s)

Indexer

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Notes of meeting held at the offices of the Strategic Health Authority, Oakley Road, Southampton. 1030 3/10/03

Present

Steve watts (SW)
Nigel Niven (NN)
Gareth Crudace (GC)
Simon Tanner (ST)
Richard Samuels (RS)

SW explained rational behind the providing of the information and the need for discretion. He explained the disciplines of the CT and that they reviewed cases in batches of 20 and that they were assessed both individually and then collectively and thereby achieving a holistic conclusions. He explained the findings were categorized against a matrix of there own design and the categories were explained.

SW explained the findings were in raw terms 25% were optimal 50% were potentially sub optimal and 25% were of grave concern. He further explained that all our results were to be quality assured in doing that we going to employ FFW Mathew Lohn and potentially other experts to provide a legalistic and medical assessment.

SW informed the meeting that the FGM meeting did go ahead on the 11/9/03 where the outcomes to date were explained albeit without the detail and certainly not the percentages. It was explained that the results needed to be validated. This was accepted by some but not all. Our relationship with AH was explained and the fact that we intend to arrive at an agreed collaborative approach in making the necessary later announcements. We will Probably not be in a position to do this before Christmas but we are keen to do the first wave of disengagements as soon as possible but this will of course flag up the fact that there are cases that do cause concern. We will work with out respective media departments to ensure a coordinated strategy.

This was agreed by all.

ST asked whether the 62 cases were the extent of the cases.

SW explained the next batch which has arisen predominately from Professor Bakers work (16) and some other that are going to be done and why.

NN asked whether the SHA had had sight of Professor Bakers report

GC said no although they had asked to be allowed.

ST explained that they had been told that the letter was with the CMO lawyers. The word 'publish' had been used in respect of it They said they will write and seek access a move which was supported by SW and NN who discussed writing as well - particularly in respect of any public publication. It was suggested that both parties write to the CMO.

SW explained the immediate way ahead which included within the coming days speaking with the CPS and FFW. The rational of the KCT and CRT and any arsing issues of culpability was mentioned. in addition to consider in due course an interview strategy for any necessary interviews with Dr Barton.

SW further mentioned that we had met with Ian Barker MDU who was made aware of the likely need to interview Dr Barton although not for some time. Barker raise the obvious issue of proven causation.

ST had thought of the causation issue from the start and wondered that despite all the impressive work being done by the police now how will we deal with the impasse later if that were the case. What would be the final strategy.

NN and SW explained the ethos of our investigation was based only on trying to establish the truth. We had open minds and no pre-conceived idea at all. We will be happy with any outcome, whatever that might be.

GC asked about the 2 previously relocated executives.

NN pointed out that they were not part of our investigation.

ST asked about the GMC.

SW We will be responding to a letter in our possession. They have been informed of our investigation to the extent that you have. There was then a discussion re the processes of the GMC. SW emphasised that our primary concern is that of public safety. There was no evidence of additional risk to public - only unrefined results of potential issues at the GWMH

ST acknowledged the situation was difficult and the situation was further discussed.

GC mentioned that in gathering evidence Prof Baker had tried to get GWMH holiday charts. It was easier when he looked at cases such as Shipman where more data was readily available.

GC referred to the GMC and contrasted grounds for suspicion between the GWMH and the general practice.

ST confirmed the difficulty in this area in respect of the GMC and evidence.

NN explained the police position. As SW said earlier - our primary concern is for public safety. We will always cooperate with our partners. However, we also have an obligation to conduct a professional and ethical investigation. Dr Barton is no allowed to work at the GWMH. She is not allowed to prescribe or administer opiates. Our early, raw and unrefined CT opinion only relates to the GWMH and involves the use of opiates. We have no evidence in respect of the general practice. Therefore we will need for the GMC to provide us with evidence of a continuing risk to public safety in writing before we can fully consider whether to provide further data. That does not preclude others looking at her general practice.

SW mentioned that we were considering exhumation and why. There was then a discussion on this subject

RS mentioned the CHI

GC and NN confirmed that all other internal investigation were on hold.

GC asked what could be said to the 2 Chief executives of the PCT.

SW stated that no mention was to be made of the word exhumation. However they 2 chief executives could be told - but only for their own information *that there were a number of cases that gave cause for concern and that would not be any further outcome before Christmas.*

NN asked that the executives be thanked for the support that their staff were giving to his team. The cooperation was of the highest order.

The meting finished at 1115

Other Document Form

Number D695

Title COPY LETTER FROM Mr WATTS TO ANN ALEXANDER 3/9/93 RE GILLIAN MACKENZIE.

(Include source and any document number if relevant)

Receivers instructions urgent action Yes/No

Document registered/indexed as indicated

Nr of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further action no(s)

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Receiver	
Code A	
O/M	SIO
Indexer	

COPY

Hampshire Constabulary
Police Headquarters
West Hill
WINCHESTER
Hampshire
SO22 5DB

Tel: 01962 871404
Fax: 01962 871251

S Watts MSc DPM MCIM
Detective Chief Superintendent
Head of CID

3 September, 2003

Ann Alexander

Code A

Dear Ann

Re: Gosport War Memorial Hospital

Please find attached a copy of a letter I have sent to Mrs Gillian Mackenzie today regarding issues she has raised in conjunction with the Gosport War Memorial enquiry.

Please do not hesitate to contact me or DI Niven if you have any enquiries, or wish to discuss any issue relating to this case

I look forward to our meeting on Thursday 11 September 2003.

Yours Sincerely

Steve Watts
Detective Chief Superintendent
Head of CID

Enc

COPY

Hampshire Constabulary
Police Headquarters
West Hill
WINCHESTER
Hampshire
SO22 5DB

Tel: 01962 871404
Fax: 01962 871251
Telex: 47361 HANPOL

S Watts MSc DPM MCIM
Detective Chief Superintendent
Head of CID

email: Code A

3rd September, 2003

Mrs Mackenzie

Code A

Dear Mrs Mackenzie

I understand that you have recently been in touch with DC Code A regarding some questions that you have regarding my involvement in the investigation of allegations relating to patients at Gosport War Memorial Hospital, in respect of which I am now the Senior Investigating Officer.

I am happy to answer them, as follows;

1. I first became aware of the allegations, which principally emanated from yourself, following your complaint regarding the investigation conducted by Detective Inspector Morgan at Gosport. At that time, I was the Detective Superintendent with responsibility for Major Crime Investigation in the East of Hampshire.

Following the findings of the investigation into your complaint, I tasked DCI Ray Burt to review and then re investigate the case. Mr Burt reported to me as his line manager on a regular basis.

2. The investigation undertaken by Gosport CID, so far as I can recall in the main pre dated my arrival in post as Detective Superintendent. As indicated above, I was aware of the case following your complaint regarding the investigation headed by DI Morgan.

I understand that in addition to the points above, raised with DC Code A that you have also spoken to my Code A, asking for my attention to be drawn to Article 2 of the European Convention on Human Rights, in particular the positive obligation of the state to investigate death. I thank you for this, but can confirm that I was and am very aware of my personal obligation in this regard and the obligations of the Hampshire Constabulary.

The investigation into the allegations made in respect of Gosport War Memorial Hospital, is, I trust you will agree thorough, meticulous and ethical.

HAMPSHIRE CONSTABULARY

As you are aware, I have at all times taken care to keep yourself and the other families fully informed, so far as I am able of the progress and conduct of the investigation. You will be aware that there is a further meeting to be held on Thursday 11 September, where I will be more than happy to answer any questions in respect of the investigation that I am directing. You will understand I am sure why I am unable to answer questions regarding complaints against Police Officers which are under investigation by others.

I trust this is helpful to you and deals with the matters you raise.

Yours Sincerely

Steve Watts
Detective Chief Superintendent
Head of CID

Other Document Form

Number D691

Title ROUGH NOTES OF DC ROBINSON RE CONTACT WITH G. MACKENZIE.

(Include source and any document number if relevant)

Receivers instructions urgent action Yes/(No)

Document registered/indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further action no(s)

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Receiver	
Code A	
O/M	SIO
Indexer	

Mrs McKenzie 0945 – 0958.

not happy with Ann Alexandra.

waiting for minutes

wire crossed – discuss submit at Lodon in house

Civil negl. comp. eng.

me not interested.

my case – criminal court – manslaughter / murder.

Stuart Warren diss. Reason that audience

ancient patients not worth preserving

hospital policy

not

Query – Field Fisher Waterhouse.

– they are Sol. advisers to GMC.

They haven't got enough evidence

my concern – indicates they think

serious by GMC.

Pd. Employer

Niece Peter - met Murdoch at all

- Nurse name came forward

sister - didn't want me to come to police.

Concerned about death certificate wrong info - not agreed.

- sister sent us post mortem.

defence will say. - Peter being nice last night.

don't want he have.

family have returned me

Mum Alex only in for an publicity + an benefit.

-: If dis. from Mum Alex. will I still be kept informed.

HAMPSHIRE Constabulary

Mrs McKenzie,

10-20 2/10/03 10-30

Spoken to journalist - remembers event

Supt Watts take up every lead.

- Passed to Ray Burt.

Tension.

- Jonathan Carter: journalist. - spoke - 1/10/03.

Prepared to spk Alexander Harris.

- Want tell number.

J.C. want asked by Ray Burt.

R. Burt

— 1 —

Check 3rd hand
Mr Redhead "There isn't a single case which could gd to court at this moment in time"

- Ann Reeves "pick it up" at meeting

CONFIDENTIAL

MRS. McK. 0930 hrs 6/10/03.

M.P. – MR Nigel Waterson Trilby evening.
ENFIELD

Asked him to raise q. to ad. Blunkett H of C.

He agreed.

MRS Mc. given str. to press associates.

7 expert medical opinions on case by Police – still

Waiting. Coroner's report.

– MP Anne Reeves – her MP constituent dau.

Pers. Ass. 'Had there been any pub before 'local papers'
Sunday Times.

Anne Reeves seized quote to Times from Policeman.

3) Ripley case - why case compensation. Mrs Meade!

17-05 Mr. McKenzie :-

Att. Gen.

28/8/02 copies letter - no accompl.
sent his to PPP.

last 4 days of life

Other Document Form

Number D.690.

Title COPY CONTRACT MATTHEW LOAN 4-9-03

(Include source and any document number if relevant)

Receivers instructions urgent action Yes/No

Document registered/indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further action no(s)

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Receiver	
Code A	
O/M	SIO
Indexer	

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Our ref: MSL/TL/2478845 v1

Strictly Private & Confidential

Detective Inspector Nigel Niven
Hampshire Constabulary
Western Area Headquarters
12-18 Hulse Road
Southampton
Hampshire S015 2JX

COPY

4 September 2003

Dear Nigel

Operation Rochester

I write further to my letter of 14 August 2003 setting out our Standard Terms of Conditions and our meeting on 1 September 2003 where certain of those conditions were constructively reviewed. As agreed I am writing to set out the basis of our agreement and a new letter. I look forward to receiving your confirmation as detailed below of your acceptance of the revised terms.

People responsible for your work

1. I will carry out most of the work in this matter. I am a partner in the Professional Regulatory Group and have ultimate responsibility for this matter.

2. We try hard to avoid changing the people who are handling your work but if this cannot be avoided, we will notify you promptly who will be handling your work and why the change was necessary.

3. I will explain to you the issues raised in your matter and keep you informed of progress. I will also advise you whether the likely outcome of your case will justify the likely charges and expenses and risk involved, from time to time, as necessary.

4. I will advise you as the matter progresses of the likely timeframe for each stage and for the matter overall.

5. We will observe the professional rules and guidelines of the Law Society and accept instructions to act for you on the basis that we will act in accordance with those rules and guidelines.

6. Some of the fee earners involved in advising you may also be bound by the rules of other regulatory bodies and you instruct us on the basis that we will also act in accordance with such other professional rules.

7. We reserve the right to disclose our files to regulatory bodies, including our auditors, in the exercise of their powers.

8. You agree that we can approach such third parties as may be appropriate for information that we consider necessary or desirable to deal with your affairs. You will co-operate by providing all information which may be needed in order for us to fulfil our obligations under money laundering regulations.

9. If you have any problems or queries over the way your matter is being handled or any way in which you feel our services can be improved please contact me. Please do raise any concerns or queries so that we can address these. We will do our utmost to provide the service you wish.

Our complaints policy

We are committed to providing a high-quality legal service to all our clients. When something goes wrong we need you to tell us about it. This will help us to improve our standards.

Our complaints procedure

If you have a complaint, in the first place please contact the partner who has overall responsibility for your business or for the particular matter concerned. If (following this) you remain dissatisfied or if your complaint concerns the partner with whom you are normally in contact, please write to the Senior Partner, who will be responsible for dealing with your complaint, though if the Senior Partner is away from the office for any material length of time the Managing Partner will deal with your complaint in his absence. This will initiate our formal complaint procedures.

What will happen next?

10. The person dealing with your complaint will send you an acknowledgement and may ask you to confirm or clarify some issues. You can expect to receive our acknowledgement within four days of our receipt of your complaint.

11. We will record your complaint in a central register and will open a file for your complaint. We will do this no later than the time when we acknowledge your complaint.

12. We will then start to investigate your complaint. This will normally involve one or more of the following steps:-

    - reviewing the paperwork for the matter to which the complaint relates;

- discussing the position with those concerned within the firm;
- seeking any further clarification we require from you.

13. Having completed our investigation we will write to you, hopefully to resolve your complaint. We would normally expect to be able to do this within fourteen days of our initial acknowledgement letter, though if more time is needed (e.g. because a key fee earner is away) we will update you on an ongoing basis at no more than ten day intervals.

14. At this stage, if you are still not satisfied you can write to us again with your reasons and we will review our decision. The review will be carried out by two members of our Management Board. Our aim will be to complete the review within fourteen days of receipt of your letter, but if more time is needed you will be notified.

15. We will let you know the result of our review within five working days of completion of the review. At this time we will write to you confirming our final position on your complaint and giving our reasons. We will also give you the name and address for the Office for the Supervision of Solicitors. If you are still not satisfied you can contact them about your complaint.

16. If we have to change any of the timescales above, we will let you know and at the same time we will explain why this is necessary. If a complaint may constitute a possible claim for compensation for negligence, then we will generally have to refer the matter to our insurers.

Charges and Expenses

17. Our charges are based, primarily, on the time spent dealing with matters. This includes advising, attending you and others, dealing with papers, correspondence, telephone calls and travelling time. Time is recorded in six minute units.

18. The rates vary according to the person dealing with the matter, and we ensure that work is carried out by the appropriate level of fee earner. My hourly rate is £215 per hour. It may be that assistance will be required from other members of the team in undertaking this operation. Should one of our assistant solicitors be required to assist their hourly rate will be £170 per hour; the hourly rate of an investigator is £120 per hour. The hourly rates will not increase unless there has been prior agreement with you. The rate per hour for travelling will be charged at £170 per hour for partners, £135 per hour for assistant solicitors and £95 per hour for investigators.

19. We may, in addition, add a mark-up to take into account the particular circumstances of the case: these will include its complexity, urgency, importance, the number and importance of documents to be prepared and the value of the claim. The assessment for each case will be different. On the basis of the information currently available to us, we expect these factors to be covered in the hourly rate. No mark up will be made unless there has been explicit

agreement from you.

20. We may incur expenses on your behalf which will be itemised on your bill. These may include travel costs and photocopying. You have agreed that we may incur first class rail fares when travelling to meetings. Our mileage will be charged at 40p per mile. Any air travel will be incurred at the lowest reasonable cost available at that time. We will, of course, advise you in advance of unusual expenses or charges and seek your approval whenever practicable.

21. Where we are obliged to charge VAT on our services and disbursements at 17.5%, this will be added to our fees and disbursements. VAT is charged to all UK clients and for all disputes relating to property in the UK as well as for some EU and other clients.

22. Generally, if we hold money for you we will account to you for interest in accordance with Law Society guidelines. You will need to account for the tax payable on this interest.

Billing

23. We normally render interim bills to you as the matter progresses at appropriate intervals, normally on a monthly or quarterly basis. We will provide a detailed narrative of the work carried out on your behalf and are happy to provide you with any additional breakdown of the bill which you may require.

24. If any bill is not settled or we do not receive monies on account of costs, within a reasonable period of request, we reserve the right not to continue acting for you.

Estimate

25. It is difficult to estimate in advance how many hours of work will be necessary in this case but I will update you once my instructions become more detailed as to the likely costs involved.

Money on account

26. We will not ask for money on account at this stage of the matter but may do so if the circumstances of the matter change. We may request further payments on account for charges and expenses to be incurred as the matter progresses. When we put these payments towards your bill/s we will send you a receipted bill. We will offset any such payments against your final bill, but it is important that you understand that your total charges and expenses may be greater than any advance.

Storage of papers and deeds

27. After completing the matter, we are entitled to keep all your papers and documents while money is owing to us. We will keep our file of papers (except for any of your papers which you ask to be returned to you) for no more than six years after sending you our final bill. We will not destroy documents you ask us to deposit in safe custody. We will keep title documents in our deed room.

28. We do not normally make a charge for retrieving stored papers or deeds held merely for safekeeping in response to continuing or new instructions to act for you. However, we reserve the right to make a charge based on the time we spend on reading papers, writing letters or other work necessary to comply with the instructions.

Termination

29. You may terminate your instructions to us in writing at any time. We are entitled to keep all your papers and documents while money is owing to us.

30. We will decide to stop acting for you only with good reason and on giving you reasonable notice.

31. If you or we decide that we will stop acting for you, you will pay our charges on an hourly basis and expenses as set out earlier.

Data Protection

32. We will hold the information which you give us which identifies you, and information identifying other individuals at your organisation which you or they give us, for the purposes of providing services to you. In addition, from time to time, we may provide you with information which we think may interest you. This will usually be in the form of legal updates, briefing papers, newsletters and details of forthcoming events or seminars which we run periodically. We may also send you contact information about the firm. Except as permitted or required by law, we will not disclose any information which you give us without your consent. By signing and returning this letter you consent to us processing for these purposes the data which you give us.

Conclusion

33. Your continuing instructions in this matter will amount to your acceptance of these terms and conditions of business. Even so, we ask you to please sign and date the enclosed copy of this letter and return it to us immediately. We can then be confident that you understand the basis on which we will act for you.

34. We hope that by sending this letter we have addressed your immediate queries about the day-

to-day handling of your work and our terms of business. If you still have any queries, please do not hesitate to contact me.

35. If you wish to speak to my secretary at any time, her name is Tina and her direct line is Code A Code A

I look forward to working with you and I will do my best to ensure that everything proceeds as smoothly as possible and that you are kept fully informed of both the progress and the costs of your matter.

Yours sincerely

Code A

Matthew Lohn

Partner
Direct Line: Code A
Mobile: Code A
Email: Code A

I confirm I ha[illegible] agree to its terms.

Code A

Signed:..... *Dated:* 24/9/07

for and on behalf of
Hampshire Constabulary Code A

PS: **This is an important document: please keep it in a safe place for future reference.**

Other Document Form

Number D686

MINUTES FGM NOTTM 11/9/03

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further actions no(s)

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

O/M	SIO

Indexer

Operation Rochester
Family Group Meeting, Netley
11th September 2003
MINUTES

The meeting was opened by Det. Ch. Supt. Watts who thanked the families for their attendance and support and explained the evenings agenda before handing to DI Niven.

DI Niven offered apologies for the absence of DC Rushworth and Ann Alexander.

The meeting was again reminded of the sensitive nature of the evenings discussions before DI Niven explained what progress had been made on this enquiry over the last year and the history of the investigation. (Script attached).

Det. Ch. Supt. Watts then informed those present of the current position and what could be expected over the coming months. Points raised included:

- That the Investigation Team have interviewed a significant number of Staff, some of which expressed concerns, but many didn't.
- An explanation of the process used by the Clinical Team.
- That the Clinical Team have indicated a number of cases where they have grave concerns over the standard of care and the way they died. That figure cannot be revealed at this time and there is a larger number of cases where the Clinical Team concluded the patient had received optimal care and died from natural causes.
- The Investigation Team want to be 100% sure before being specific about figures to ensure the absolute final answer is given in relation to care of individual patients. This information will be forwarded at the earliest possible opportunity.
- Findings will most probably be forwarded via post to enable everyone to receive answers at the same time.

Det. Ch. Supt. Watts explained that the Clinical Team had been picked to represent a wide spectrum of clinical expertise, adding that a further team of experts will be required to focus on those cases of concern. A group view had been gained, as intended, but there was now a need for other medical experts to look in fine detail, and in isolation, at these cases for reasons of integrity and to eliminate the risk of suggestions of collusion or persuasion if this investigation came to trial. Det. Ch. Supt. Watts added that quality control is therefore required and to this end the Investigation Team had employed the services of Field Fisher Waterhouse Solicitors who are specialists in medical matters.

Before the end of this session the meeting were informed of what the next phase of the investigation would involve:

- Evidential Review to take place.
- Further interviews of Practitioners, possibly under caution.
- A highly experienced Tactical Interview Manager has joined the Investigation and will be working with Field Fisher Waterhouse.

Det. Ch. Supt. Watts went into the break by explaining that the job of the Investigation Team was to gather evidence ethically, thoroughly and professionally before presenting that evidence to the Crown Prosecution Service. It was then the decision of the CPS whether there was a case and whether it was in the public interest. He further explained that the strategy adopted had been discussed with the CPS and was regarded good practice, but the next process would not be completed before this time next year, adding that he apologised for the time scale but that this was due to the size of the investigation.

After a short break there was a Question and Answer Session in which the families could air any queries.

Q When you decided that there was some culpability, what are the reasons for getting a fresh set of experts and only looking at some cases?

A Det Ch. Supt Watts: We need to quality assure our findings and make sure the notes were the right ones.

Q Those cases that are deemed no cause for concern, is it not fairer that the families are told now?

A Det Supt Watts: Yes, we understand your concerns and we have thought what we would want in this situation. We are continuing our investigation and we will re-look at these cases to double check. I will give an undertaking to make absolutely sure of our findings before making them open.

Q I am concerned that Mr Niven mentioned the investigation covering the past 10 years, my father died 13 years ago.

A DI Niven: The reason you are here is because we are investigating your case. I was just talking in broad terms and rounding figures.

Q You mentioned that some cases were cause for concern and some showed no cause for concern or natural causes, why say that if you can't confirm individual cases at the moment?

A Det. Ch. Supt Watts: I apologise if I caused concern but we want to be certain before confirming any results. I mentioned a year, but it will be at least a year before any possible prosecution, you will know which are no cause for concern.

Q Are you saying that you don't feel confident with this team of Clinical Experts and their findings?

A Det. Ch. Supt Watts: One option would be to tell you the results now but we are carrying out a thorough investigation and we will double check those findings.

Q What about the statements we have provided are these considered or is it just the medical records that are being looked at?

A Det. Supt Watts: Your statements are being taken into account.

Q Will you take into account what we want to hear. Can you not tell us if there is cause for concern at this stage rather than letting us wait a long time?

A Det. Ch. Supt Watts: I understand what you are saying, we want to quality assure our results but we will review our position.

Q I appreciate that you may change your mind on these results, but why another team?

A DI Niven: This meeting is to provide an update of the investigation we are conducting. It will achieve answers, but we are insistent that we will quality assess what we have done so far. Before exposing anyone to our views of what has happened we are employing further experts to quality assure our results. This process has to be re-checked and it will be checked as vigorously as the current process. IF there was any prosecution, it would be at least year into the future. Before that you will know what has happened to your loved ones.

Q I didn't expect definitive answers now, but how long do we have to wait?

A DI Niven: In terms of any prosecution these things do take that long. In terms of knowing what happened to your loved ones it will be much sooner, but as Mr Watts said, we do have to quality assure these things.

A Det. Ch. Supt Watts: To answer your question, it is going to take at least a year before any possible prosecution, but in the cases of no culpability you will know sooner.

Q I was told by an Officer that I would know by September.

A Det Ch. Supt Watts: That was never going to be the case, we know much more as a result of last weekend, but this is a massive and complex case requiring quality assuring and lengthy legal processes.

Q Mr Niven mentioned that investigation process was refined 20 years ago, new systems introduced. My father died 5 years ago. There was a case recently north of the country where two nurses were found guilty within months.

A Det. Ch. Supt Watts: We have spoken to Officers in that case and there were issues within that case that meant it could be resolved far quicker.

Q The Press say it's similar.

A Det. Ch. Supt Watts: The press would say that by the nature of what they do. The issues within that one made it quicker to review.

Q Why quicker?

A Det. Ch. Supt Watts: This is a massive investigation with far more cases, this other incident involved 5 individual cases, circumstances were very different.

Q How many investigations like this are there currently running in this country?

A Det. Ch. Supt Watts: I don't know the figures on that.

Q Can you tell us how many, not mentioning individual details, how many concerns you have in this case?

A Det. Ch. Supt Watts: I cannot divulge any information relating to findings so far for the reasons mentioned.

Q The records that you have are copy's of what the Doctors and Nurses wrote at the time, is the quality of those notes good enough?

A Det. Ch. Supt Watts: We can only deal with the information we have in our possession.

Q Is your investigation based purely on what one or two Doctors or Nurses wrote in their notes?

A Det. Ch. Supt Watts: Plus statements taken from Doctors and Nurses.

A DI Niven: Some of the medical notes are of a poor quality but we have in effect really good copies of poor documents and if necessary can supply the original records. Record keeping within the hospital has been an issue that has been the subject of the CHI report and has been dealt with. Where copies are poor, originals have been gained. But in terms of record keeping, this is an issue taken into account.

Q Is there any progress from Professor Baker?

A DI Niven: I spoke to Professor Baker this morning and he has submitted his report to the Chief Medical Officer in which he will articulate any concerns. This should be available to us soon and when it is we will be able to consider his findings.

Q When will you get his report?

A DI Niven: Not too far down the line.

Q Claire Amos (Alexander Harris) on behalf of the families: Will the Clinical Experts have chance to look at the Officers Reports?

A DI Niven: No, we asked them to look at the medical records as they exist without clouding their minds. They have to focus on and identify their own issues, i.e. whether there were palliative care concerns etc. It will assist us here that we have employed Field Fisher Waterhouse. They will scrutinise and quality assure those results. There will be a time when other concerns will be dealt with but in first instance we are just looking at the records.

Q Claire Amos (Alexander Harris): But you will look at everything?

A DI Niven: Absolutely. But we want to make sure that at each stage the system they use is recorded.

Q Will the CPS have to look at whether it is in the public interest? What does that mean?

A Det. Ch. Supt Watts: They look at whether there is sufficient evidence. Public interest, whether there is a case to be heard and it is of value to the interest of the public to carry out a case for prosecution, was mentioned for completeness and this shouldn't be an issue here.

Q You don't think it will be an issue?

A Det. Supt Watts: I can't pre-empt these things, but I can't see it being an issue.

Q Gillian McKenzie: In the Shipman case this was a major incident that came to light in August 1998 and in September Shipman was arrested. They got their act together, I can't say the same for this investigation. I am also concerned about the 1991 report where there were obviously some concerns from Nurses. In 1999 to 2001 two nurses came forward, the press contacted a Nurse and had a damning conversation with her. This journalist was called to Police Head Quarters but no statement was taken from him with regards to this information yet a statement was issued by the Police regarding this investigation. You never found out what that journalist or the Nurses allegations were. The journalist was Jonathan Carter, I have passed on his information to the Police but he was never cross examined.

A Det Supt Watts: I will speak to you individually on this matter. I know Jonathan Carter, I have spoken to him before and I have no recollection of speaking to him on this case? I have not spoken to him regarding this at all.

A DI Niven: This investigation didn't start as a result of the 1999 documents but rather due to the publicity provoked by Professor Bakers involvement. Then the 1991 documents were handed in and then there was publicity which bought a lot of you forward.

Q Gillian McKenzie: on the 16th of September Ann Alexander approached Hampshire Constabulary who said they wouldn't take the case on, two days later they decided to take it on. There are a number of things the public are not aware of and I want to make sure they are made aware.

Q In relation to administration of drugs, did staff have the right to administer or was there a process of double checking?

A Det Supt Watts: This varied. We can't give details. We can't specify on individual cases.

Q I don't want you to give individual answers, but want to know if you have come across this during this investigation?

A Det Supt Watts: I can't comment at the moment as this is subject to the investigation.

Q But if it is will it be a Hospital Management matter?

A Det Supt Watts: Yes.

Q Would you consider notifying families in any other way than that suggested?

A Det Supt Watts: Yes, we want your feedback hence this meeting. What we were looking for was the best method to ensure you all found out at the same time. Due to the size of the investigation to knock on doors would mean that some would get answers before others and it is a close knit community some of you know others and may not be happy to find out someone else has been told and you are still waiting. We are open to ideas on the best practice.

Det. Ch. Supt. Watts reiterates that it will be a thorough, ethical and professional enquiry and thanks the families for their support before introducing Claire Amos and Patricia Rowe from Alexander Harris.

The Investigation Team depart the Lecture Theatre.

Other Document Form

Number D 678

Title MINUTES CLINICAL TEAM MTNG 7/9/08

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / (No)	Code A
Document registered / indexed as indicated	Code A
No(s) of actions raised	
Statement readers instructions	Statement Code A
Indexed as indicated	Code A
No(s) of actions raised	
Examined - further action to be taken	O/M | SIO
Further actions no(s)	Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Operation Rochester
Conference at Marriott, Northampton
7th September 2003
MINUTES

Present:

Professor R Forrest	Det Ch Supt Watts
Doctor R Ferner	DI Niven
Doctor A Naysmith	DS Kenny
Irene Waters	DS Grocott
Doctor Peter Lawson	WDC Robinson
Matthew Lohn	DC Yates
	Code A

Professor Forrest presented the findings of the Clinical Team, that have now been produced onto an excel spreadsheet.

The meeting discussed the definitions of the care bands A, B, C and 1, 2, 3 after which Det. Ch. Supt. WATTS asked for clarification of band C. Professor FORREST explained that in basic terms the treatment a patient falling into that care band had received had killed the patient. DI NIVEN asked why this was not specified on the chart. Doctor NAYSMITH responded that the definition should read there was no explanation for the treatment meted out to patients falling into band C. No explanation for treatment was agreed as the rating explanation.

The Clinical Team identified seven cases that had raised concerns, all given a B3 rating – B. Cause of death unclear, 3. Negligent care – and are listed as follows:

1. CUNNINGHAM (BJC15) – Treated by several Doctors. Rapid escalation of diamorphine for no apparent reason. Midazolam given caused concern to the family, who had not been informed by Staff at the Hospital. Dr NAYSMITH added that this man would have died and would have been suffering some pain, but not the type that would respond to the drugs administered. She also added her concern over how rapidly the doses were increased.
2. Elsie DIVINE (BJC16) – The team noted that this lady had showed difficult behaviour and was demented and aggressive, but had shown no signs of pain and was due for transfer to a Rest Home. Fentanyl patch was administered, an alternative to an infusion of Diamorphine, for pain relief. It appeared to the Clinical Team that this had been prescribed to calm the patient rather than treat any pain which they described as a very dangerous practice. The Team added that this patient then died shortly afterwards.
3. Sheila GREGORY (BJC21) – This patient was suffering from a severe chest infection, the oral morphine prescribed would have been appropriate for a cancer patient, but was totally inappropriate for patients in the condition GREGORY was in. there was then mention of Pharmacokenetic's, the study of how the body handles drugs. Dr NAYSMITH went on to add that she was frail and may not have recovered from her chest infection but, "they never

gave her that chance". Irene WATERS further added that on the notes it had been left for the Nurses to confirm death, which suggests expectation. Dr Lawson noted that the day she was admitted she had been written up for Diamorphine.

4. Elsie LAVENDER (BJC30) – With this patient Staff had made a 5 fold leap in the effective dose from Morphine to Diamorphine. The team suggested the argument could be that the dose was increased as necessary, but conclusions were that it was a vast leap and "at least negligent" and "a bad mistake". Dr Ferner referred to BNF, British National Formulary published by the British Medical Association and the Royal Pharmaceutical Society to support the argument that these were excessive dosages.
5. Enid SPURGIN (BJC45) – Inappropriate antibiotic therapy followed by rapidly escalated Opiates. It was left to the Nurses discretion to initiate between 20 and 200g doses of Diamorphine a day, felt to be a particularly large dosage scope. Dr Ferner added that this patient was among others that were given prescriptions for high doses.
6. Jean STEVENS (BJC46) – Some earlier notes relating to this patient's stay at Hasler Hospital were missing, but the only mention on the transfer letter between hospitals was that she was suffering some skin irritation. The patient died within 48 hours after receiving high doses of medication.
7. Robert WILSON (BJC55) – This patient was suffering from liver disease but as with those previously mentioned, was given high doses of Morphine, causing him to put on 30lbs of fluid. There is no documentation of any measures taken to deal with this. The Clinical Team concluded that Morphine was inappropriate as his liver was incapable of metabolising stating it would be very dangerous prescribed to a patient with liver dysfunction.

Det. Ch. Supt. WATTS asked the Investigation team if they had any questions/queries regarding these findings.

DC Code A asked in the case of Enid SPURGIN what would the Clinical Team consider to be a normal prescribed dose. A discussion followed starting with Dr Lawson suggesting that under normal circumstances this would be judged on a daily basis and there should be no requirement to write a dosage range. Dr NAYSMITH queried what the procedure would be if there was no Doctor available to which Dr Lawson responded that in his experience an appropriate dose would be decided allowing a range of double that quantity. Dr NAYSMITH concurred. Irene WATERS added that this prescription practice was excessive and she would expect a safer range from a GP. Dr NAYSMITH concluded that these were patients with aches and pains and the drugs administered were inappropriate, while Dr FERNER suggested that small doses via injection rather than a variable rate infusion to deal with extra pain would be appropriate. At the end of the day these measured doses and infusions would be calculated to assess future appropriate quantities.

The Clinical team were thanked for their continued support and the meeting was reminded of the Family Conference being held at Netley on the 11th September, stating that no detailed information would be given at this meeting as the investigation is still at an early stage, but it would be stated that progress had been made.

All of the Clinical Teams original notes were requested by Det. Ch. Supt. WATTS, 1. for disclosure purposes and 2. as part of the analytical process. This will be facilitated over the next couple of weeks.

Det. Ch. Supt. WATTS then revealed a further 20 cases that have been highlighted, 16 by Professor BAKER and the other 4 from concerned families coming forward in light of the current investigation.

A: Dr NAYSMITH reminded the meeting that 2 of the current batch had the wrong case notes attached.

Professor FORREST asked if any statistical work would be carried out. Det. Ch. Supt. WATTS stated that there would be no requirement at the moment and he didn't want to draw any parallels to the SHIPMAN enquiry.

Professor FORREST finally stated that the Clinical Team had been and would continue to be happy to work together, adding that two of the benefits of these latest meetings were having a Nurse present and in this latest session, having a Police Officer included in the meeting as an independent observer. Whilst in no way contributing to the conclusionary text the officer was able to confirm that it was sufficiently clearly written for the lay individual to understand.

DI NIVEN concluded the meeting by thanking the teams.

Other Document Form

Number D.677

Title MINUTES CLINICAL TEAM MTG 14/6/03.

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / (No)

Receiver

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Code A

Indexed as indicated

(s) of actions raised

Examined - further action to be taken

O/M | SIO

Further actions no(s)

Indexer

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Operation Rochester
Conference at Courtyard Marriott, Northampton
14th June 2003
MINUTES

Present:

DI Niven	Professor Forrest
DS Kenny	Dr Ferner
DC Tenison	Dr Lawson
Code A	Mrs Waters
	Dr Naysmith

Code A

DI NIVEN opened the meeting by welcoming the Clinical Team and thanking them for their continued work. He stated that the purpose of this meeting was to discuss and review the 2nd batch of 20 cases and resolve any contractual issues.

Code A from the National Crime Faculty was present to talk through the contracts with the team, addressing any concerns.

DI NIVEN went on to say that Professor Richard BAKER had identified a further 16 cases of some concern, but assured the meeting that in order for the investigation to reach a conclusion a line may have to be drawn under an agreed amount. Further discussion would be required on how and when to tackle these additional cases.

The Clinical Team were left to consider the latest batch.

P.M.

The Clinical Team put forward their conclusions. For the purpose of the meeting the findings were categorised as either no concerns, 'middle', and of concern. Further elaboration of their findings were given where necessary.

No Concerns

Code A – most of the team were comfortable with this decision though there were some discrepancies.
– there were concerns that the team felt should be reported to the Coroner, but none relating to Gosport.
– Died after high doses of Morphine, though the team felt this was probably of little concern.

Middle

BJC34 – a few concerns, but only quibbles. 2A.
BJC35 – P222 of the original documentation is required as part of the page is is missing.
BJC22 – also an A2
BJC23 – named as Code A The team categorised this case as 2A Moving to 2B. They also pointed to a gap in the notes asking whether a drug chart was possibly missing.
BJC36 – Code A asked if the date of the Hazard Notice could be Retrieved and what sort of Graseby Device was used along with the Date of retrofit.
BJC26 – this case was graded A2, with Mrs WATERS placing it at 2B.
BJC37 – care was described as 'inept not incompetent', questioning Giving opiates to opiate insensitive patients who would get none of The positive effects, just side effects.

Serious Concerns

BJC28 – Clifford HOUGHTON
BJC29 – Thomas JARMAN, this was described as 'at the very least Negligence'.
BJC30 – Mrs LAVENDER (3B)
BJC31 – Catherine LEE (2B), some concerns but there were worse cases.

Professor FORREST summarised by saying that although in the previous batch there had been a number of cases of note, files in this 2nd batch raised higher concerns.

The Clinical Team expressed a desire to have sight, at the appropriate time, of the Wessex Protocol. DI NIVEN confirmed that this would be made available when it suited the needs of the investigation.

Other Document Form

Number D676

Title MINUTES CLINICAL TEAM MTNG 26/4/05

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further actions no(s)

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

O/M	SIO

Indexer

Operation Rochester
Conference at Initial Conference Centre
26th April 2003
MINUTES

Present:

Det Ch Supt Watts	Professor Forrest
DI Niven	Professor Ferner
DS Kenny	Dr Naysmith
DC Robinson	Dr Lawson
DC Rushworth	Code A
Code A	
DC Yates	

Det Ch Supt Watts thanked the team for their attendance and work so far then offered Dr Forrest the floor to present the findings of the Clinical Team to date.

Remunerations

The Clinical Team reported no problems with the financial arrangements and agreed that the moneys received covered the work undertaken up to current date.

DVD's

Problems with the software were highlighted by Dr Neysmith and Dr Forrest. All members of the team found difficulties with bookmarking and the 'Find' function. Dr Forrest and other members of the Clinical Team found that the application was hardware intensive, restricting which machines had the capacity to run the programme, subsequently restricting where the investigations could be carried out.
A: Dr Neysmith requested a lesson in the use of the software - which can be arranged through WORM.

Presentation of Notes

Dr Forrest pointed out that for a civil case Doctors notes are sorted, filed and tabulated making them easier to navigate. Det Ch Supt Watts explained that the practise was time intensive, that Major Crime did not possess the expertise and would rather present the evidence in an unabridged state.

E Mail Group

The Team had discussed the possibility and possible need for setting up an e mail group to maintain communications between the members. It was decided that the current arrangement of 6-8 weekly meetings was adequate.

Hierarchy and Culture

There was a lengthy discussion on the hierarchy and culture within Gosport. A comparison was drawn between the structure within the Police, where there is a more rigid hierarchical structure, and the Care professions, leading the Clinical team to conclude that the culture within Gosport wasn't what they were used to within their profession where communications are generally very good with staff working to a common cause.
The Clinical team requested a copy of the Wessex Protocol.

Screening

Dr Ferner has developed a new screening sheet using visual analogue scales with different parameters. This scale was based deemed to be more analytical than the previous which drew more on emotional analysis. Det Ch Supt Watts asked whether there was a template curve the team would be happy with. Dr Ferner agreed that there was a mark beyond which suspicion increases.

The Investigation

Dr Forrest stated that after discussing half of the material available with the rest of the team the consensus was that between 10 and 20% of cases was indicative of possible deliberate harm. Dr Ferner scored lower stating that intent to cause harm was difficult to argue. Det Ch Supt Watts reminded the team not to concern themselves with legal definitions.
The team further agreed that the standard of Nursing was poor with Nurses seemingly following orders without questioning the appropriateness, when this could possibly be called into question. There is some evidence that Nurses are requested to carry out work that does not come under their remit/they would not have received appropriate training for.
Significant parts of the records were either missing, absent or had not been completed.
Irene Waters read extracts of an article on Dr Graham Pink where careers had been ruined through 'whistle blowing'.
Dr Forrest went on to say that a lot of the records had prescription sheets missing, which he deemed to be one of the most vital documents. Det Ch Supt Watts told the group that a written request would be put in to the Strategic Health Authority. Dr Neysmith mentioned that, armed with dates, details could be obtained from the Controlled Drug Register. DS Kenny stated that Dr Baker was currently in possession of this information.
Further discussion on the quality of care showed that there were omissions in note making where major medical decisions had been made, i.e. why a patient had been placed on a syringe driver. Also Doctors were giving Nurses authority to certify death as long as the Doctor was informed immediately raising the question of whether there was a cultural expectancy that when a set of events happens, is that patient expected to die.
Irene Waters stated that she would have expected Nurses to make notes of medical interventions or any concerns as this is their only defence, but this hasn't been recorded. At this point Det Ch Supt Watts requested that the team make notes of names to highlight on individual cases. Any queries over names or signatures could be cross referenced with the Controlled Drugs Register which maintained a list of

names and signatures for authenticity purposes. Dr Forrest told the group that pharmacies keep similar records.

Dr Forrest then went round the group asking if they had anything to add. Dr Neysmith noted that the more medical records analysed, the more habitual prescribing patterns appear. She said that this was not necessarily bad, but demonstrated a definite pattern which, she said, was why the group would like to see the Wessex Protocol.

Code A again questioned the level of care meted out by Nurses who, although not expected to understand, should discuss with Doctors the finer points of care. She stated that there were many instances where Nurses had gone ahead and administered drugs inappropriately without noting any concerns or queries on the patients records. The new matrix would aid with differentiating between low levels of care that may not necessarily have contributed to death and dangerously inappropriate care. Presently her scorings are clustered and not diametrically opposed, and s he concluded that no cases could be held up as good practice and some were already raising serious concerns.

Dr Lawson said that he needed to look at the cases further in more detail. Having worked in similar practices, some of the cases, he felt, could fall within margins of error whilst others fall below that.

Dr Ferner concluded that so far results do not suggest they represent the practice of one Doctor, rather they suggest more a practice specific to the hospital.

Victimology

Det Ch Supt Watts asked whether there was a commonality in the profile of people affected. Dr Ferner replied that it was difficult to say except that those who died do not have conditions such as cancer that require this level of treatment. Dr Neysmith added that on some notes there is no mention of pain. Some notes suggested the patients were difficult, noisy or disruptive. Det Ch Supt Watts suggested a study in victimology, via a statistical analysis around certain perameters to identify any clustering. Dr Forrest stated that this was already one area the team were looking at in their analysis and would make note of any finding. Dr Forrest added that initial results suggested there was something less than random. He further suggested that there was a need to look at all patients for comparison purposes. Dr Neysmith suggested a comparative study with other hospitals.

Code A also stated that she was aware of 'unpopular patient' tensions but as the investigation progressed it would this may produce a host of other questions, therefore it is too soon to produce any sort of questionnaire to progress the theory beyond analysis of patients notes. Det Ch Supt Watts concluded that any for the time being the team could flag up any issues where the patient has been written up as disruptive, any further investigations into this area could be dealt with if evidence of an emerging pattern is established, with possibly an independent panel reviewing any retrospective questionnaires of patients behaviour in comparison with the experts findings. Dr Forrest suggested that Dr Furners scale would most likely identify any trends in patients.

Dr Forrest supplied a list of patients with missing drug charts :

BCJ 12	06 (no information on patients prior health)
8A	M17
02	BCJ 09
01A	

Also supplied was a list of patients whose treatment caused most concern:

17
16
15
04

The meeting was concluded to allow the experts to discuss more individual cases.

A date will be set for a meeting between the Clinical Team in approximately six weeks time.

Other Document Form

Number D.675

Title NOTES OF MEETING WITH MATTHEW LOHN IN MANCHESTER 24/9/03

(Include source and any document number if relevant)

aivers instructions urgent action (Yes) No AS INDICATED ON DOCUMENT

Document registered/indexed as indicated

No(s) of actions raised A761 A762 A763 A764 A765 A766 A767 A768

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further action no(s)

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Code A

O/M	SIO

Indexer

Operation ROCHESTER

Notes of meeting with Matthew LOHN in Manchester 24th September 2003

Present:

Matthew LOHN
Nigel NIVEN
Owen KENNY

NN briefed ML on contents of family group meeting 11/09.

Clinical team:

Current clinical team have been employed to provide an analysis of case notes and provide a filtering system. This process will continue and be key to any future 'disengagements' of cases. They will continue to be employed as the key team, but if any case was later considered to be appropriate for any form of proceedings, then a separate team of experts will be used. Teams to be referred to as 'Key Clinical Team' and 'Clinical Review Team.'

Peter LAWSON and Ann NAYSMITH will be used to further refine certain cases.

ML indicated that IF Dr NAYSMITH had not been part of the key clinical team she would have been ideal for the Clinical Review Team

ML recommended Professor Irene HIGGINSON as Palliative care expert.

Patient Profiles:

OK handed to ML patient record DVD's and clinical team briefing pack.
A 161 ARRANGE FOR ADDITIONAL 20+ CASES TO BE COPIED TO DVD
Further 20+ cases, including 16 identified by Professor Richard BAKER to be copied to DVD and passed to current clinical team for review in same manner as first 62.
NN will visit team members individually and brief them.

Consideration will be given to cold calling FGM's of 16 cases identified by Professor Richard BAKER.
A 162 ARRANGE FOR PATIENT RECORDS TO BE PRINTED FROM DVDS
Arrangements are in hand for patient records to be digitally printed from DVD's by Hampshire Police graphics department. Hard copy prints will at a later stage be compared against original files for quality assurance.

Records of comments made by individual clinical team members and the conclusions of the clinical team to be obtained. A 163 OBTAIN RECORDS OF NOTES MADE BY INDIVIDUAL CLINICAL TEAM MEMBERS
ML stressed the importance of the written records recorded by Professor FORREST during the discussion held during the review process, as they are a record of his management of the group.

NN outlined the Policy in respect of Professor FORREST.

ML will review cases using medical records, clinical team comments and Officers Reports and will devise questions for Peter LAWSON and Ann NAYSMITH.

ML will review cases which currently fall into categories 1A and 2A as a priority with a view to disengaging cases of no concern asap.

Agreed timescales:

Friday 17th October - Hard copy files, including additional information from experts, to be generated by.
Saturday 6th December - Clinical team meeting to be held for review of additional 20+ cases.

Other issues:

ML requested copies of previous issues of Wessex Protocol as current issue is not relevant as it dates from 1999. OK informed him that we are having difficulties obtaining previous issues despite speaking to the author but we will endeavour to obtain issues from 1987. ML suggested the Royal Society of Medicine library, of which he is a member. A 764 OBTAIN ALL EDITIONS OF WESSEX PROTOCOL SINCE 1987 – CONSIDER ROYAL SOCIETY OF MEDICINE LIBRARY.

ML suggested obtaining information on patterns of prescribing, identifying peaks and troughs and prescribing pattern changes. Drug charts should be checked through for dates and amounts of diamorphine prescribed.
A 765 RESEARCH PATTERNS OF PRESCRIBING
ML suggested contacting the Prescription Pricing Authority (PACT) for data.

Report of Professor BAKER to be reviewed when obtained for references to the volume of diamorphine consumed. A 766. OBTAIN COPY OF REPORT BY PROF. BAKER TO ASSIST CMO

Causation discussed. Toxicology needed – consideration to be given to exhumations in order to establish levels of diamorphine. OK stated that 3 of the 3B cases are burials and contingency plans have commenced in respect of these.
A 767 CONSIDER EXHUMATIONS TO ESTABLISH LEVELS OF DIAMORPHINE
NN mentioned that Ian Barker – legal representative for Dr Jane BARTON – had been seen and informed that we are likely to need to interview her again but this may not be for some time.

ML suggested obtaining copy of Interim Audit from GMC. A 768 OBTAIN COPY OF INTERIM AUDIT FROM GMC

NN will arrange meetings with Chief Executives of the Primary Care Trust and the Strategic Health Authority to discuss current state of investigation including the IOC in respect of Dr BARTON. A 769 ARRANGE

Issues of costs in respect of ML discussed.

Owen J Kenny

Other Document Form

Number Code A

Title Unused Rd 1/V Code A

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

amined - further action to be taken

Further actions no(s)

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Receiver	
Code A	
O/M	SIO
Indexer	

Operation ROCHESTER

Aide-memoire for interviews with staff at GWMH 1988-2002

Name: Code A

Post held: staff nurse. Btn dates: 1993 - Sept 2003.

Responsibilities General Patient care.

Ward(s) Bedelia, Sultan + Drysdale + Nightingale annexe.

1. General patient care

   Very good.

2. Use of syringe drivers (including any concerns etc)

   YES.

3. Use of Diamorphine (including any concerns etc)

   YES.

4. Training in syringe drivers

   YES.

5. Knowledge of any matters connected with the Police investigations

   Only via Press.

6. Knowledge of any matters connected with internal investigations

   Worker with by Ch.

7. Rumours/any other information

8. Details of medical staff you know of, including visiting GPs.

Other Document Form

Number D672

...le LETTER FROM JI NIVEN TO ANN REEVES 26/9/03.

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / (No)

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

...s) of actions raised

...amined - further action to be taken

Further actions no(s)

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Receiver

Code A

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Indexer

HAMPSHIRE CONSTABULARY

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Western Area Headquarters
12-18 Hulse Road
Southampton
Hampshire
SO15 2JX

Tel. 0845 0454545
Fax. 023 80599838

Our Ref.

Your Ref.

26th September 2003

Mrs A Reeves

Code A

Dear Mrs Reeves,

I am writing to acknowledge receipt of your letter dated the 16th September 2003, in which you raise a number of issues.

At this moment in time I am unable to prepare a detailed response to you but I will in the near future. When I have done so I will write to you again and address the specific points you have raised as far as I am able.

In the meantime, you may well receive a visit from Detective Constable Kate Robinson, who is now our Family Liaison Officer, having taken over from DC Peter Rushworth. I have asked Kate to visit all our family group members to introduce herself in person and to address any issues that currently prevail.

If I can assist you any further please do not hesitate to contact me.

Yours sincerely

Nigel Niven
Detective Inspector
Major Crime Department

Other Document Form

Number D671

LETTER AND COPY EMAIL TO DI NIVEN FROM HRS ANN REEVES

ude source and any document number if relevant)

Receivers instructions urgent action Yes/No

Document registered/indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

nined - further action to be taken

Further action no(s)

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Receiver	
Code A	
O/M	SIO
Indexer	

Mrs A Reeves

Code A

Detective Inspector N Niven
Western Area Headquarters
12-18 Hulse Road
Southampton
Hants
SO15 2JX

16th September 2003

Dear Mr Niven

Thank you for inviting me for the meeting at Netley Headquarter to update us on Operation Rochester's investigation.

Whilst I fully appreciate the sensitivity of this case and what you can and cannot discuss, I was still completely shattered regarding the decisions made and the context of the meeting. There appeared to be little thought or consideration for those involved and the effect it was going to have on people and in particular, the lack of professional support at hand.

At the last meeting we had with you, it was explained that the experts would be looking at the cases alphabetically and after every 20 cases you would be updated. It has been a very stressful time waiting for your decision and we have been patiently awaiting an answer regarding the events that surrounded the death of our loved ones.

What I cannot understand is the procedure you are taking regarding the officer's reports that you have taken from the families, as I understand you will not be taking these onto the experts at Field Fisher and Waterhouse.

Listening to families that evening regarding the reports taken, it would appear that there was no consistency regarding detail. This might not seem important to you but this is an aspect that I have not been comfortable with for sometime. After Mr Owen Kenny visited me I did have concerns especially as is was the first time an officer had come to hear my complaint so I am now putting those concerns to you writing.

In December 2002 Mr Kenny came to my home regarding the death of my mother at the Gosport War Memorial he did not take any notes. However, at the end of his two an half hour visit I mentioned to him about Mrs Dorie Graham, who had been in touch with me regarding the death of her late husband. I explained to him that she had previously spoken to Mr Ray Bert with her concerns and was anxious to be heard, this was the only time Mr Kenny put pen to paper saying that he would make sure someone went to see her and an officer did so in February 2003. I did not think too much about Mr Kenny not taking notes at the time however, as time passed I was hearing different stories from other people how their interviews were conducted and being concerned I emailed Peter Rushworth. Mr Kenny replied and explained the procedure as in part 4 of his email which I have enclosed.

Following this Mr Peter Rushworth came to visit me and said he would like to make another report, I told him firstly I wanted to know what was already in the report from Mr.Owen Kenny. He returned a few days later and had to tell me that there was very little in the report, only regarding the high levels of diamorphine. I was extremely unhappy to hear this because what was the point of Mr Kenny's two and half-hour visit?

In light of Mr Kenny's email and the conversations I have had with Mr Peter Rushworth the last being on the 11th July 2003 when he informed me that he would be the one coming to inform me of your decision. I question him about this comment with a follow up phone call and asked him how he knew he would be the one to visit me. He told me that he would be visiting everyone which I replied to as being a very long wait for some people. It now appears that policies have changed again and goal posts moved.

During our meeting with Deputy Chief Constable Readhead with regard to Supt John James, I expressed my concerns regarding the length of time this investigation is taking. This was in regard to one of the reasons that Supt.John James gave for not taking this case forward. 'The length of time it would take to get this into court and that the evidence would be too long in the public domain, thus damaging the prospect of a conviction'.

I am sure you have very good reasons for taking the path you are taking however, I do think it insensitive to mention at the meeting that there are cases where patients died of natural causes but you will not be informing the family members yet. It would have been more appropriate to have said nothing.

In closing and on reflection of the meeting on the 11th September 2003, I am assuming that the route you are now taking is because there is no concrete evidence in any one case that the experts have looked at. However, perhaps the missing link maybe found in the various families' evidence.

Thank you for taking the time to read my letter. I hope you can appreciate that this is my last chance of finding out why my mother died at the Gosport War Memorial Hospital and having been down this route before I want to be sure this time no stones go unturned.

I look forward to hearing from you.

Kind Regards

Code A

Ann Keeves

Cc Detective Superintendent S Watts

Subj: **RE: GWMH**
Date: 03/17/2003 12:41:08 PM GMT Standard Time
From: owen.kenny@ Code A
To: BLR55555@aol.com
CC: Code A
Sent from the Internet (Details)

Dear Ann

It is regarding your e-mail to Peter on 14th March, which I read today. I thought it would be better for me to clarify the issues by telephone or in person. I am happy to speak to you or visit you to answer any queries which Peter is not in a position to answer.

I am sorry if I mislead you in any way regarding the taking of a statement. When I spoke to you, we (the investigation team), were in the process of visiting all relatives in order to explain our investigation process and to give reassurance that all cases will be reviewed. Statements were not to be taken at that stage but the relatives concerns were recorded on Officers reports.

The hospital medical records of 62 patients have been copied to DVD and provided to a team of 5 medical experts. Each expert is required to read all entries in relation to all 62 so it is difficult for them to estimate how long this will take. It is not practical at this stage to provide any further information to the experts. I recall that when we met we discussed the fact that not all cases were likely to be of concern, so the first task of the medical experts is to screen out those which do not fulfil certain criteria and concentrate on those which do.

The next stage is to provide the experts with further material, including the Officers reports, in relation to the cases of concern. We are weeks, probably several months away from that stage. However in the meantime we will continue to gather information but we will not be taking statements until we know which cases, if any, are likely to result in a prosecution.

It is extremely unlikely that the case of your mother would be screened out in the first instance. I am very much aware of your concerns and the existence of further information in possession of yourself and Ann Alexander. It has always been my intention, in due course, to obtain the further information from you. I have, today, discussed this with Peter Rushworth and instructed him to visit you and obtain all information that you feel may be of assistance to the enquiry.
If you have made a written record of your concerns, as we discussed, that would be very helpful but it is not necessary at this stage to put that in statement form.

I hope the above answers some of your concerns. Once again, I apologise for not making myself clear when we met.

Regards,

Owen.

-----Original Message-----
From: Code A
Sent: 17 March 2003 11:29
To: Kenny, Owen
Subject: Re: GWMH

Dear Owen

Thank you for your email.

If this is in respose to my query to Peter Rushworth please email me.

Other Document Form

Number D660

Title MINUTES CLINICAL TEAM CONFERENCE 7/9/03

(Include source and any document number if relevant)

Receivers instructions urgent action Yes/No

Code A

Document registered/indexed as indicated

No(s) of actions raised

Code A

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Code A

Examined - further action to be taken

O/M	SIO

Further action no(s)

Indexer

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Operation Rochester
Conference at Marriott, Northampton
7th September 2003
MINUTES

Present:

Professor R Forrest	Det Ch Supt Watts
Doctor R Ferner	DI Niven
Doctor A Naysmith	DS Kenny
Irene Waters	DS Grocott
Doctor Peter Lawson	WDC Robinson
Matthew Lohn	DC Yates
	Code A

Professor Forrest presented the findings of the Clinical Team, that have now been produced onto an excel spreadsheet.

The meeting discussed the definitions of the care bands A, B, C and 1, 2, 3 after which Det. Ch. Supt. WATTS asked for clarification of band C. Professor FORREST explained that in basic terms the treatment a patient falling into that care band had received had killed the patient. DI NIVEN asked why this was not specified on the chart. Doctor NAYSMITH responded that the definition should read there was no explanation for the treatment meted out to patients falling into band C. No explanation for treatment was agreed as the rating explanation.

The Clinical Team identified seven cases that had raised concerns, all given a B3 rating – B. Cause of death unclear, 3. Negligent care – and are listed as follows:

1. CUNNINGHAM (BJC15) – Treated by several Doctors. Rapid escalation of diamorphine for no apparent reason. Midazolam given caused concern to the family, who had not been informed by Staff at the Hospital. Dr NAYSMITH added that this man would have died and would have been suffering some pain, but not the type that would respond to the drugs administered. She also added her concern over how rapidly the doses were increased.
2. Elsie DIVINE (BJC16) – The team noted that this lady had showed difficult behaviour and was demented and aggressive, but had shown no signs of pain and was due for transfer to a Rest Home. Fentanyl patch was administered, an alternative to an infusion of Diamorphine, for pain relief. It appeared to the Clinical Team that this had been prescribed to calm the patient rather than treat any pain which they described as a very dangerous practice. The Team added that this patient then died shortly afterwards.
3. Sheila GREGORY (BJC21) – This patient was suffering from a severe chest infection, the oral morphine prescribed would have been appropriate for a cancer patient, but was totally inappropriate for patients in the condition GREGORY was in. there was then mention of Pharmacokenetic's, the study of how the body handles drugs. Dr NAYSMITH went on to add that she was frail and may not have recovered from her chest infection but, "they never

gave her that chance". Code A further added that on the notes it had been left for the Nurses to confirm death, which suggests expectation. Dr Lawson noted that the day she was admitted she had been written up for Diamorphine.

4. Elsie LAVENDER (BJC30) – With this patient Staff had made a 5 fold leap in the effective dose from Morphine to Diamorphine. The team suggested the argument could be that the dose was increased as necessary, but conclusions were that it was a vast leap and "at least negligent" and "a bad mistake". Dr Ferner referred to BNF, British National Formulary published by the British Medical Association and the Royal Pharmaceutical Society to support the argument that these were excessive dosages.
5. Enid SPURGIN (BJC45) – Inappropriate antibiotic therapy followed by rapidly escalated Opiates. It was left to the Nurses discretion to initiate between 20 and 200g doses of Diamorphine a day, felt to be a particularly large dosage scope. Dr Ferner added that this patient was among others that were given prescriptions for high doses.
6. Jean STEVENS (BJC46) – Some earlier notes relating to this patient's stay at Hasler Hospital were missing, but the only mention on the transfer letter between hospitals was that she was suffering some skin irritation. The patient died within 48 hours after receiving high doses of medication.
7. Robert WILSON (BJC55) – This patient was suffering from liver disease but as with those previously mentioned, was given high doses of Morphine, causing him to put on 30lbs of fluid. There is no documentation of any measures taken to deal with this. The Clinical Team concluded that Morphine was inappropriate as his liver was incapable of metabolising stating it would be very dangerous prescribed to a patient with liver dysfunction.

Det. Ch. Supt. WATTS asked the Investigation team if they had any questions/queries regarding these findings.

Code A asked in the case of Enid SPURGIN what would the Clinical Team consider to be a normal prescribed dose. A discussion followed starting with Dr Lawson suggesting that under normal circumstances this would be judged on a daily basis and there should be no requirement to write a dosage range. Dr NAYSMITH queried what the procedure would be if there was no Doctor available to which Dr Lawson responded that in his experience an appropriate dose would be decided allowing a range of double that quantity. Dr NAYSMITH concurred. Code A added that this prescription practice was excessive and she would expect a safer range from a GP. Dr NAYSMITH concluded that these were patients with aches and pains and the drugs administered were inappropriate, while Dr FERNER suggested that small doses via injection rather than a variable rate infusion to deal with extra pain would be appropriate. At the end of the day these measured doses and infusions would be calculated to assess future appropriate quantities.

The Clinical team were thanked for their continued support and the meeting was reminded of the Family Conference being held at Netley on the 11th September, stating that no detailed information would be given at this meeting as the investigation is still at an early stage, but it would be stated that progress had been made.

All of the Clinical Teams original notes were requested by Det. Ch. Supt. WATTS, 1. for disclosure purposes and 2. as part of the analytical process. This will be facilitated over the next couple of weeks.

Det. Ch. Supt. WATTS then revealed a further 20 cases that have been highlighted, 16 by Professor BAKER and the other 4 from concerned families coming forward in light of the current investigation.

A: Dr NAYSMITH reminded the meeting that 2 of the current batch had the wrong case notes attached.

Professor FORREST asked if any statistical work would be carried out. Det. Ch. Supt. WATTS stated that there would be no requirement at the moment and he didn't want to draw any parallels to the SHIPMAN enquiry.

Professor FORREST finally stated that the Clinical Team had been and would continue to be happy to work together, adding that two of the benefits of these latest meetings were having a Nurse present and in this latest session, having a Police Officer included in the meeting as an independent observer. Whilst in no way contributing to the conclusionary text the officer was able to confirm that it was sufficiently clearly written for the lay individual to understand.

DI NIVEN concluded the meeting by thanking the teams.

Other Document Form

Number D659.

Title AGENDA FOR CLINICAL CONFERENCE 5-6 SEPT 2003

(Include source and any document number if relevant)

Receivers instructions urgent action Yes/(No)

Document registered/indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further action no(s)

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Receiver	
Code A	
O/M	SIO
Indexer	

Clinical Conference

Northampton 5th – 6th September 2003

Saturday 6th September 2003

	0815	0845	0900	0930	1100	1120	1300	1345	1530	1550	1700	1800	1930
Investigational team	Breakfast		Welcome to clinical team by DI Niven, update of investigation to date.	Preparation re family group meeting on 9/11/03	Coffee	Resume	Lunch	Strategy and planning re interviewing GP's and Doctors who worked at GWMH	Coffee	Briefing by Clinical team.	Clinical and investigation teams to select strongest evidential cases.	Conclude	Informal drinks at the bar followed by dinner
Clinical team		Arrival	Welcome to clinical team by DI Niven, update of investigation to date.	Clinical team to de-brief of final 21 records	Coffee	Resume	Lunch	Clinical team to de-brief of final 21 records	Coffee	Clinical team to brief investigation team on final 21 records	As above	Conclude	Informal drinks at the bar followed by dinner

Sunday 7th September 2003

	0815	0900	1045	1100	1230	1315	1540	1600	1700
Investigational team	Breakfast	Final preparations for 9/11/03	Coffee	As below	Lunch	As below	Coffee	Debrief	Conclude
Clinical team	Breakfast	Clinical team to start preparation for final case work	Coffee	Clinical team to identify what further material may be required for case preparation and brief investigation team accordingly.	Lunch	Presentation by Code A to include a question and answer session.	Coffee	Debrief	Conclude

Other Document Form

Number 1658

Title COPY SPREADSHEET OF CLINICAL TEAM FINDINGS SEPT 2003

(Include source and any document number if relevant)

Receivers instructions urgent action (Yes)/No AS INDICATED ON DOCUMENT

~~AS~~

Document registered/indexed as indicated

No(s) of actions raised As attached.

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further action no(s)

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Code A

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Indexer

Number	Name	Score	Clinical Comment	Missing Data
BJC/03	Attree, Lily N168	1A		
BJC/06	Baker, Ellen N161	1A		No prescription chart
BJC/10	Clarke, Hubert N163	1A		
BJC/11	Clifford, Alice N153	1A		
BJC/14	Cresdee, Ronald N165	1A		
BJC/18	Ellis, Kathleen N252	1A		
BJC/19	German,Mary(Marie) N248	1A		Poor quality prescription chart
BJC/20	Graham, Leonard N242	1A		
BJC/24	Hall,Nora N171	1A		
BJC/25	Hillier, Eileen N143	1A		
BJC/27	Hooper,Albert N335	1A		
BJC/32	Martin, Stanley N326	1A		
BJC/33	Middleton, Dulcie N310	1A		
BJC/50	Walsh,Frank N332	1A		
BJC/51	Wellstead, Walter N337	1A		
BJC/53	Williamson,Ivy N294	1A		
BJC/54	Williamson,Jack N243	1A		
BJC/57	Midford-Millership,Douglas	1A N772		
BJC/49	Vince, Dorothy N150	1B	Notes scanty.	
BJC/07	Carby, Stanley N284	2A	Moribund	No Haslar notes
BJC/12	Clissold, Walter N301	2A	Dying; advanced recurrent cancer on admission. Nursing notes describe starting on fentanyl and then rapid escalation of opioid dose following initial prescription of fentanyl.	A second prescription chart is missing, prescription data from nursing record.
BJC/13	Cox, Doreen N350	2A	End stage heart failure. Indication for midazolam initial prescription and subsequent dose escalation unclear from the clinical notes.	
BJC/22	Hadley,Harry N299	2A	Natural death, but sub-optimally managed	Haslar notes missing
BJC/26	Hobday,Alan N366	2A	Dying from stroke, midazolam appropriate but why was he given diamorphine?	
BJC/34	Packman, Geoffrey N346	2A	Multiple pathology, dying from lower gut bleeding and would not have been a candidate for surgery. Septic. Rapid increase in diamorphine dose.	
BJC/35	Page, Eva N2	2A	Prescription of fentanyl for agitation and confusion associated with rapid clinical deterioration. Dying of lung cancer.	
BJC/36	Parr, Gwendoline N330	2A	Multiple pathology. Use of fentanyl for sedation, reduction in heart failure treatment.	

A 745
LOCATE PRESCRIPTION CHART ELLEN BAKER

A A746
LOCATE HASL NOTES CARBY

A 747
LOCATE MIS PRESCRIPTION CHART

A 748
LOCATE

BJC/37	Purnell, Edna N241	2A	Rapid escalation to use of Oramorph and tripling of equivalent dose when switch to diamorphine syringe driver. Became very drowsy and fluid intake decreased. Very frail lady, very poor prognosis.	
BJC/38	Queree, Margaret N297	2A	Rapid escalation of opiate dose.	
BJC/40	Reeves,Violet N320	2A	Diifficult management problem. Notes show a nurse noticed the discrepancy between the advice of a visiting neurologist and the consultant geriatrician and left a note for the consultant geriatrician. Rapid escalation of diamorphine doses.	
BJC/41	Richards, Gladys N1	2A	High dose of diamorphine given she was likely to have been opiate sensitive.	
BJC/42	Ripley,James N221	2A	Use of diclofenac when renal impairment established; balance of risk and benefit for this particular NSAID not recorded in the case notes.. Diagnosis of opiate overdose at Haslar not clearly justified given the clinical finding	
BJC/48	Tiller, Sylvia N174	2A	Rapid escaltion of opiate dose. End stage heart failure	
BJC/01a	Abbatt, Victor N353	2B	Seriously ill, unlikely to survive with optimal prescription	No prescription chart, no PMH
BJC/02	Amey, Denis N159	2B	Dying, high diamorphine doses, but in absence of prescription chart cannot judge dose escalation.	No prescription chart
BJC/04	Aubrey, Edith N302	2B	High dose of opioids, explicitly prescribed to calm her.	
BJC/05	Aubrey, Henry N303	2B	Dying. High doses of opiates and midazolam prescribed.	
BJC/06A	Batty, Charles N304	2B	Frail, dependent, but nothing specific to cause his death at the time he died, given thioridazine which you shouldn't give with Lewy body dementia. Rapidly escalated opiate therapy.	
BJC/06B	Brickwood, Dennis N69	2B	Dying from chest infection, unlikely to survive even with optimal prescription. Rapid escalation of opiate therapy following lack of response to antibiotic therapy.	
BJC/09	Chivers, Sydney N251	2B	Transferred to Gosport after a stroke, reason for his deterioration after June 14 1999 unclear. High dose of diamorphine initially prescribed, only half dose prescribed given by nurses, but the dose he actually received was still a high dose. His diamorphine dose was subsequently increased further. Also he received a high dose of midazolam.	Missing drug chart. Fentanyl administration recorded in nursing record, but not on prescription record in notes.
BJC/17	Dicks,Cyril N308	2B		Missing drug charts. No record of diamorphine infusion.

A 749 Locate Chart

A 750 Locate Chart

A 751 Locate Chart

A 752 Locate Chart

BJC/23	Hall, Charles N260	2B	Dying but no account apparently taken of renal failure when prescribing opiates	Uncertainty over drug charts, possibly one missing, medication describing in nursing record not documented in drug chart
BJC/31	Lee, Catherine N284	2B	Fentanyl patch for agitation	
BJC/44	Rogers, Elizabeth N291	2B	prescription data obtained from nursing records. Very ill lady with end stage Parkinson's disease and possible stroke. Rapid progression of opiate dose.	No medical notes and no prescription charts available.
BJC/47	Taylor,Daphne N333	2B	Rapid use of fentanyl patches in a very frail lady with subsequent rapid opioid dose escalation	
BJC/08	Carter, Edwin N319	3A	End stage cancer on admission, given inappropriately large dose of diamorphine, but no significant effect on time of death	
BJC/28	Houghton, Clifford N253	3A	Going to die no matter what treatment was or was not given, but management inappropriate. Very high doses of midazolam and diamorphine without justification in clinical notes.	
BJC/29	Jarman, Thomas N147	3A	Confused, couldn't sleep. Definitely dying, but large doses of opiates and sedatives used.	
BJC/56	Windsor,Norma N157	3A	Delay in recognition of severity of a potentially treatable illness and delay in arranging transfer for appropriate care.	
BJC15	Cunningham, Arthur N4	3B	Several Doctors involved in care, rapid escalation of diamorphine doses, family told midazolam doses were small doses, which they were not.	
BJC/16	Devine, Elsie N290	3B	Was she actually dying before she was given fentanyl? Deteriorated once fentanyl started. Why was fentanyl started in first place? Fentanyl used inappropriately for sedation. Note psychogeriatric opinion	
BJC/21	Gregory, Sheila N238	3B	treatment of ?chest infection with oramorph and no antibiotics is appropriate in palliative care but not in a rehabilitation patient. Pharmacokinetic issues not taken into account in drug treatment.	
BJC/30	Lavender, Elsie N322	3B	5 fold increase in equivalent dose of morphine when switched from morphine to diamorphine.	

A 753

A 754

BJC/45	Spurgin,Enid N323	3B	No evidence of consultation with appropriate specialist over management of her operation wound infection. Rapid escalation of opiate dose. Note the poor drug prescription when diamorphine infusion was commenced; nurse could have set up anything from a dose of 20 to 200 mg/day and still have been in compliance with the prescription.	
BJC/46	Stevens,Jean N313	3B	Pain not mentioned in initial clerking, alert on admission,immediately started on morphine with rapid dose escalation	Haslar notes missing
BJC/55	Wilson,Robert N5	3B	Initial dose of morphine inappropriate in a person with known alcoholic liver disease. Rapid opiate dose escalation. Rapid increase in body weight documented in notes with no apparent clinical response.	
BJC/08A	Chivers, Edith N374	No score		No prescription charts, missing notes. Insufficient information available to realistically classify.
BJC/52	Wilkie,Alice	No score		No medical notes, missing drug chart
BJC/58	Corke,James N771	No score		No notes relevant to final illness available.
BJC/39	Ramsey, Joan N245		Wrong set of case notes provided.	
BJC/43	Ritchie,John		Wrong set of case notes	

A 755 LOCATE HASLAR NOTES

A 756 LOCATE CHARTS NOT

A 757 LOCATE CHARTS NOT

A 758 LOCATE & ADMISSION NOTES

A 759 OBT CORRECT NOTES/RECORDS

A A760 OBT CORRECT RECORDS

Scoring:

Care

1 Optimal care

2 Sub-optimal Care

3 Negligent Care. That is to say, care outside the bounds of acceptable clinical practice.

Death/Harm

A natural death
B Causation of death and/or harm unclear
C Death and/or harm unexplained by natural disease.

Other Document Form

Number 1655

le Unused RV 1/V **Code A**

clude source and any document number if relevant)

ceivers instructions urgent action Yes No

ocument registered/indexed as indicated

lo(s) of actions raised

Statement readers instructions

Ind as indicated

No. of actions raised

Examined - further action to be taken

Further action no(s)

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Receiver	
Code A	
O/M	SIO
Indexer	

Operation ROCHESTER

Aide-memoire for interviews with staff at GWMH 1988-2002

Name: Code A

Post held: S.N. Egrade Days RIP. Btn dates: Jan 2001 – Jan 2002

Responsibilities Assessment + Evaluation patient care. Taking charge of ward. - Care plans.

Ward(s) Daedalus.

1. General patient care Very good.

2. Use of syringe drivers (including any concerns etc) Aware of use
No concerns

3. Use of Diamorphine (including any concerns etc) Aware of use.
No concerns.

4. Training in syringe drivers: Trained prior to coming to GWMH
At Q.A. (medical ward). - or previous hospital (East Surrey Hospital)

5. Knowledge of any matters connected with the Police investigations
Not until received notification from Police.

6. Knowledge of any matters connected with internal investigations
Yes. Internal by CHI.

7. Rumours/any other information No.

8. Details of medical staff you know of, including visiting GPs.
Dr. Barton
Dr. Joseph Yokana.
Dr. Ward - consultant

Code A 22/08/03

Other Document Form

Number D634

T[redacted] Code A

lude source and any document number if relevant)

Receivers instructions urgent action Yes No

Document registered/indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

[redacted]ined - further action to be taken

Further action no(s)

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Receiver

Code A

O/M	SIO

Indexer

Operation ROCHESTER

Aide-memoire for interviews with staff at GWMH 1988-2002

Name: Code A

Post held: Staff Nurse P/T nights. Btn dates: August 1989 – Current

Responsibilities Overall Charge of Ward. Occasionally have responsibility for hospital

Ward(s) Male + Female wards, Radcliff Annex, Nightingale Annex, Sultan.

1. General patient care Good, – Very caring

2. Use of syringe drivers (including any concerns etc) Aware of use. No.

3. Use of Diamorphine (including any concerns etc) Aware of use No.

4. Training in syringe drivers Yes, trained at St. Marys

5. Knowledge of any matters connected with the Police investigations
Yes – via from press, updates from hospital manager.

6. Knowledge of any matters connected with internal investigations
Yes – didn't take part in it.

7. Rumours/any other information
No.

8. Details of medical staff you know of, including visiting GPs.
No – so many –

Code A 15.8.03

HAMPSHIRE Constabulary

Code A QPM LL.B MA DPM MCIPD

PRIVATE

Our Ref. : OP Rochester

Park Gate Police Station,
62, Bridge Road,
Park Gate,
Southampton.
SO317HN

Your Ref. :

Code A

Tel: 0845 045 45 45
Direct Dial:
Fax: Code A

Email:

12th August 2003

Dear Code A

I have been given your details in connection with an investigation that is currently being undertaken by the Hampshire Constabulary.
The enquiry relates to the Gosport War Memorial Hospital.
It is the intention of the Police to speak with every member of staff who worked at the hospital between 1988-2000.
Staff records inform me that you worked in one capacity or another, at the hospital during the relevant period.
Due to the large numbers of people that have to be seen, I would be most grateful if you could contact me on the direct line above, or on my mobile phone Code A This will assist me in contacting as many people as possible, over a short time frame.
The Fareham and Gosport Primary Care Trust have sent a letter to the addresses of all such staff members, I have included a copy for your assistance.

Yours sincerely

Kate Robinson
Detective Constable 424
Major Crime Investigations.

PRIVATE

Other Document Form

Number 1630

● Unsigned letter Code A

(Include source and any document number if relevant)

Receivers instructions urgent action Yes/No AS LISTED AT Q 8.

As shown.

Document registered/indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

●mined - further action to be taken

Further action no(s)

When satisfied all actions raised Office Manager to endorse other Document Master Number Form

Code A

O/M	SIO

Indexer

Code A 18/8/03

Operation ROCHESTER

Aide-memoire for interviews with staff at GWMH 1988-2002

Name: Code A

Post held: S.N.E 5 DAYS P/T. Btn dates: AUGUST 1988 – CURRENT

Responsibilities GIVE MEDICATIONS, HAVE CHARGE OF WARD.

Ward(s) BANK, REDCLIFFE/NORTHCOTE SULTAN

1. General patient care : EXCELLENT

2. Use of syringe drivers (including any concerns etc) AWARE OF USE.
   No.

3. Use of Diamorphine (including any concerns etc) AWARE OF USE:
   No

4. Training in syringe drivers YES. DR. BEE WEE (CONS. CENTRAL MTB.)

5. Knowledge of any matters connected with the Police investigations
   No

6. Knowledge of any matters connected with internal investigations
   YES. TOOK PART IN CHI REPORT.

7. Rumours/any other information
   No

8. Details of medical staff you know of, including visiting GPs.
   80% of GP's in Gosport.

Code A Code A Code A Code A Code A Code A

HAMPSHIRE Constabulary

Code A QPM LL.B MA DPM MCIPD

PRIVATE

Our Ref. : OP Rochester

Park Gate Police Station,
62, Bridge Road,
Park Gate,
Southampton.
SO317HN

Your Ref. :

Mrs.K.Pease,

Code A

Tel: 0845 045 45 45
Direct Dial: Code A
Fax:

Email:

12th August 2003

Dear Code A

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The Fareham and Gosport Primary Care Trust have sent a letter to the addresses of all such staff members, I have included a copy for your assistance.

Yours sincerely

Kate Robinson
Detective Constable Code A
Major Crime Investigations.

PRIVATE