4013

F=4857334

FFW/94105

FILE NUMBER: 4/PWJ/LXM/4013	COMPUTER NO.: 145634.000025
CLIENT: GENERAL MEDICAL COUNCIL	
MATTER: DR. JANE BARTON	
CORRESPONDENCE FILE NO.: 1	FROM: 18 Oct 2004 TO: 27 Feb 2007

X379564

7510000379564

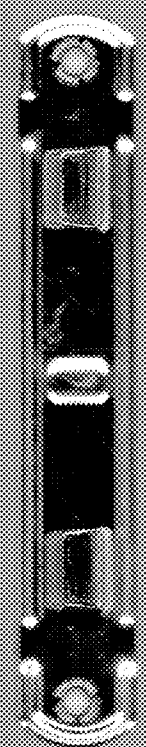
STRONGHOLD GEMINI POCKET FILE

An Oyez Straker product

General Commercial Litigation
File Information Sheet

Code A

Fee earner	
Supervisor	
Date of Rule 15 letter	21/12/04
Limitation	
Date of expiry of limitation period	
Date of entry in central diary (*i.e. required where proceedings are not being commenced within 7 days*)	
Pre-action protocol?	
Pre-action offer under r 36.10?	
Date made	
Claimant or defendant?	
Part 36 offer?	
Date made	
Claimant or defendant?	
Date of defendant's Part 36 payment (*i.e. into court*)	
Issue of proceedings	
Date of issue of claim form	
Date of entry in central diary (*i.e. where proceedings not to be served immediately*)	
Automatic strikeout Date of automatic strikeout (*if a date for this has been given pre 26th April 1999 it will still apply and central diary entry should have been made*)	
Date for filing **allocation questionnaire** and **costs statement** (*Reminder: serve costs form on client as well as other parties. Claimant pays fee.*)	
Track allocated?	
Date(s) of CMC(s)	
Dates set out in **case management timetable**:	
Further information by	
Disclosure by	
Exchange of witness statements by	
Exchange of experts reports by	
Other	
Date for filing **listing questionnaire/pre-trial checklist** and **costs statement** (*Reminder: serve costs form on client as well as other parties. Claimant pays fee.*)	
Any other notable dates e.g.	
• mediation	
• listing hearing	
• pre-trial review	
• other	
Trial date/window	
Funding	
Costs limit?	
Insurance?	
Policy limit?	
CFA?	



FILE NO:	4/PWJ/RRR/4013
CLIENT:	GMC
MATTER:	**Code A**
COMPUTER NO:	145634.000025
CORRESPONDENCE SPIKE NO:	1
NUMBERS OF FILE:	
FEE EARNER:	RRR

Code A

From: Code A
Sent: 16 May 2007 14:47
To: Code A
Subject: Operation Rochester

Dear Code A
I refer to our telephone conversation this afternoon and confirm that the General Medical Council has instructed a new firm of solicitors to deal with this matter. They are Field Fisher Waterhouse , Tower Business Centre, Portland Tower, Portland Street, Manchester M1 3LF. The solicitor dealing with the matter is Code A Code A I am in the process of sending all the paperwork to FFW by door to door courier. This includes all the files and documents which you provided to me.
Thanks for all your help to date. I have given Code A your name as the police point of contact.
Regards

Code A

Code A
International: +44 20 7497 9797
www.eversheds.com

EVERSHEDS

4013

attendance

Client General Medical Council (4/PWJ/RRR/4013)

Date 27 February 2007

Matter Code A

F/E Code A

Attendees

On 27 February, I telephoned Code A I spoke to Code A on 21 February and agreed to retrieve from storage the documents that we currently hold relating to his mother.

When I called him on 27 February, I confirmed that I had retrieved the documents. There are about 5 files in all. I have not looked at each document in any detail, but quickly flicked through the bundles. They all appear to be medical notes relating to his mother. There do not appear to be any documents in the paper work relating to the police's investigation concerning his mother's death.

He thanked me very much for taking the trouble to check the documents. He said that he would not need copies of his mother's records to deal with the complaint which he is making to the IPCC - complaint about the way the police handled the investigation into his mother's death.

We agreed that I would send all the records back to storage to keep them in a safe place.

EVERSHEDS

attendance

Client	General Medical Council (4/PWJ/RRR/4013)	Date	27 February 2007
Matter	Code A	F/E	Code A
Attendees			

On 27 February, Code A from Hampshire Police telephoned. He tried to call me yesterday. I tried to call him, but we missed each other. He confirmed that he has two boxes of documents to send to me by courier. We agreed that he would use a local courier in Gosport and let me know when the documents are on their way.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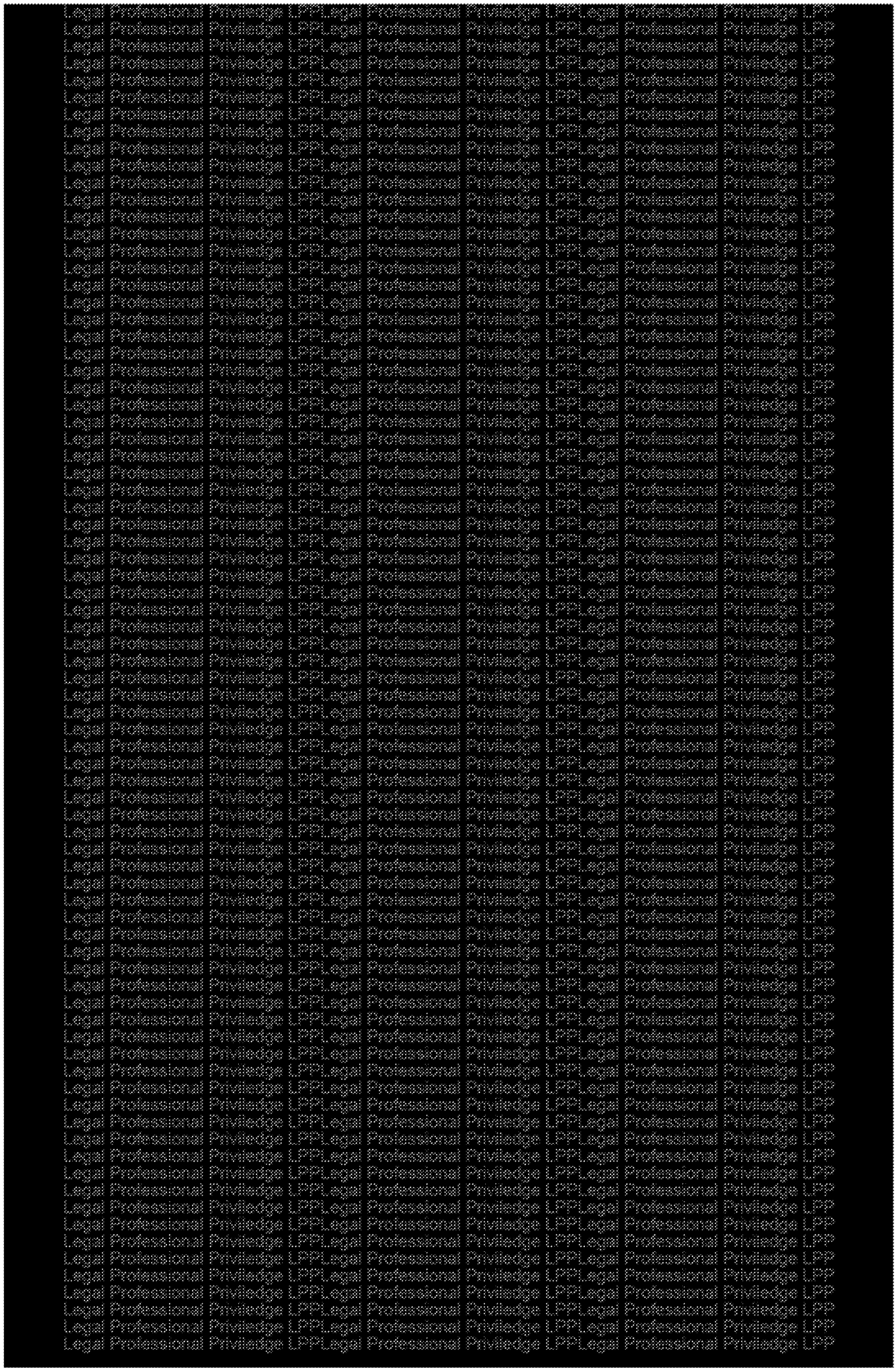
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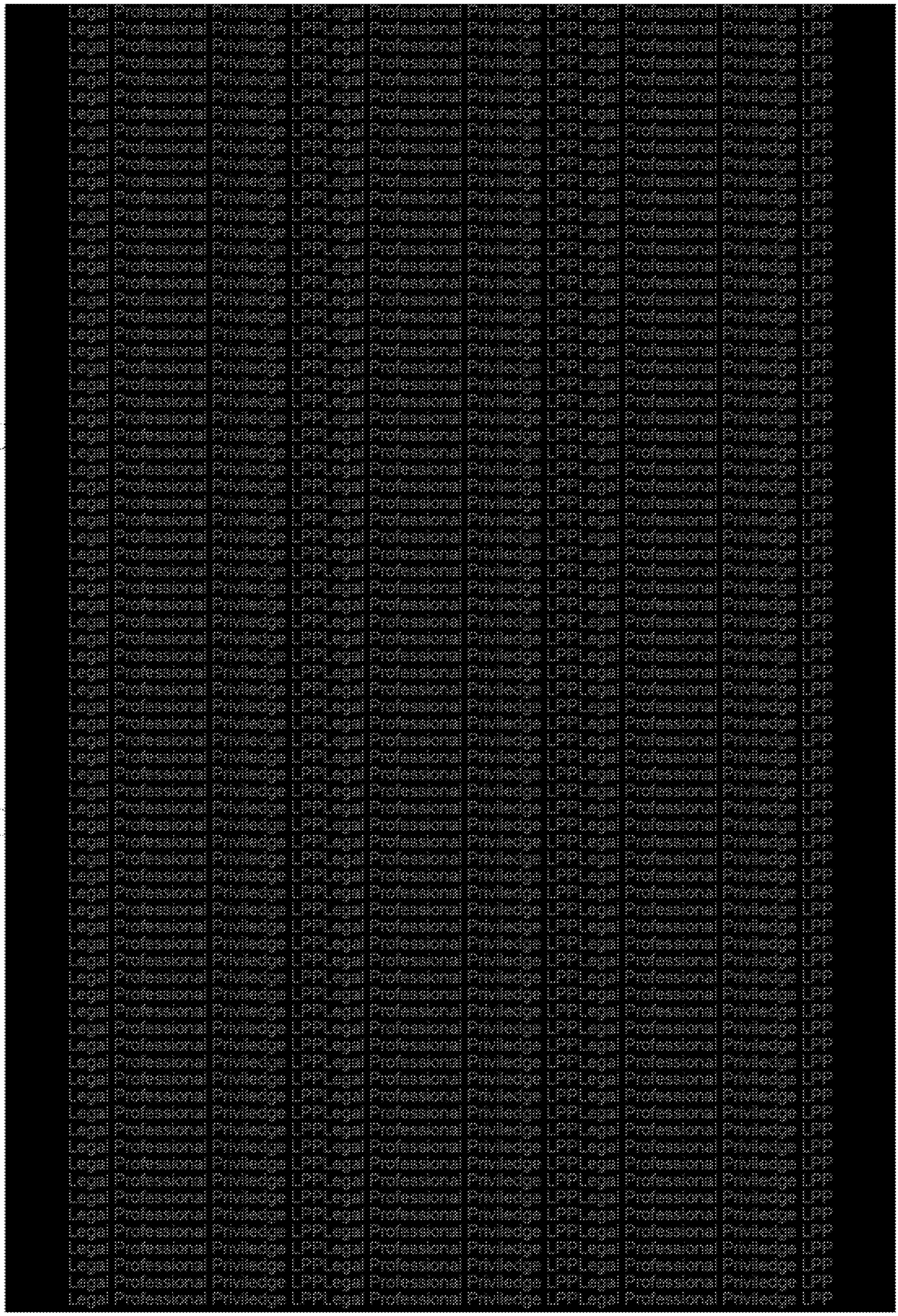
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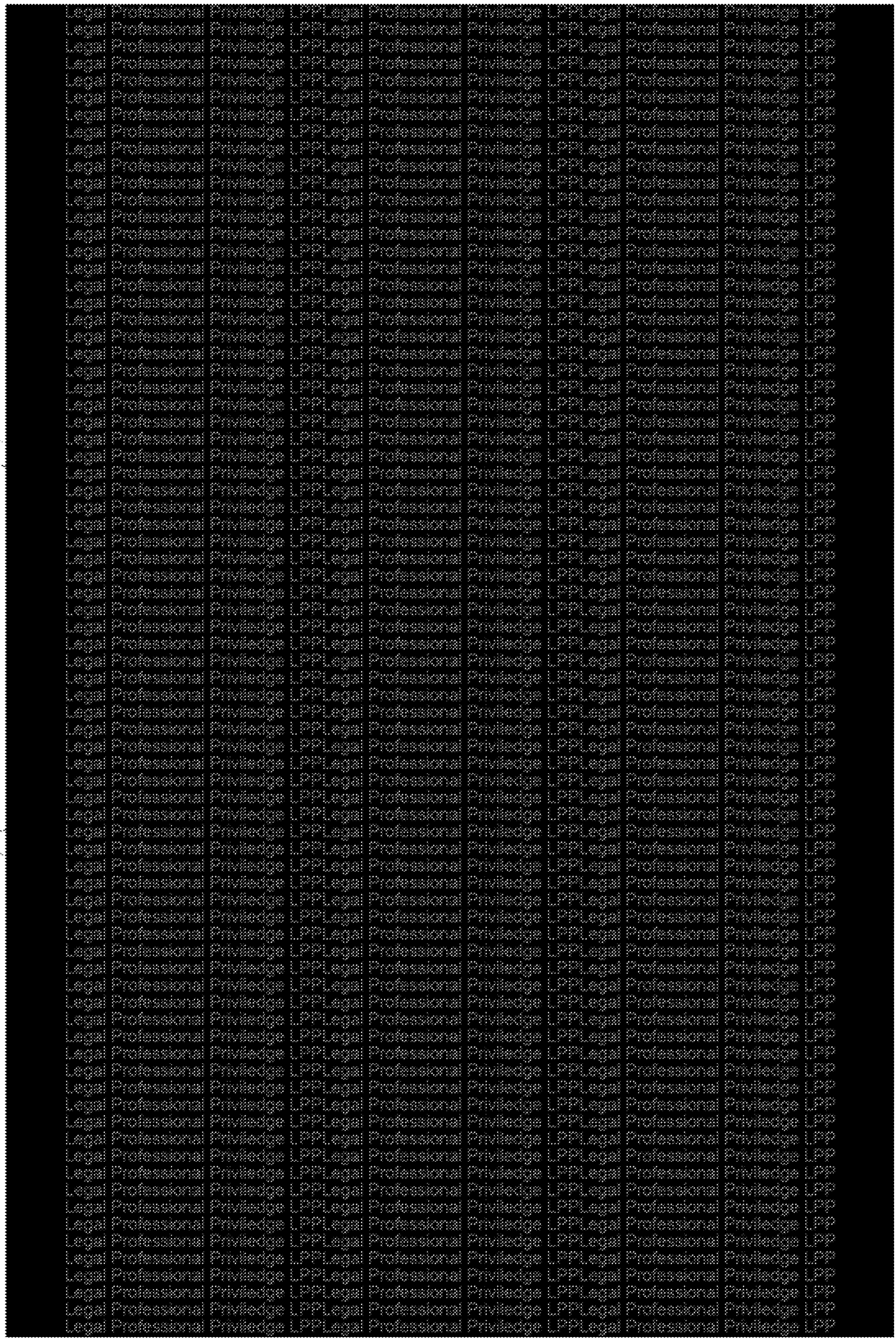
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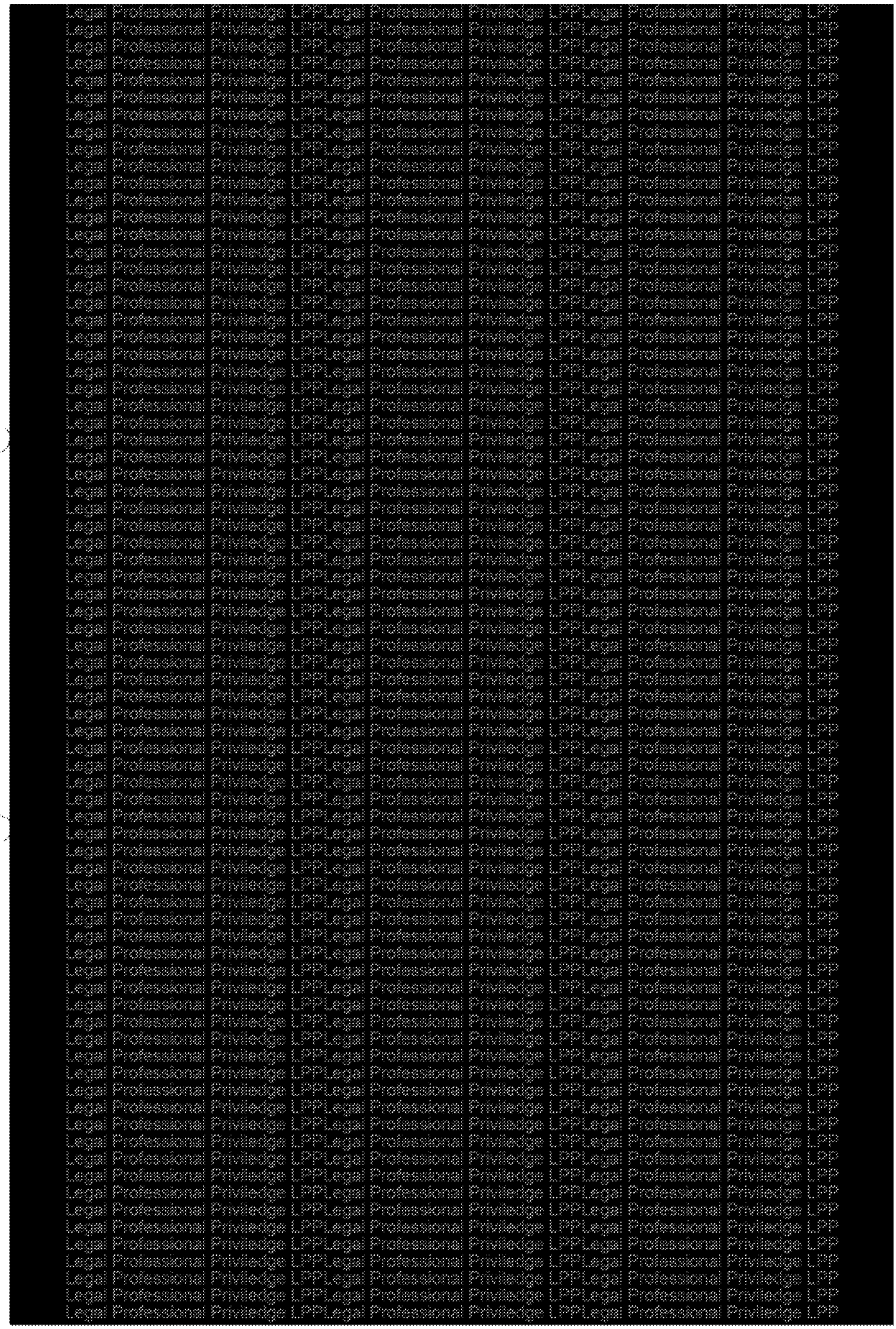
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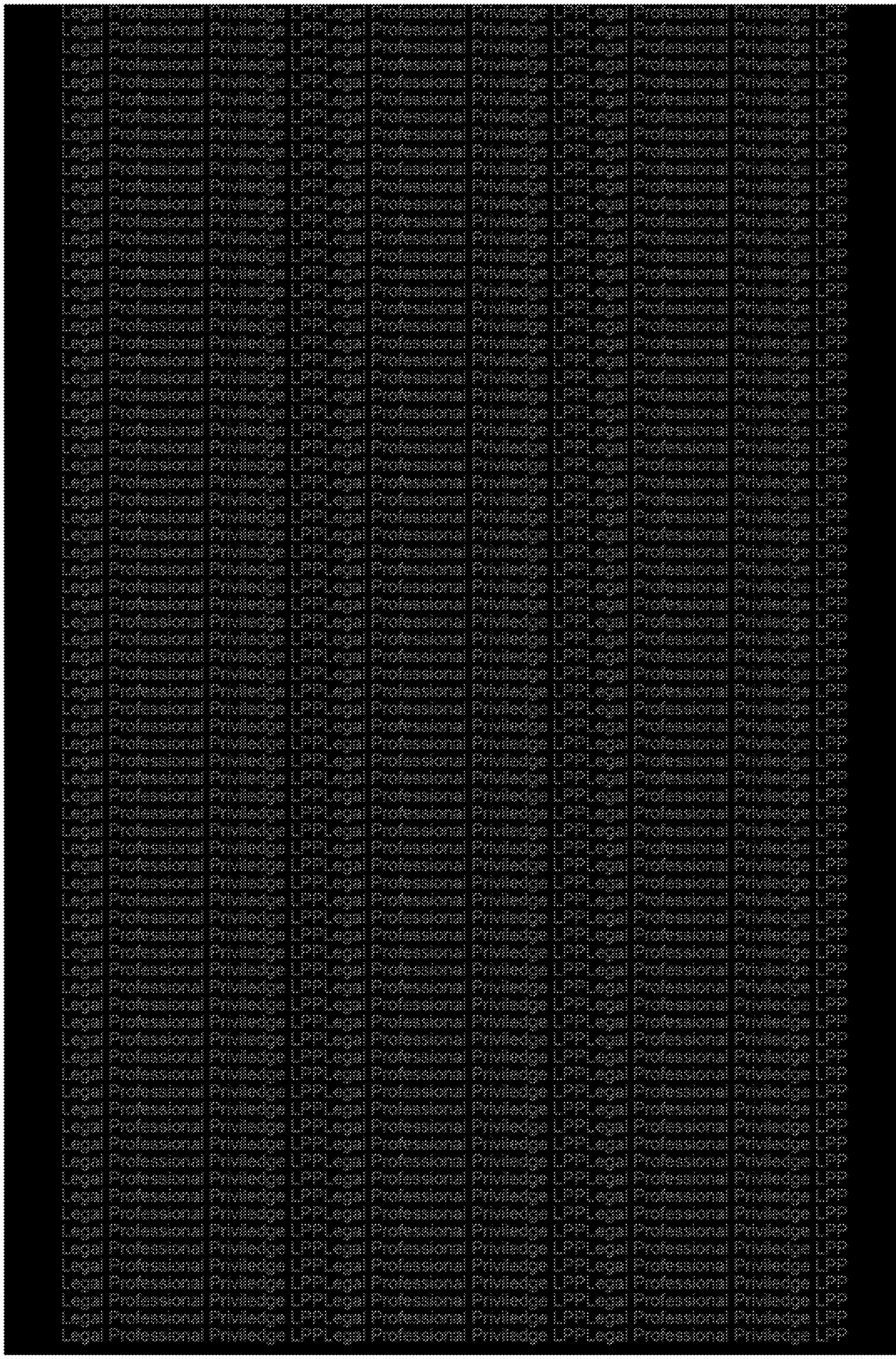
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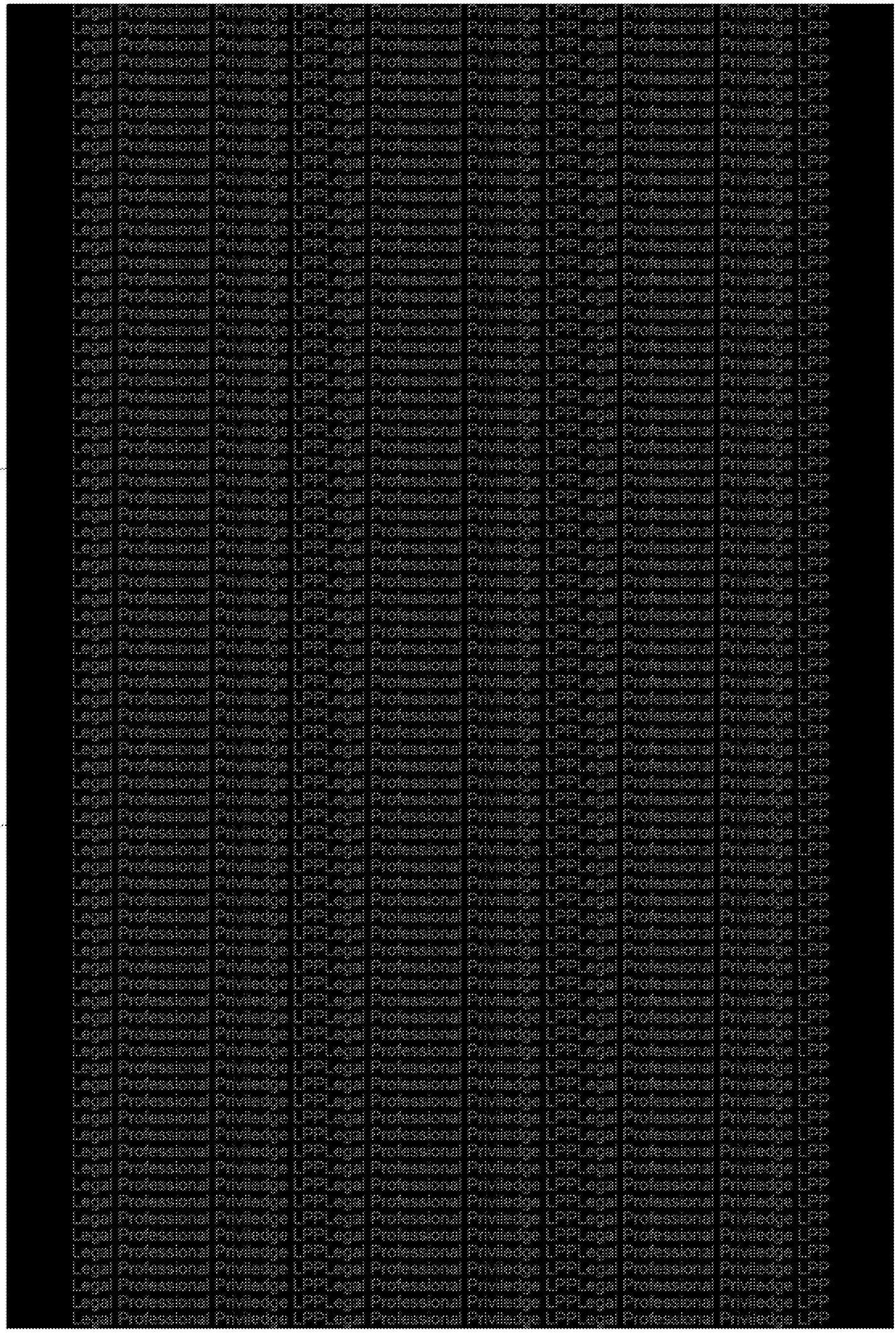
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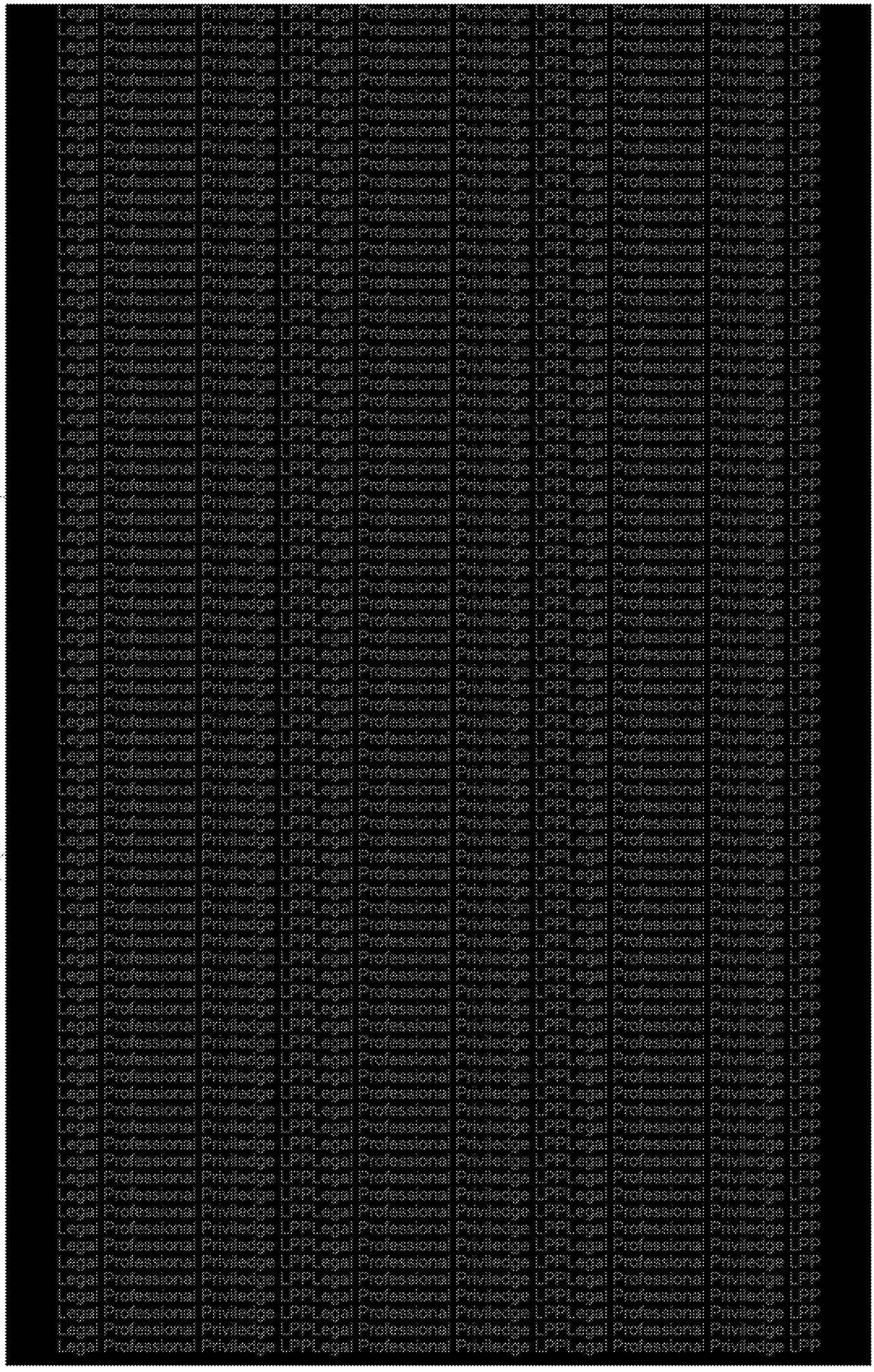
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EVERSHEDS

Client General Medical Council
Matter Code A
Attendees

Date 21 February 2007
F/E Code A

I got a message to call Code A He had left a message saying he has authority to send the documents which I have requested by Courier. The charge will be £160. I said that we would pay the Courier fee on submission of an invoice.

Code A

EVERSHEDS

Client	General Medical Council	Date	21 February 2007
Matter	Code A	F/E	Code A
Attendees			

Code A called again. He had called yesterday and left a message.

He has received a letter from the Independent Police Complaint's Commission and has a number of issues with the way that the Police have dealt with his mother's case.

He wanted to know whether or not the documentation relating to his mother's case had been sent to the GMC.

I explained that following the message which he had left yesterday, I had checked to see whether we have any information. I confirmed that there is reference to material relating to his mother in our system. However, this has been archived. I also explained that the material can be easily retrieved if necessary.

I then briefly explained our involvement in the case. I referred to the Crown Prosecution Service's decision not to make any prosecutions relating to Code A. Following that, the GMC had asked us to look at a number of cases. We are currently reviewing a total of 13 cases. I explained that Code A is not one of these cases.

Code A told me that he is not pressing to open a case and in fact he expressed a view that given the fact that so many people are involved, he would find it difficult to envisage how the individuals can be picked out. He did, however, say that he always thought it very strange that his mother was prescribed oramorph when she went to Gosport, having not received any such medication whilst she was at Haslar.

We agreed that I would retrieve the paperwork relating to his mother from our archives and then contact him when I had done this to let him know what we have.

His telephone number is ***023 9242 0833***

Code A

Code A

From: Code A
Sent: 21 February 2007 11:30
To:
Cc: Code A
Subject: GMC Code A

I was contacted today by a Code A who has asked what docs we have relating to her. On a quick review of the archive list I see that docs relating to Code A are listed as being in in various archive boxes. Could you please arrange for all her docs to be retrieved from storage
Thanks

Code A
Associate

Direct Dial: Code A
International: +44 20 7497 9797
www.eversheds.com


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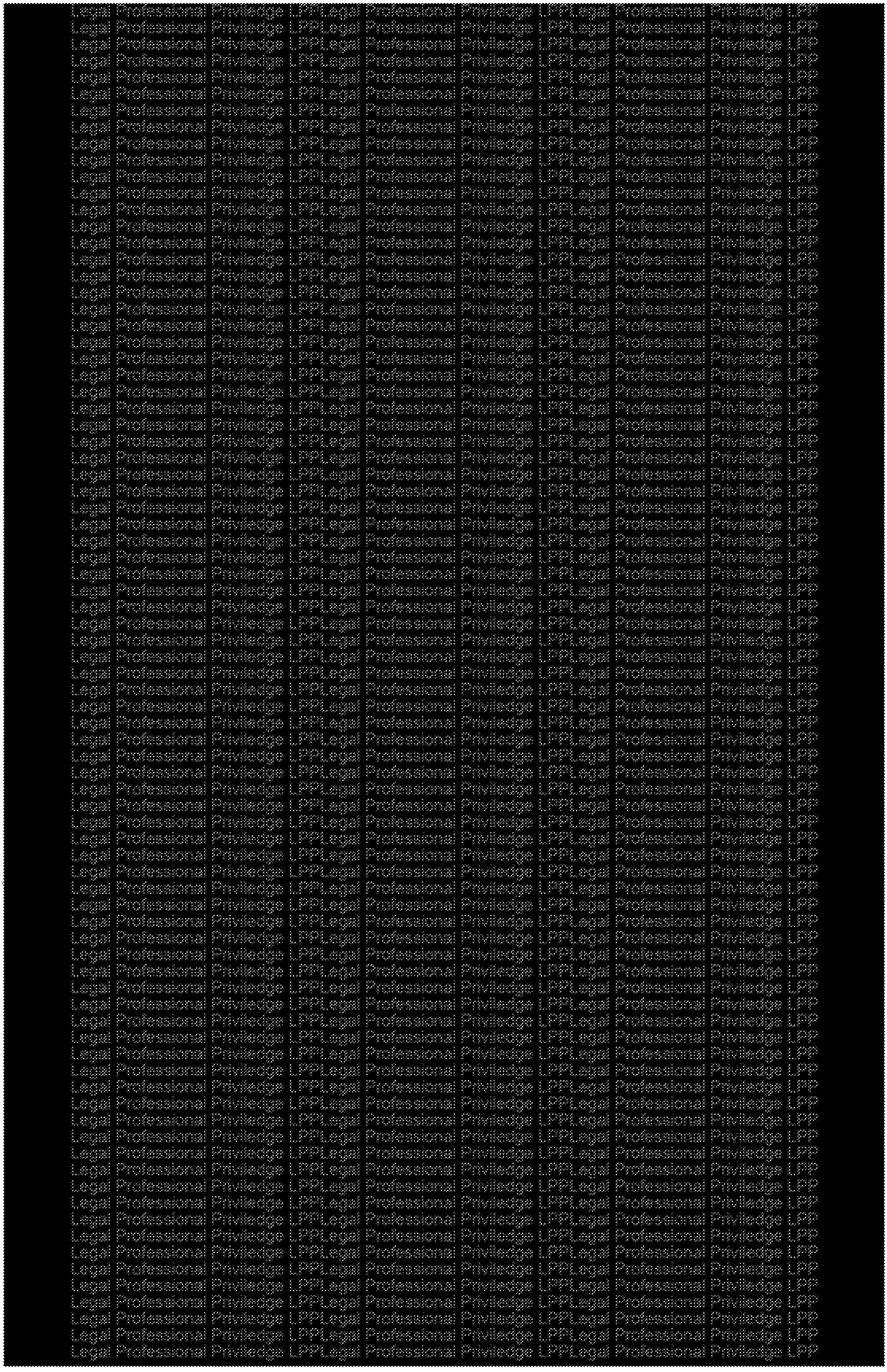
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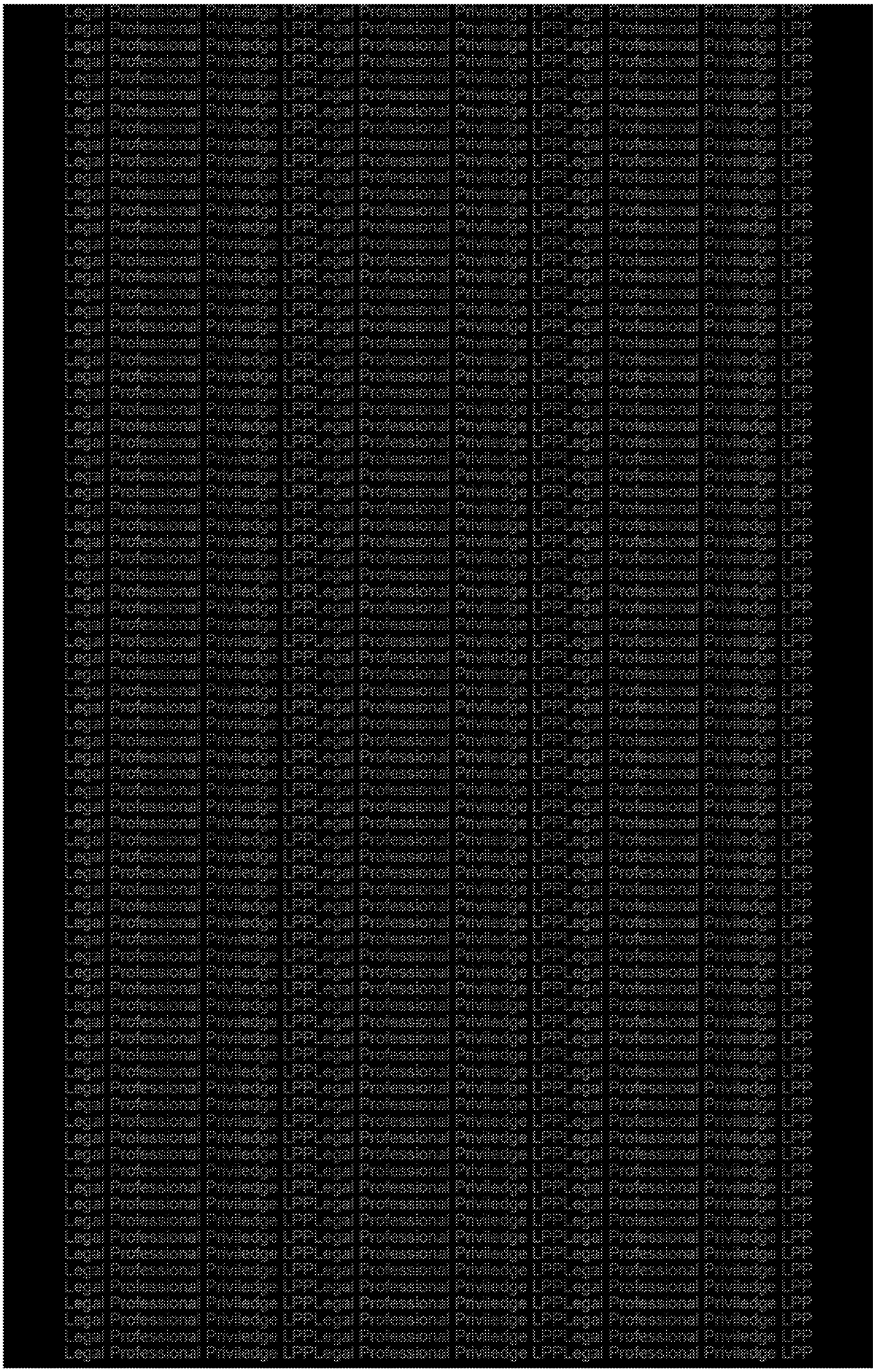
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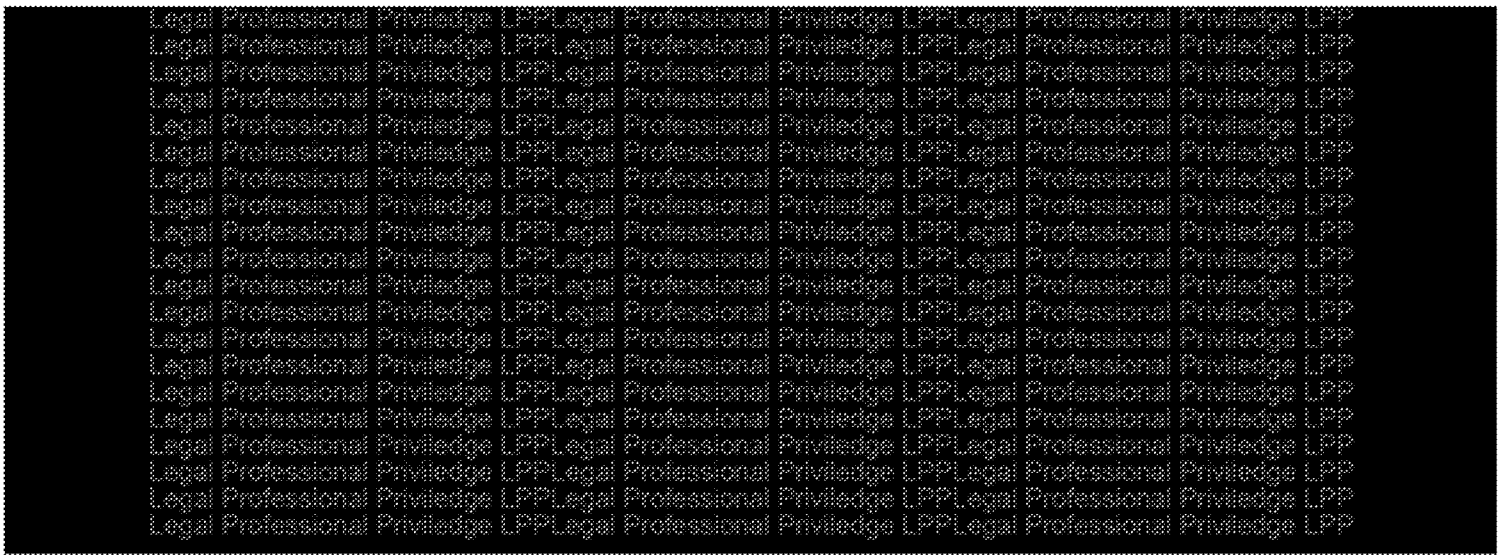
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EVERSHEDS

attendance

Client	General Medical Council	Date	20 February 2007
Matter	Code A	F/E	Code A
Attendees			

Code A left a message on my voicemail. He said that he was the second person to make a complaint against Code A as concerning the death of one of his relatives, Code A Code A

Code A indicated that Code A was one of the 13 cases, which the police looked at (being that it was one of the category 3 cases).

He indicated also that he had been in touch with the police recently but had not received a response. He wanted to know whether the GMC had received papers relating to Code A Code A

He said he would call again tomorrow and did not leave a contact number.

Following the call, I checked the list of files, which we have archived. These include a number of references to Code A

Code A

EVERSHEDS

Client	General Medical Council	Date	20 February 2007
Matter	Code A	F/E	Code A
Attendees			

I received an email from Code A We discussed the two boxes of files that he has. He said that somebody from Hampshire will be coming to South Wales in the next two weeks if we could wait that long. I asked whether he would be prepared to use a private courier to send the documents up sooner. He said he would check with his Superintendent and let me know.

Code A

Code A

From: Code A
Sent: 19 February 2007 17:32
To: Code A
Subject: Operation Rochester

Dear Code A

RE: Operation Rochester

I am sorry that I was not around this morning to take your call. If I am not at my desk when you call again please speak to one of the secretaries and they will find me.

I have a further query - on reading the papers in connection with patient ED I note that the case was considered by an Independent Review Panel set up by the PCT. There is also reference in the notes to oral evidence being given as part of the review. Please could you let me know whether the police obtained a transcript of the evidence?

Regards,

Code A

Direct Dial: Code A
International: +44 20 7497 9797
www.eversheds.com


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EVERSHEDS

telephone

Client General Medical Council
Matter Code A
Attendees

Date 15 February 2007
F/E Code A

Code A telephoned me whilst I was working at home in response to my recent query concerning Code A told me that he had now looked at the key clinical team assessment form. He explained that whilst she had originally been categorised as a Class 3 case, i.e. where negligence was believed to have been involved, it appears that her case was down-graded, firstly to a category 2 case (where there is still believed to be suboptimal care) and by at least one member of the team to a category 1 case (where optimal care has been delivered).

He referred me to a letter which had been sent to Code A explaining the position. He will send me a copy of the letter, together with the key clinical team findings. He will also send copies of witness statements taken from Code A and one or two other witnesses, in connection with the same case.

The main reason why Code A case was reclassified was due to the fact that initially the key clinical team worked with medical notes from Gosport which showed that the patient had been prescribed morphine. When the key clinical team received notes from the Haslar Hospital it appeared that the patient had been receiving morphine whilst at the Haslar Hospital.

Code A

Part of GMC
Code A dietatian
(15.1.07)


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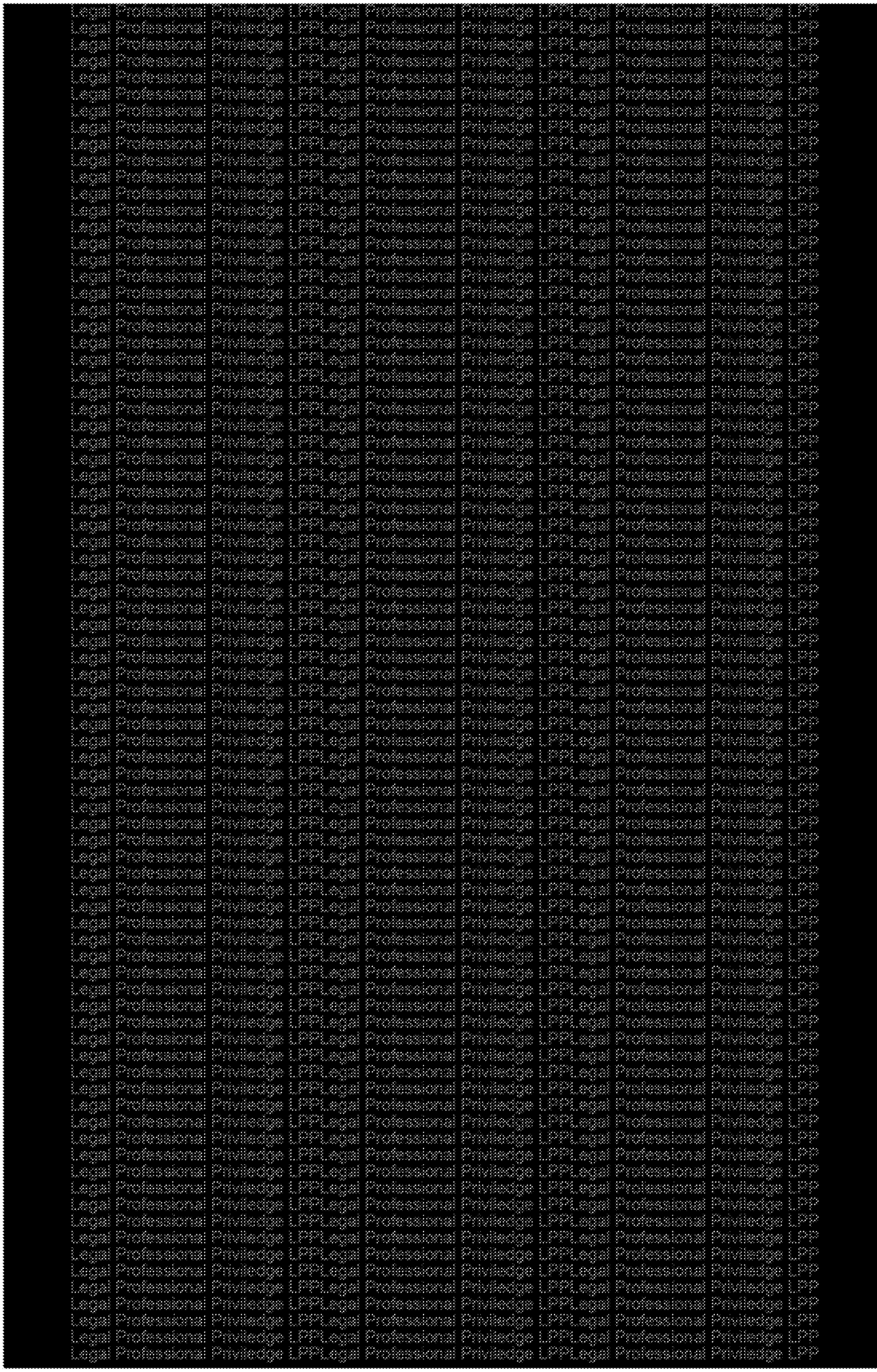
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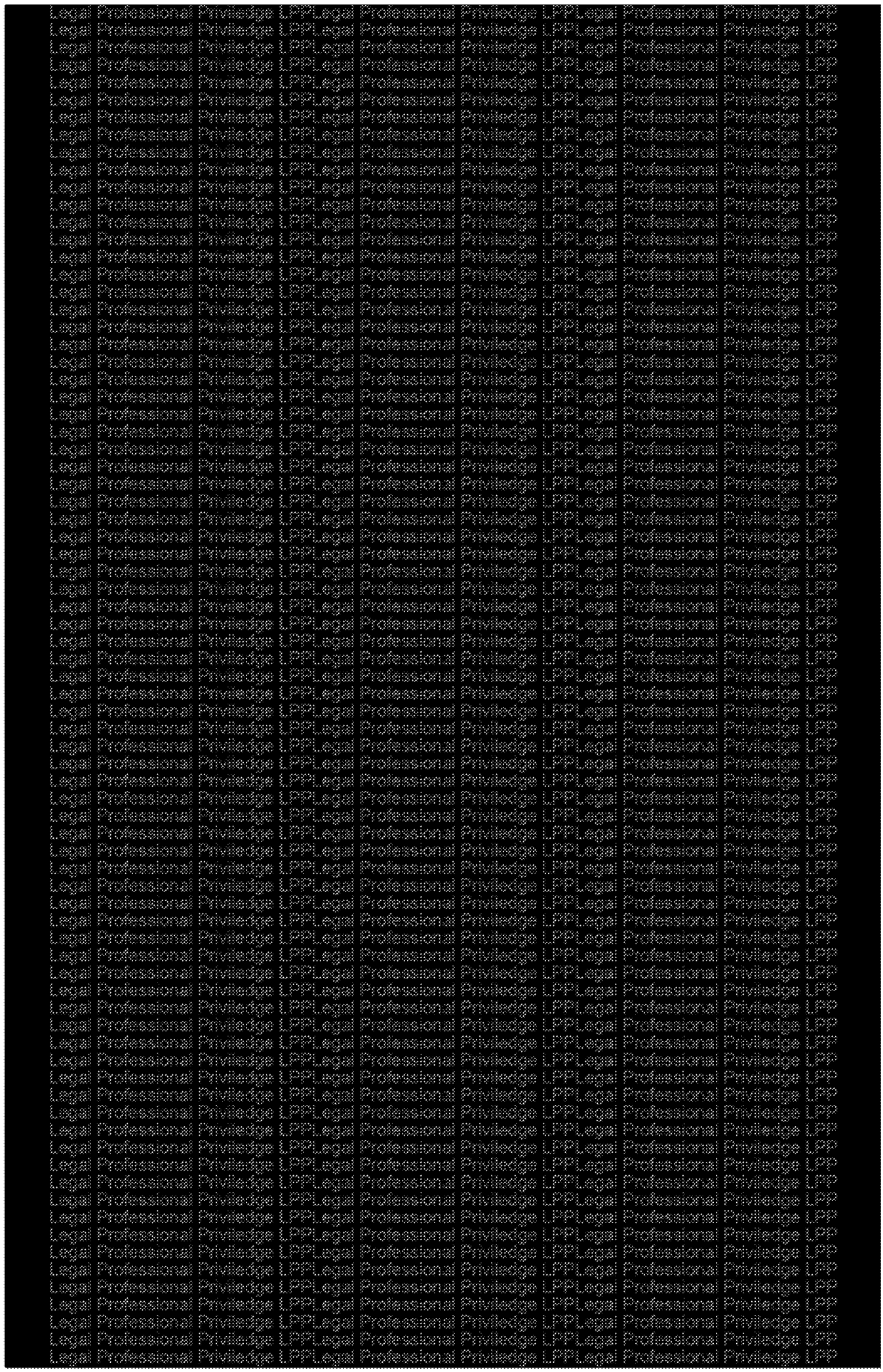
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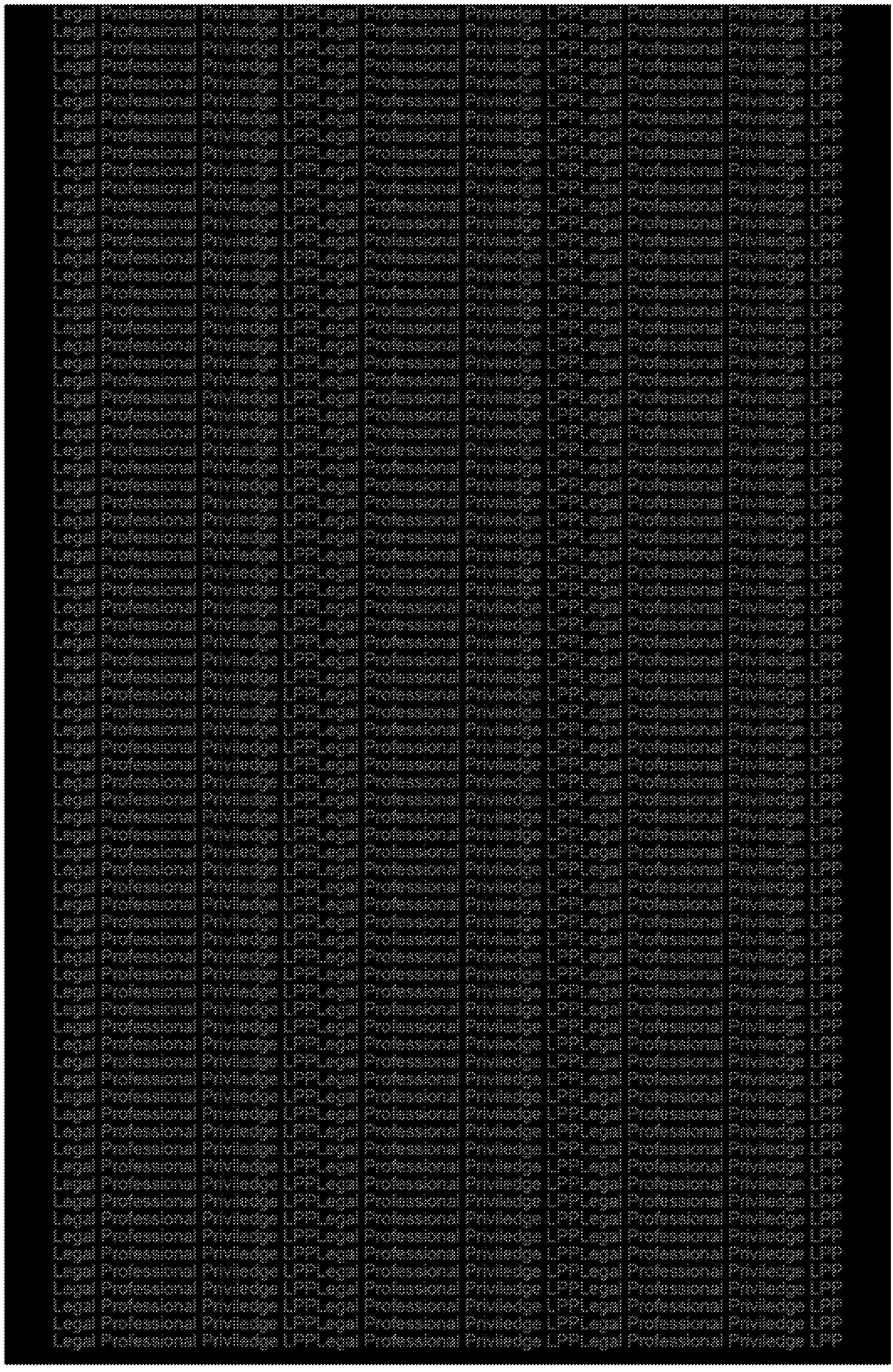
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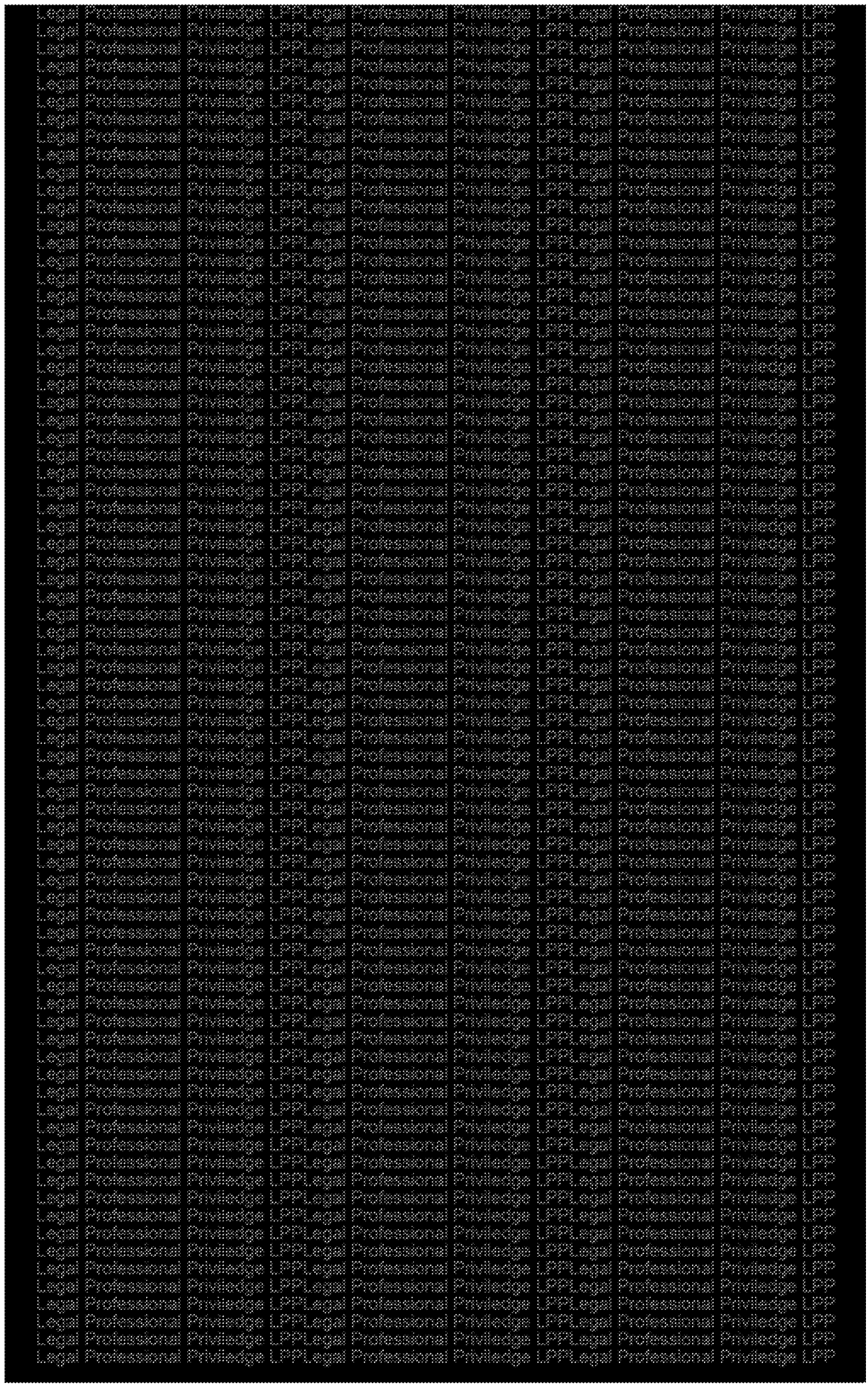
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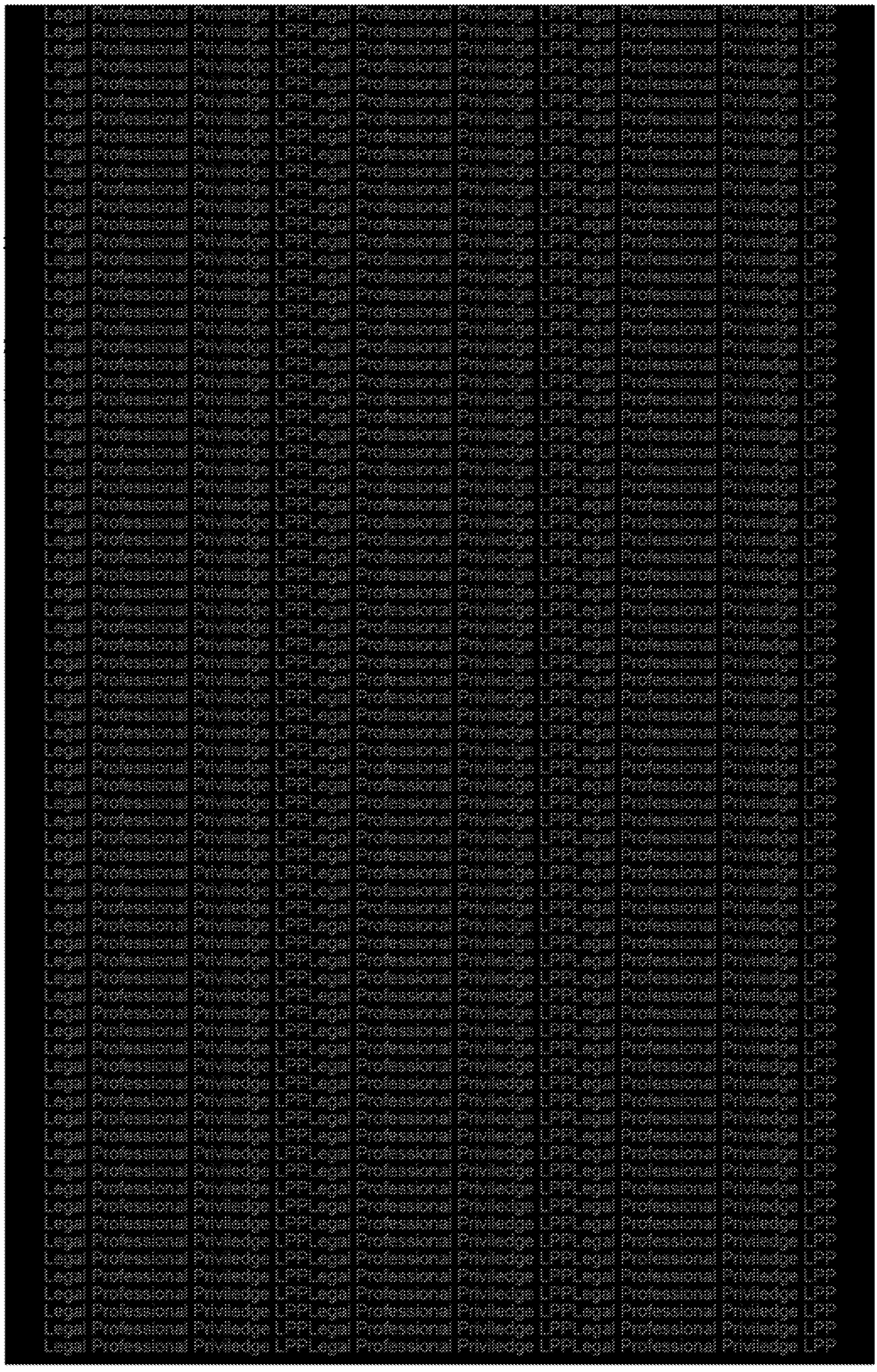
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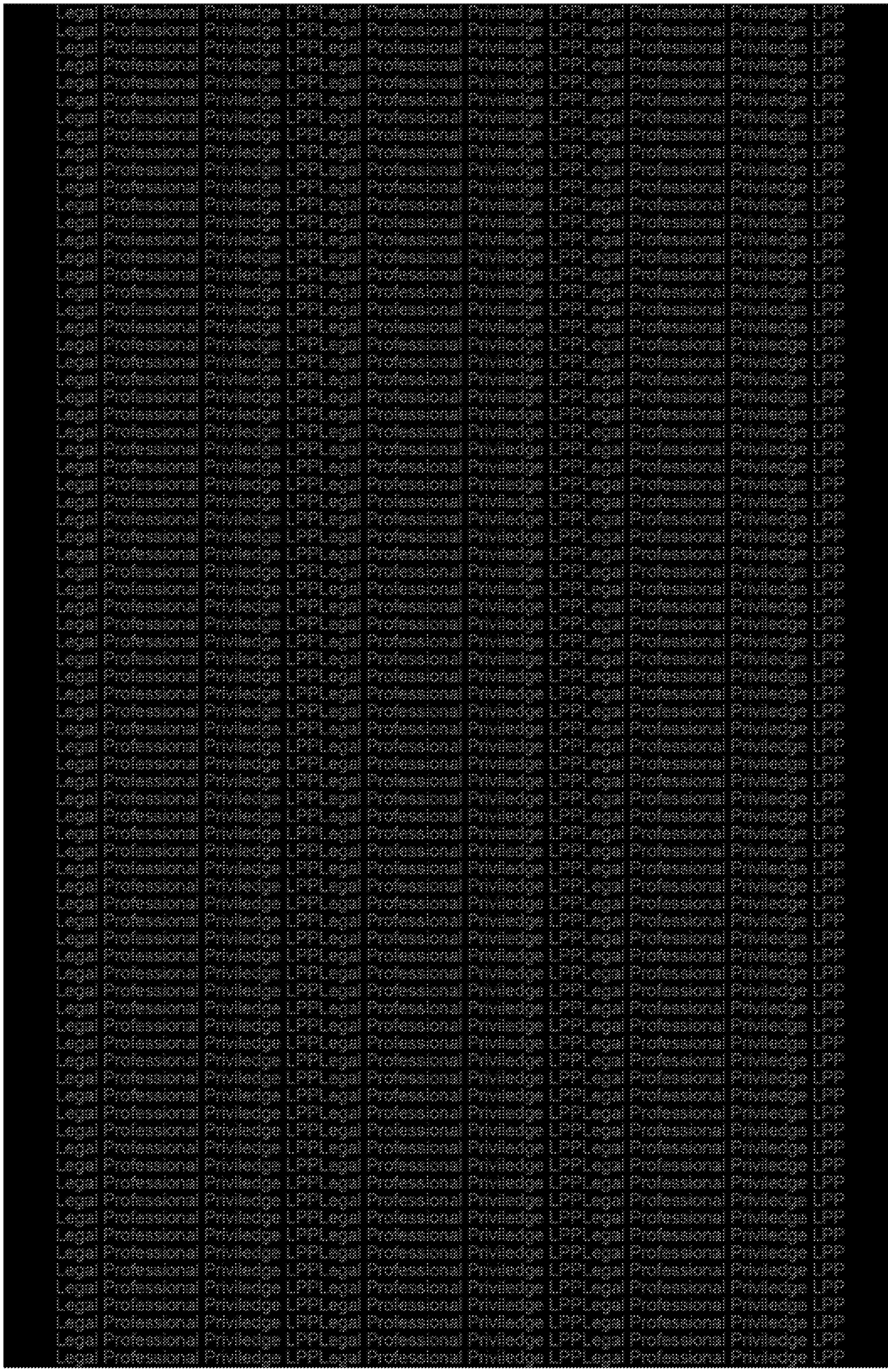
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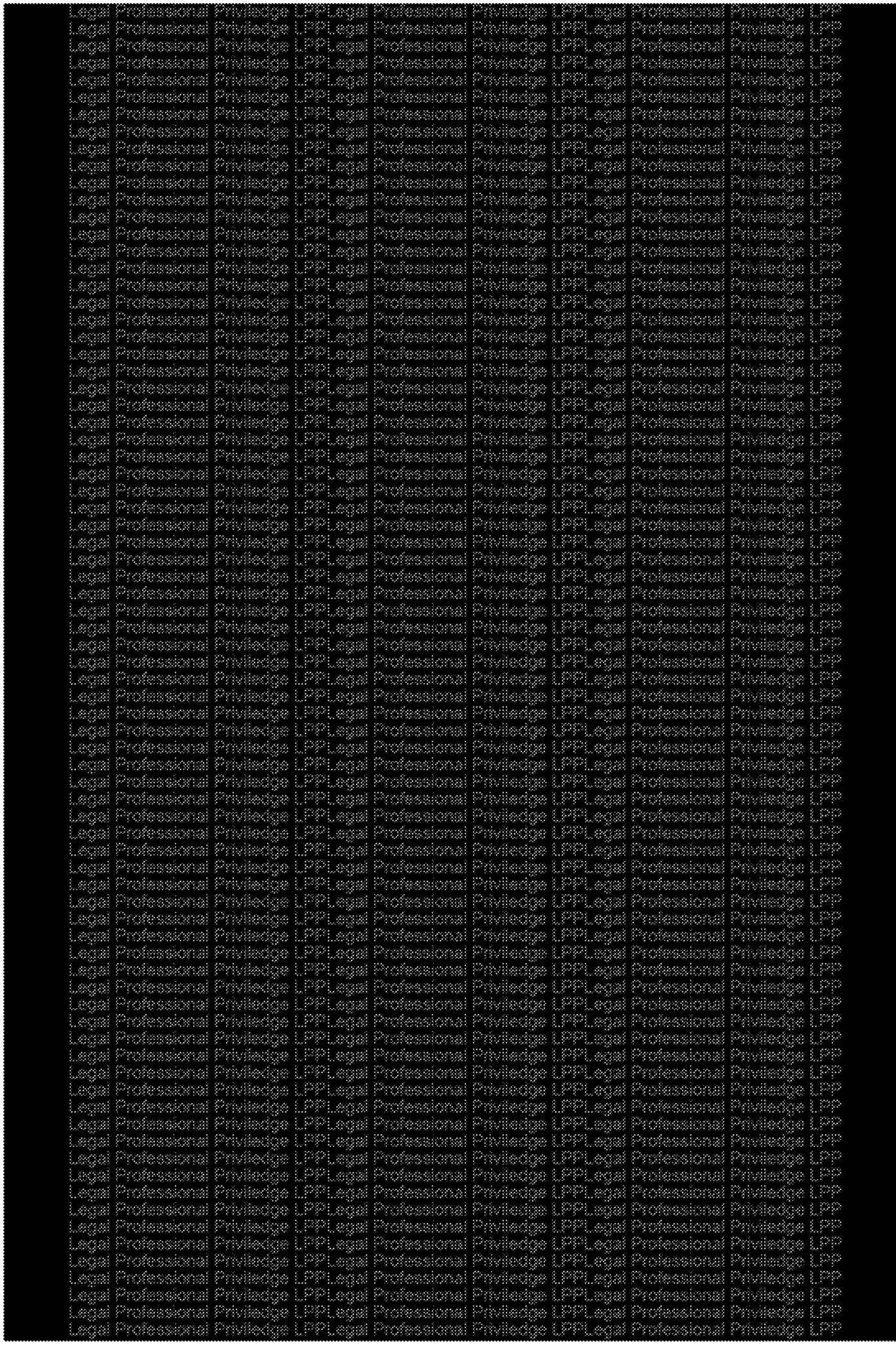
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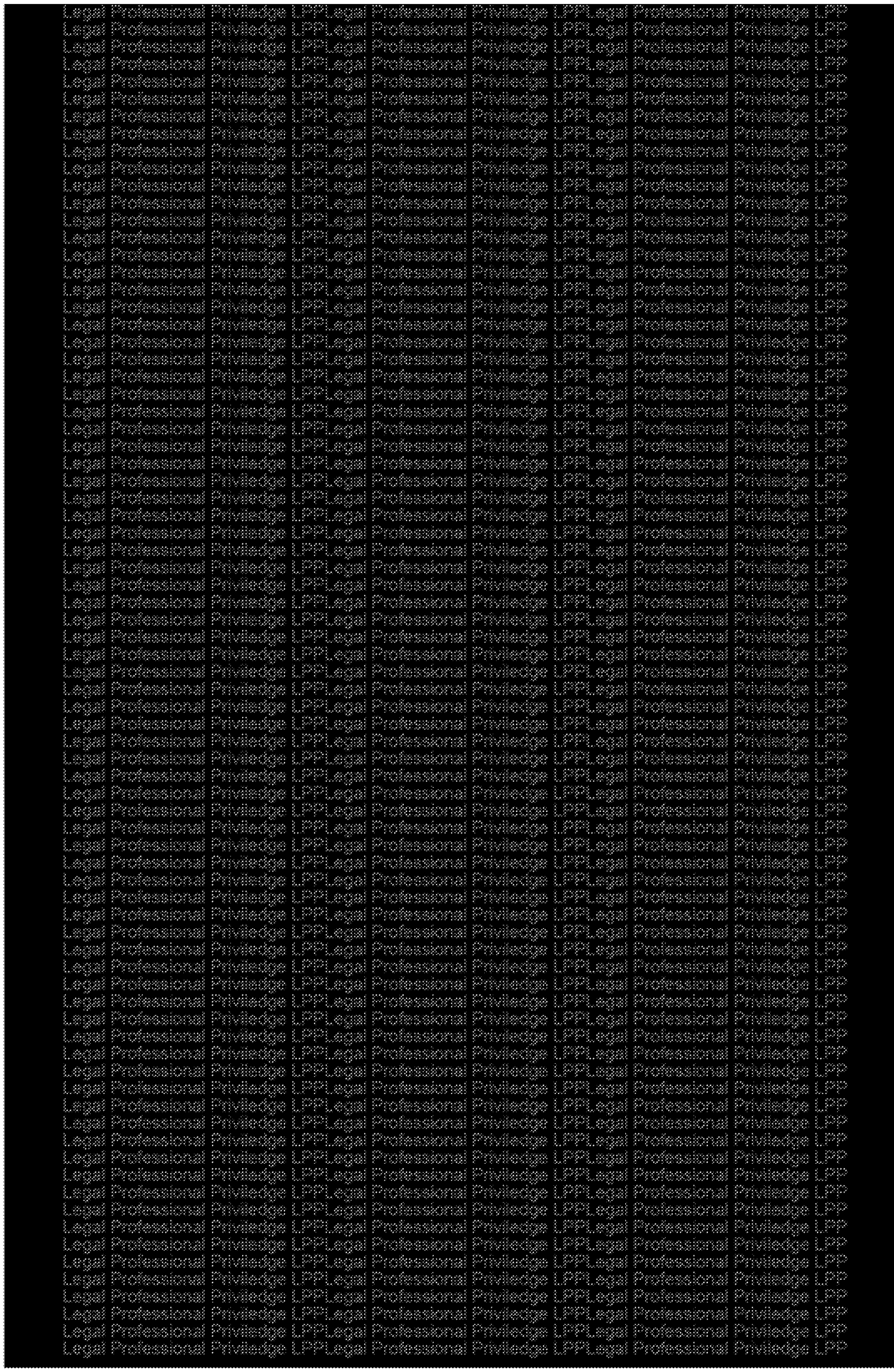
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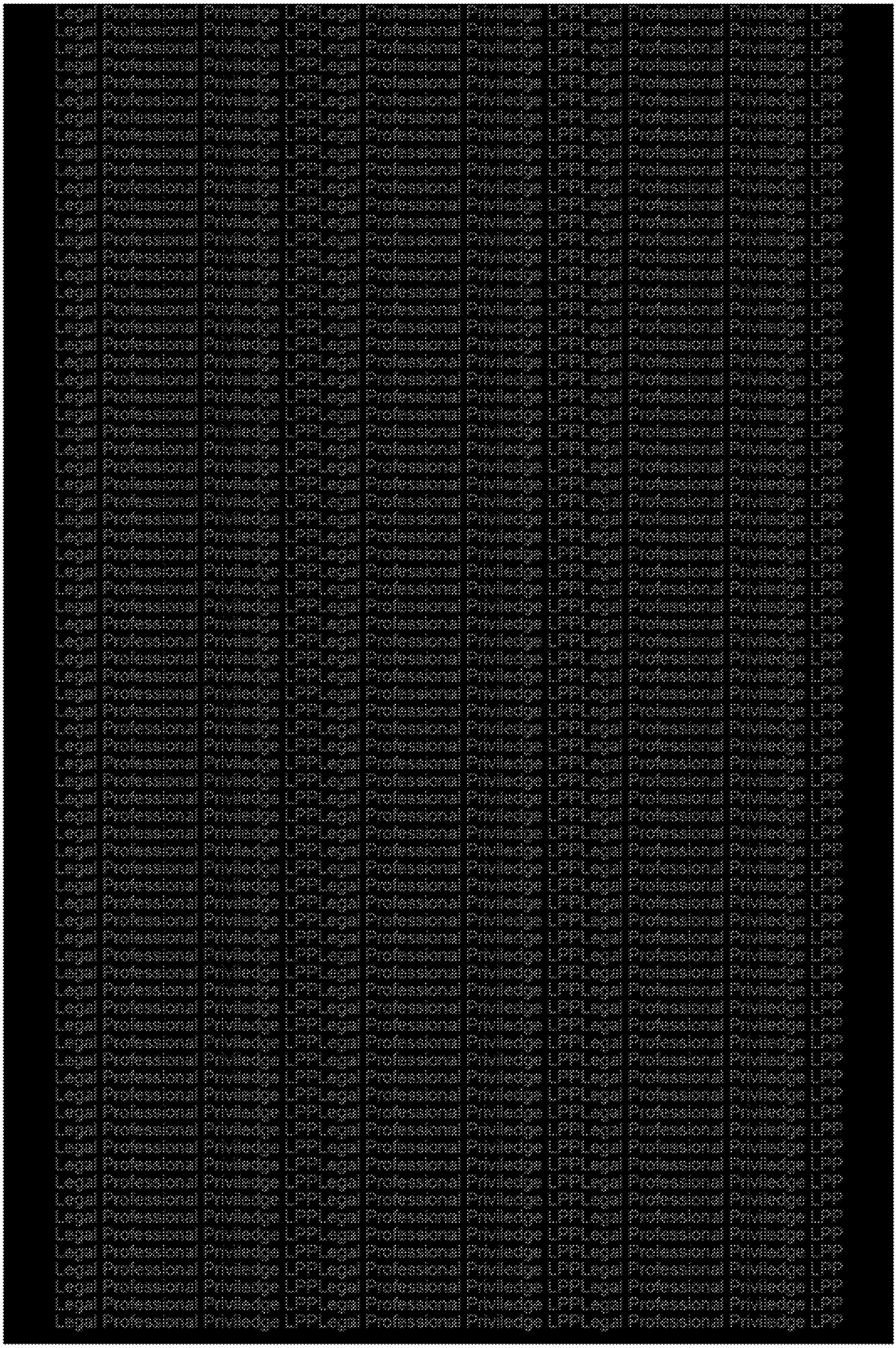
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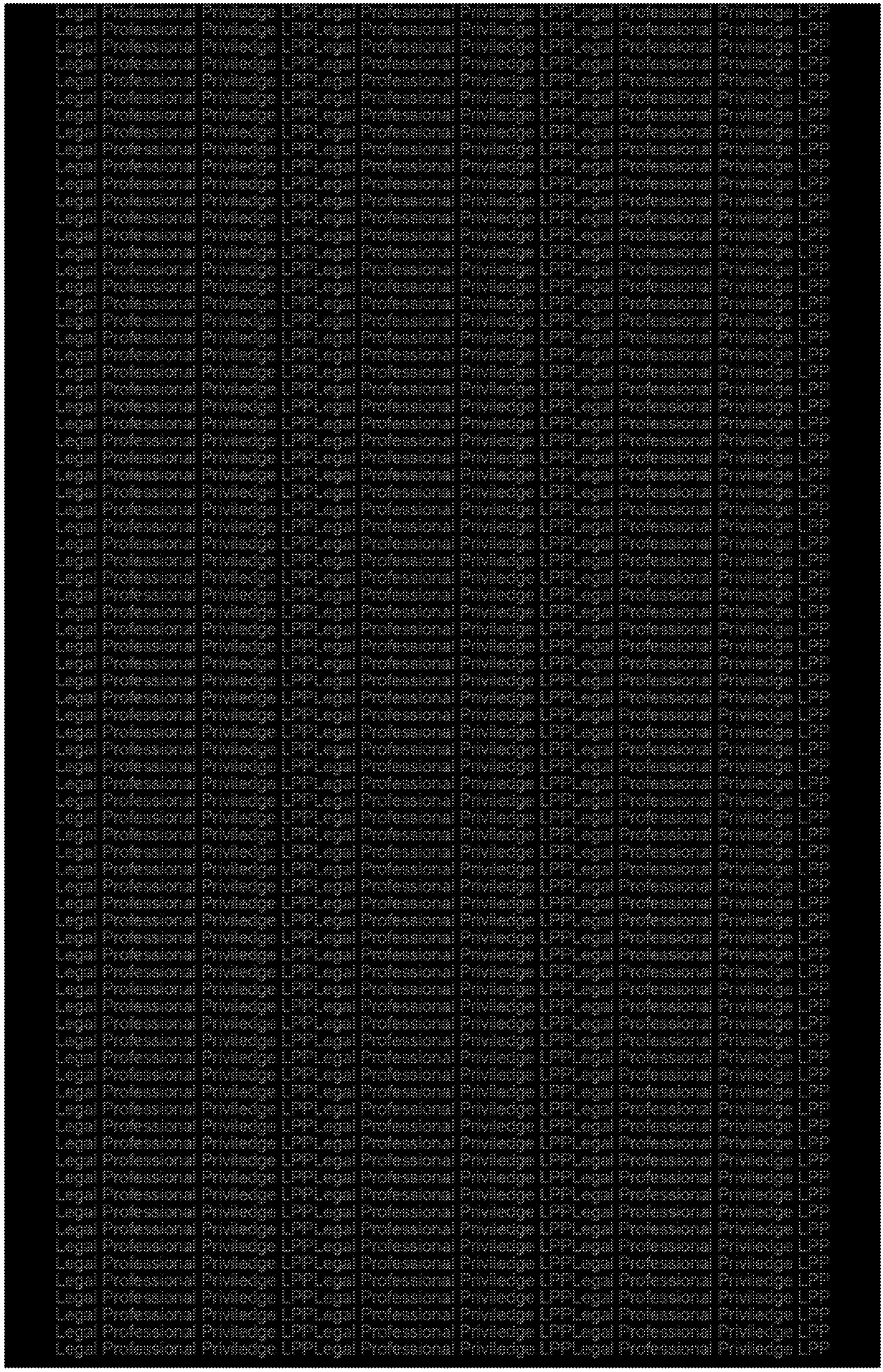
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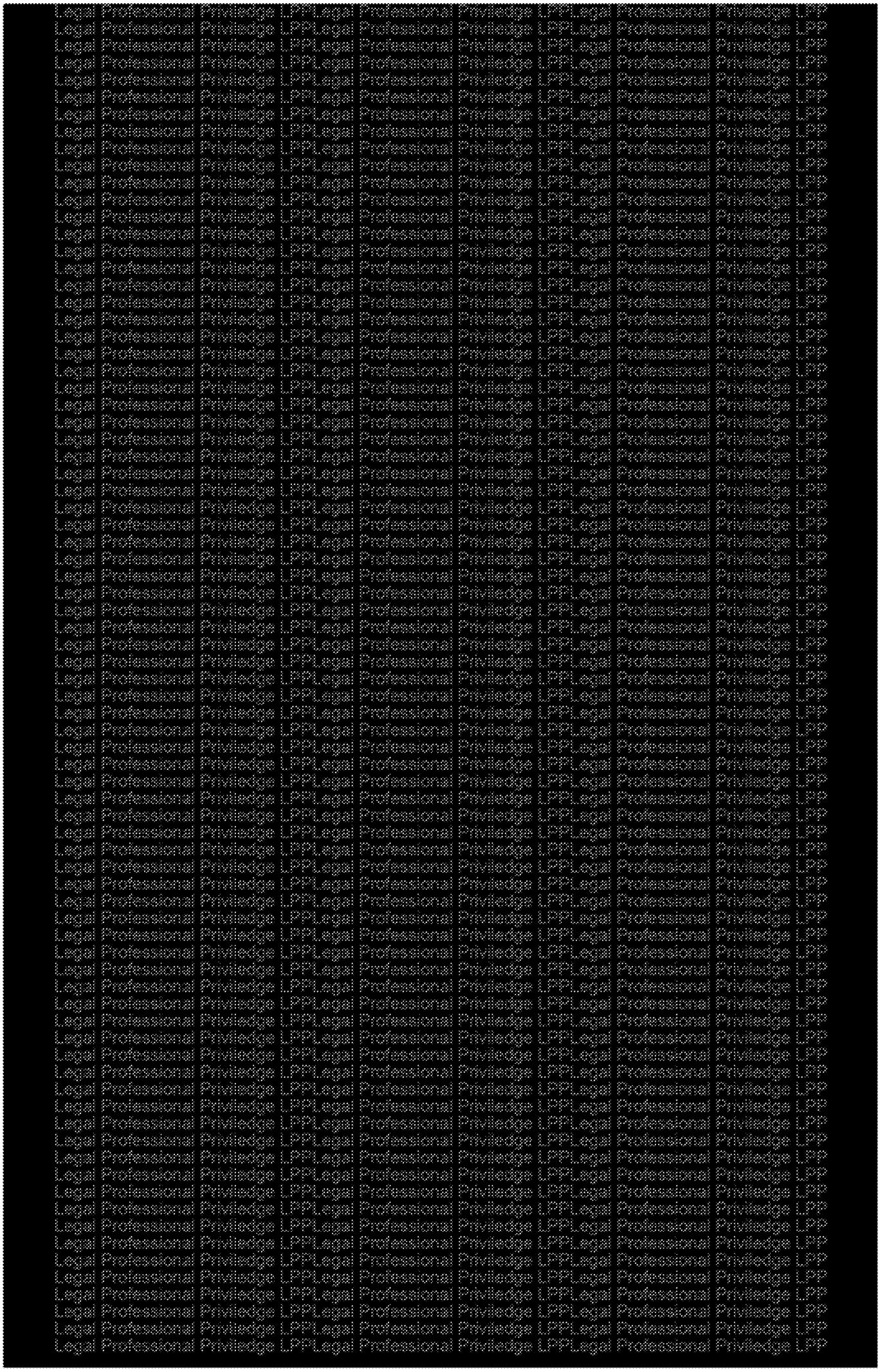
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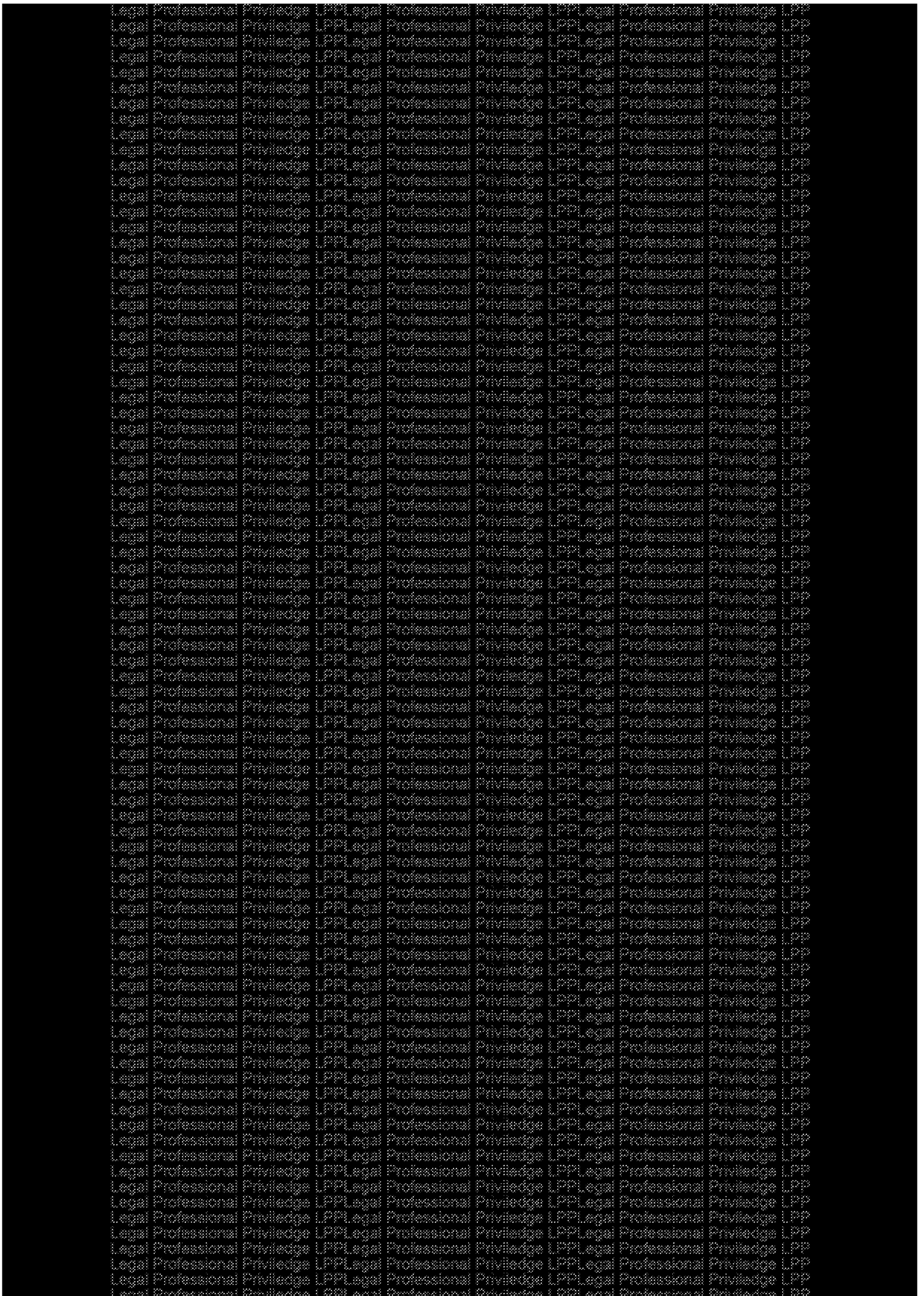
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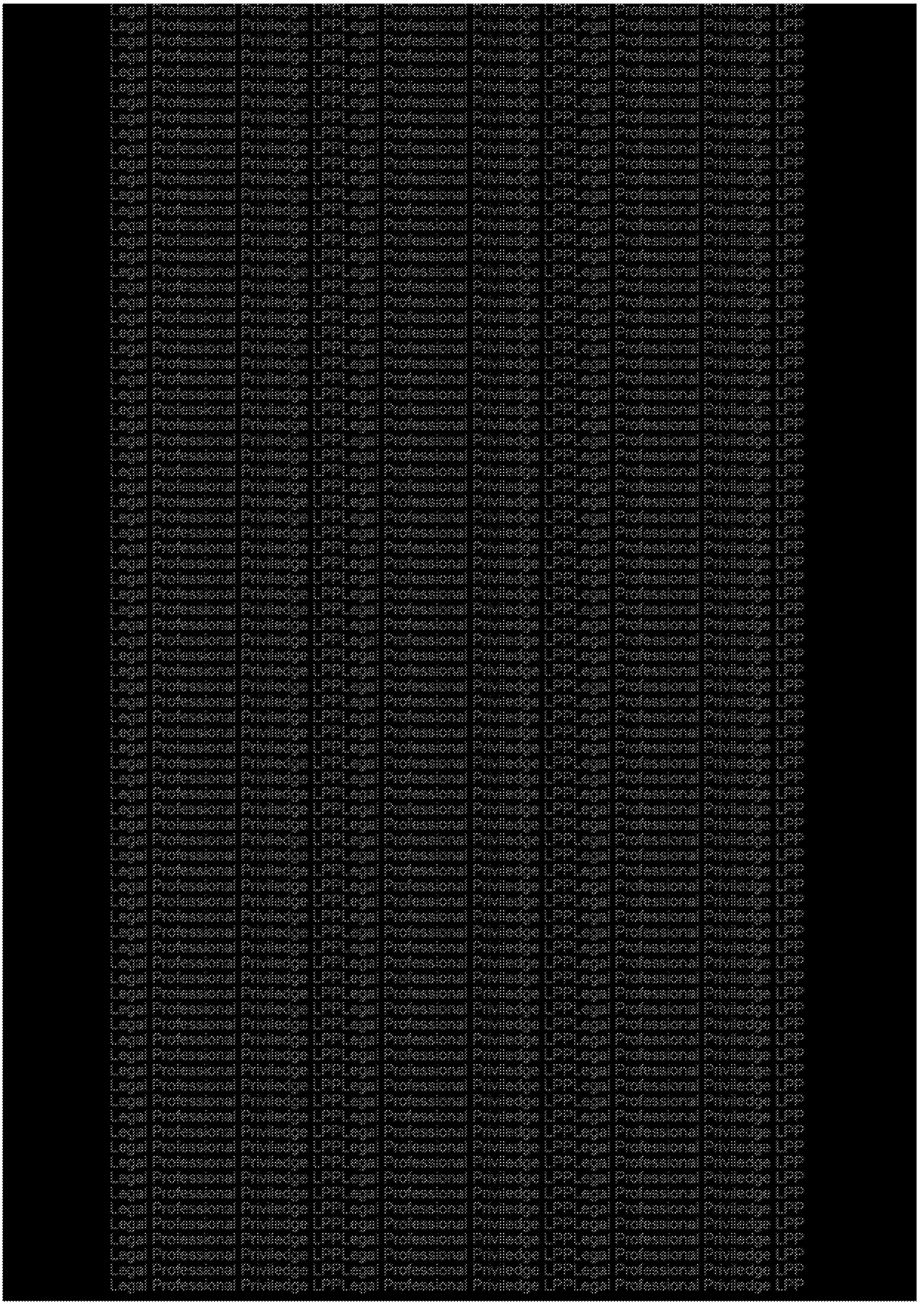
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EVERSHEDS

Code A

From: Code A
Sent: 15 February 2007 16:19
To: Code A
Subject: Operation Rochester

Dear Code A

RE: Operation Rochester

I am sorry that I was not around this morning to take your call. If I am not at my desk when you call again please speak to one of the secretaries and they will find me.

I have a further query - on reading the papers in connection with patient ED I note that the case was considered by an Independent Review Panel set up by the PCT. There is also reference in the notes to oral evidence being given as part of the review. Please could you let me know whether the police obtained a transcript of the evidence?

Code A
Associate

Direct Dial: Code A
International: +44 20 7497 9797
www.eversheds.com


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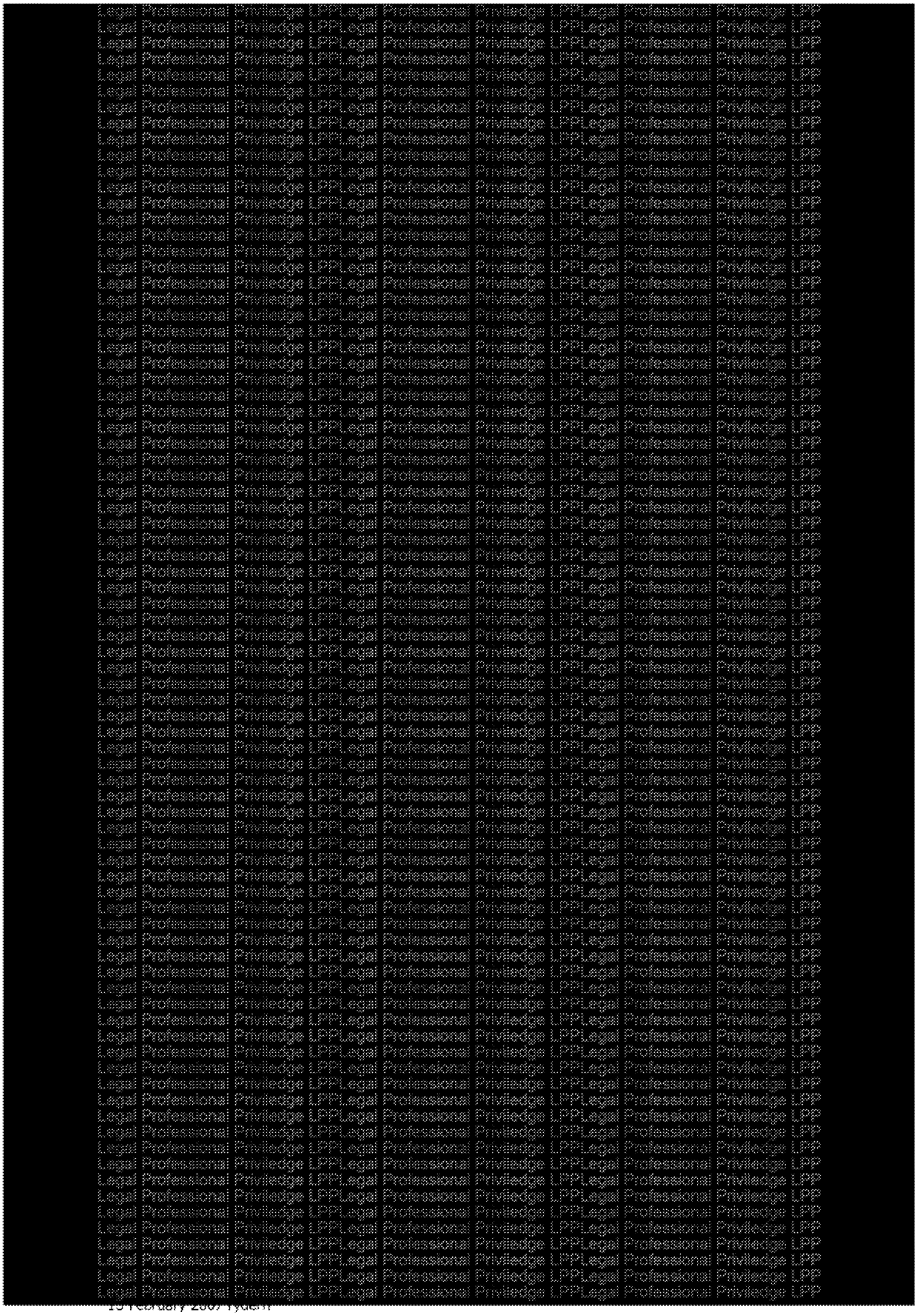
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EVERSHEDS

attendance

Client	General Medical Council	Date	14 February 2007
Matter	Code A	F/E	Code A
Attendees	Code A		

I telephoned Code A responding to a message left on the 13 February 2007 that he had called in connection with this file of Code A

He told me that he had spoken recently to Code A and she had suggested that he call me.

He told me that Code A were instrumental in getting the Police inquiry started. They both have ongoing unresolved issues with the Hampshire Police.

I explained that Eversheds had been instructed by the GMC to deal with the witness to practice proceedings involving Code A I am dealing with the matter. I obtained from the Hampshire Police recently a substantial amount of documentation relating to the Police investigation. Included in the paperwork are records relating to Code A I am aware from discussions with the Police that they have not yet received consent to disclose the records to me. I stressed that I have not yet looked at the records. I also explained that it would be helpful to obtain consent from the relatives as soon as possible.

Code A told me that strictly speaking, Code A next of kin is his late father's widow. However, he explained that it would not be worth writing to her as she was not capable of responding.

He also told me that Code A has been recently widowed. He is overwhelmed with other matters at the moment. Code A told me that the family would have no issue with the GMC seeing Code A medical records and he gave me consent on behalf of the family. He said that he would follow this up with formal consent in writing once he had spoken to his brother. He told me that I could look at the files pending written confirmation.

He asked me to clarify my role and the work I am doing on the case at the moment.

I said that I am currently looking at a total of 13 cases which had been investigated by the Hampshire Police. These cases include the case of Code A I will need to prepare a report for the GMC in due course outlining the strengths and weaknesses of the case. It will be for the GMC to decide whether all or some of the cases go forward to the Fitness to Practice Panel.

Code A said that he had recently attended a meeting with Code A the individual at the CPS who made the decision not to prosecute. He also met with Code A QC, the Counsel instructed by the CPS. Code A had explained to Code A the problems in bringing a prosecution and the reasons why a prosecution has not been brought.

Code A suggested I contact Messrs Close and Perry. I explained, from my experience in previous cases that Police are usually unwilling to disclose the reasons behind a

decision not to prosecute. Having said this, the Police are given full cooperation in other regards, principally by disclosing virtually all the material involved in their investigation.

Code A asked whether I would be getting any further information before preparing a report for the GMC. I explained that given the amount of detail already available (in each case 20+ witness statements have been obtained and at least two individual expert opinions) - it is unlikely that further investigation will be carried out before the GMC makes its decision as to which cases are to proceed.

I also explained that once a decision on how many cases will be referred to the Fitness to Practice Panel has been made, we will not be constrained with regard to any further evidence which we think may assist the Fitness to Practice Panel.

I also explained that in fitness to practice proceedings whilst the criminal rules of evidence apply and the criminal burden of proof applies, the main issues are a failure to comply with the medical practice coupled with issues of impairment. We would not necessarily be approaching the case in exactly the same way as the Police. The Police were looking at criminal negligence.

Code A told me that the families had instructed some time ago, Code A a solicitor who coordinated an initiative which resulted in the Police investigation. Code A Code A told me that Code A is in possession of tape recorded interviews obtained by a journalist which gives a revealing insight into the thoughts of the people who worked at the hospital with Code A He told me that the Police were not able to use this material in their investigation but it may be something which could be made useful in the GMC case.

I explained that I have over 60 lever arch files of documentation to read and analyse. It will therefore take a little time to prepare a report for the GMC. However, I am working on the case virtually full time at the moment and within the next few weeks, I hope to send an initial report to the GMC.

Code A

EVERSHEDS

attendance

Client	General Medical Council	Date	14 February 2007
Matter	Code A	F/E	Code A
Attendees			

I returned a call from Code A who called on the 13 February 2007.

He has spoken to Code A about Code A

Code A wanted to know whether I have in my possession all his wife's medical notes and statements taken by the Police in their investigation. I explained that I would need to check the position and call him back.

I then telephoned Code A who was not available. I left a message asking him to return my call.

I then checked the position with regard to files sent to storage. Code A provided a list which shows that we have archived some material relating to Code A in boxes 23 and 24. I arranged for these to be called back from storage.

I then called Code A again to let him know that we have some documents relating to his wife. They are currently in storage but they would be returned probably today. I will check to see exactly what documents we have. It is possible that we have medical records and/or Police witness statements. He told me that he had sent Police witness statements to Code A

EVERSHEDS

attendance

Client General Medical Council
Matter Code A
Attendees

Date 14 February 2007
F/E Code A

Code A telephoned. She said that she had spoken recently to Code A who had passed on some details of Code A conversation with me a few days ago. Code A Code A is concerned about the notification from Code A regarding the possibility of private prosecution. Code A wanted me to know that as far as she is concerned, she does not intend to pursue a private prosecution. She does not believe that anyone else will do so either.

She also told me that she had spoken to Code A and suggested that he call me. I confirmed that I had spoken to Code A this morning.

Code A

From: Code A
Sent: 14 February 2007 14:49
To: Code A
Subject: GMC Code A

A note to remind you to contact Code A to find out whether the police obtained a transcript of the oral evidence given to the Independent Review Panel in the Code A Case.

Ta
Me

Code A

Direct Dial: Code A
International: +44 20 7497 9797
www.eversheds.com

Code A
Code A


Legal Professional Privilege LPP

Code A

From: Code A
Sent: 14 February 2007 10:42
To: Code A
Subject: RE: GMC Gosport War Memorial Hospital Code A

Code A
Many thanks
Regards
Code A

From: Code A
Sent: 14 February 2007 10:39
To: Code A
Subject: GMC Gosport War Memorial Hospital Code A

Good Morning

Thank you for telephoning me this morning.

I have now spoken with my brother and can confirm his agreement for you to use my father's medical records.

Code A represented the interests of the relatives and may have some information that could aid your report. There is a tape and transcript of an interview with a journalist from The Times that indicates the state of mind of staff at the hospital. Code A recently merged with Code A

Code A

Regards

Code A

Code A

Code A

From: Code A
Sent: 13 February 2007 10:13
To: Code A
Subject: FW: Operation Rochester

Code A
Secretary to Code A
Code A
International: +44 20 7497 9797
www.eversheds.com

From: Code A
Sent: 13 February 2007 10:11
To: Inscoe, Code A
Subject: FW: Operation Rochester

Code A - I have received the attached e-mail - it was sent to me following an e-mail I had sent on Code A behalf.

Code A
Secretary to Code A
Cardiff
Code A
Direct Fax: 0845 498 7144
www.eversheds.com

From: Code A
Sent: 12 February 2007 10:15
To: Code A
Subject: RE: Operation Rochester

For the attention of Code A
I have copied some papers that were previously sent to the GMC regarding the case's of Code A and am in the process of getting together the other bits as requested. I will forward all to you as soon as possible.

Code A

From: Code A
Sent: 05 February 2007 10:13
To: Code A
Subject: Operation Rochester

*** *Before acting on this email or opening any attachment you are advised to read the Eversheds disclaimer at the end of this email.* ***

Sent on behalf of Code A
Dear Code A
I have started to go through the files which I collected from you on 18 January 2007.
In the files which I have looked at so far, one or two documents are missing.
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Also, in volume 1 relating to patient ES, page 5 of the summary at the front of the file is missing. Please could you send me a copy of this as well.
Regards

Code A
Associate

Code A

www.eversheds.com

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+44 (0) 845 045 45 45 or email to postmaster@hampshire.pnn.police.uk immediately. Please then delete this email and destroy any copies of it.

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****

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To: Code A
Subject: FW: Operation Rochester

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Secretary to Code A
Cardiff

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www.eversheds.com

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Code A

Associate

Code A

www.eversheds.com

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********** [http://www.eversheds.com/] **********

****

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+44 (0) 845 045 45 45 or email to postmaster@hampshire.pnn.police.uk immediately. Please then delete this email and destroy any copies of it.

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to and from the Hampshire Constabulary may be subject to monitoring. Replies to this email may be seen by employees other than the intended recipient.

****

Code A

From: Code A
Sent: 22 December 2006 14:12
To: Code A
Subject: RE: Code A

Thanks Code A

My fear has always been that we would have too little information in respect of Code A and too much information in respect of doctors who are not yet referred. Once all the information is in and you have had a chance to analyse it we will be in a position to decide whether Code A or any other doctor, should be referred to IOP.

Paul

-----Original Message-----
From: Code A
Sent: 22 Dec 2006 14:06
To: Code A
Subject: Code A

**** Before acting on this email or opening any attachment you are advised to read the Eversheds disclaimer at the end of this email. ****

Dear Code A

I refer to the summaries of expert evidence prepared by the police for each of the fourteen "category 3" cases which they investigated. I understand from Code A that you have already been sent copies.

The summaries are all critical of the quality of care afforded to patients and will almost certainly form the basis of a strong case of serious professional misconduct. Clearly the GMC will wish to review the IOP position in this case. Code A and I have considered whether there is sufficient material in the attached summaries to put before an IOP. In our view, whilst the summaries are useful, without seeing the reports which have been summarised, we have no way of knowing whether the summaries are accurate. Therefore I think we need to see the reports and these would need to be made available to the IOP. There is a further difficulty in that some of the summaries appear to criticise some of the Doctors and other medical staff working with Code A It is not clear from the summaries in some cases, whether the criticisms made relate in part to other Practitioners. I think this needs to be clearly understood and clarified before the IOP can deal with the matter.

We have already been in touch with the police to ask them for disclosure of evidence relating to the fourteen cases. They have told us that this comprises 45 lever arch files and that they will start to copy this immediately after Christmas in the expectation that the material will be ready to be collected by us by the middle of January.

Given the importance of experts reports in the context of a possible IOP review I have sent an email today asking the police to prioritise the copying of experts reports in hope that these can be made available to us before the middle of January.

Code A

From: Code A
Sent: 13 February 2007 09:46
To: Code A
Subject:
Importance: High

Hi Rob

Please call Code A re his wife's death at the War Memorial Hospital in Gosport. He spoke with Code A at GMC and Code A asked him to give you a call. He will be in all day on 14/2/07.

Ta
Me

Code A
Secretary to Code A

Code A
www.eversheds.com

Code A

Code A

5 cents.

10/13

→ 20 minutes

→ 20-50 minutes

→ 2 exercises.

→ Between 2-6 exercises.

+ 2 exercises. au choix

→ Plan available

↔ 20 exercises.

4 8 12 16 20 4

5 exercises.

Code A

From: Code A
Sent: 13 February 2007 12:51
To: Code A
Subject: Code A

Hi Code A

Code A phoned at 12:30p.m. re Code A in connection with the GMC/Code A case. Can you please give him a call.

Ta
Code A

Code A
Secretary to Code A

Code A
www.eversheds.com

Code A

→ GMC [illegible] ←
→ Code A
→ [illegible]
Code A

– [illegible] – [illegible]
[illegible]
– [illegible]
Shortly [illegible]
– but not [illegible]
[illegible]
contact [illegible]
recently [illegible]
[illegible]
have no [illegible]
GMC [illegible] medical records

will contact [illegible]
get his consent →
→ [illegible] consent – by
[illegible] →
→ leave a letter.

(PTO)

Ptw → my wife - upset - he
consider + thy decide
what action they

→ Looking to later.

→ x 3 occasions where they instructed +

→ 13 - case → Hospital police

→ CPS - decided not to proceed →
invited to CPS - not [Code A] -
stop who made decision + [Code A] BC -
- be explored CPS; police + why no
charges for boy 22

→ Phone Attacker → the actor is calling
group friends - co-ordinated, action is

[Code A]

a lot of who - type threatened
by journalist → people working at
hospital.

Code A

4013

Code A

From: Code A

Sent: 05 February 2007 10:13

To: Code A

Subject: Operation Rochester

Sent on behalf of Code A

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Also, in volume 1 relating to patient ES, page 5 of the summary at the front of the file is missing. Please could you send me a copy of this as well.

Regards

Code A
Associate

Code A

www.eversheds.com

Code A

From: Code A
Sent: 12 February 2007 17:03
To: Code A
Subject: Re: GMC / Code A

Dear Code A

Thank you for telephoning me this afternoon.

As promised, I am sending you this email to confirm that I have obtained from the Hampshire police documents concerning the police's investigation into the death of Code A Code A. The papers received from the police include evidence obtained by the police in their investigation and your mother's medical records.

You mentioned that to date you have not given consent to the police to release your mother's medical records. I confirm that whilst the records are in my possession I have not looked at them. You kindly indicated on the telephone that although you have not given your consent to the police to release the records, you are happy for me to look at them.

Yours sincerely

Code A
Associate

Code A
International: +44 20 7497 9797
www.eversheds.com

EVERSHEDS

telephone

Client General Medical Council
Matter Code A
Attendees

Date 12 February 2007
F/E Code A

Code A telephoned.

She referred to a letter which we had sent in December. The main purpose of the call was to find out from me whether I had in my possession any papers relating to her mother. I explained that about two weeks ago I had collected from the Hampshire Police a large volume of documents relating to various patients, including Code A Code A feels very strongly that the Police should not have released her mother's papers to us without her consent. They had written to her to seek her consent but her consent had not been given. I asked whether there was any particular reason why her consent had not been forthcoming. She did not explain to me the reason for this but said that she was happy for me to read the papers. (I explained to her before this that whilst I had obtained her Code A papers from the Police I had not yet read them.) I agreed, at her request, to send her an email to confirm that I had received her mother's papers from the Police.

She also referred to a recent meeting with Code A is instructed by the Police/CPS and meetings with individual family members had been arranged to explain the reason why the Police/CPS had decided not to prosecute in this case.

Individual appointments had been made with relatives to meet Code A

Code A made it clear to me that she is not satisfied with the decision not to prosecute or with the way the Police investigated her mother's case. She told me that she has lodged a complaint with the Independent Police Complaints Commission. She feels that the decision not to prosecute is purely political and that there has been a "cover up" to protect the Trust.

She told me that both she and some of the other relatives are in the process of taking legal advice with a view to pursuing a private prosecution against Code A I asked if she could give me some indication as to when a decision would be made in connection with this. She was either not prepared or unable to tell me when a decision would be made. However she understands that if a prosecution is pursued, the GMC will put the Fitness to Practice Proceedings on hold. I explained that that would be a decision for the GMC to make. It would not necessarily follow that they would place everything on hold, given that the complaints relate to matters which occurred between 7 and 10 years ago.

I explained that I am looking at a total of 13 cases at the moment. These include the 5 cases which have already been referred to the Fitness to Practice Panel. 2 of the 5 cases are included in the list of 10 cases which were investigated by the Police. I explained that the GMC may decide to pursue all 13 cases or a selection of cases. It is a matter for the GMC to decide.

Code A clearly feels very strongly that Code A was responsible for her mother's death. She is convinced that there was "intent". She said that her mother had been admitted to hospital for respite care. The reference in the medical records that her

telephone

mother was suffering from dementia is untrue. Code A said that shortly before she died her mother wrote her a letter and she would not have been able to do this if she was suffering from dementia.

From what Code A said, she is clearly very unhappy about the way the Police and the Trust have dealt with her mother's case. With regard to the Trust she said that it had taken 16 months rather than 12 weeks (the usual period for investigation) to be conducted. She said the Trust were allowed to drag their heels whilst the Police made a decision whether or not to prosecute in the case of Code A Code A

Code A

EVERSHEDS

attendance

Client	General Medical Council	Date	12 February 2007
Matter	Code A	F/E	Code A
Attendees			

I telephoned Code A and referred to my recent email with requests for documentation.

He said that he had dealt with this and he had sent me an email in response.

In anticipation that I may also need some further documents, he has already started copying some other sections of the Police Records.

When we discussed this, it was agreed that he would send me the following :-

The key Clinical Team Assessments and Code A Assessments for the following patients :

- Code A

He is also going to send me all the medical records for Code A

He told me that as part of the investigation into Code A death, eleven nurses/ health workers were interviewed under caution. Transcripts of the interviews will be copied and sent to me. In addition, one witness statement was obtained. Those too will be sent to me. Code A told me that no witnesses were interviewed and no suspects were interviewed under caution in respect of the Code A cases.

Upon receipt of the additional documentation we will need to check that in addition to the above, copies of any expert reports regarding Code A and Code A have also been copied and sent.

Code A said he hoped to have all the copying done by the end of the week. He said he would contact me then to review how they would be sent to us. He mentioned that either he or his colleagues are due to come to South Wales shortly and it may be that they can bring the material with them.

Code A


Legal Professional Privledge LPPLegal Professional Privledge LPPLegal Professional Privledge LPP

GMC AND Code A INDEX OF FILES ON 18 JAN

→ 2, 3, 4, 5, 6, 7
12, 13, 14, 15,
22, 23, 24, 25,
39, 40

1. Index of all evidence obtained
2. Generic Case File
3. Generic Case File (exhibits)
4. Generic Case File (exhibits)
5. Generic Case File (further exhibits)
6. Generic Case File further evidence re: Code A
7. Generic Case File further evidence - interviews with Code A
8. Code A Volume 1
9. Volume 2
10. Additional Evidence
11. Hospital Medical Records
12. Code A Volume 1
13. Volume 2
14. - further evidence
15. - further evidence
16. Hospital Medical Records
17. Hospital Medical Records
18. Code A Volume 1
19. Volume 2
20. Hospital Medical Records
21. Hospital Medical Records
22. Code A Volume 1
23. Volume 2
24. - further evidence
25. police interviews with Code A
26. Hospital Medical Records
27. Code A Volume 1

GMC AND Code A INDEX OF FILES RECEIVED FROM HAMPSHIRE POLICE ON 18 JANUARY 2007.

1. Index of all evidence obtained
2. Generic Case File
3. Generic Case File (exhibits)
4. Generic Case File (exhibits)
5. Generic Case File (further exhibits)
6. Generic Case File further evidence re: Code A
7. Generic Case File further evidence - interviews with Code A
8. Code A Volume 1
9. Volume 2
10. Additional Evidence
11. Hospital Medical Records
12. Code A Volume 1
13. Volume 2
14. - further evidence
15. - further evidence
16. Hospital Medical Records
17. Hospital Medical Records
18. Code A Volume 1
19. Volume 2
20. Hospital Medical Records
21. Hospital Medical Records
22. Code A Volume 1
23. Volume 2
24. - further evidence
25. police interviews with Code A
26. Hospital Medical Records
27. Code A Volume 1

28. Code A Volume 2
29. Hospital Medical Records
30. Hospital Medical Records
31. Code A Volume 1
32. Volume 2
33. Hospital Medical Records
34. Hospital Medical Records
35. Volume 1
36. Volume 2
37. Hospital Medical Records
38. Hospital Medical Records
39. Volume 1
40. Volume 2
41. Hospital Medical Records
42. Hospital Medical Records
43. Code A Volume 1
44. Volume 2
45. Hospital Medical Records
46. Hospital Medical Records
47. Hospital Medical Records
48. Code A Volume 1
49. Volume 2
50. Hospital Medical Records
51. Further evidence re: Code A
52. GP Records for
53. GP Records for Code A
54. Copy Extracts from Patient Admission Records
55. Extracts from controlled drugs record book dated 26 June 1995 - 24 May 1996

EVERSHEDS

attendance

Client General Medical Council
Matter Code A
Attendees

Date 19 January 2007
F/E Code A

GMC and Code A notes of meeting with Code A at Fareham Police Station on 18 January 2007.

Code A introduced himself. He is one of the officers who was involved in the Code A investigation. He was involved for three years in total i.e. not for the whole of the investigation. However he had all of the paperwork and was able to fully brief me on the papers that he handed over at the meeting. If I need any further information / documents in future I can contact him. His contact telephone number is Code A

He handed over 7 large boxes of files containing papers relating to the following patients;

1. Code A
2.
3.
4.
5.
6.
7.
8.
9.
10.

NB: that in this list of ten strongest cases, only two patients who were involved in the police's initial investigation of five patients have been included - i.e. Code A Cases in respect of the other three patients involved in the initial enquiry are not considered to be strong enough to be included in the top ten i.e. Code A

I was told that all the papers relating to Code A had been sent to the GMC on the following dates respectively - 16 December 2004, 29 September 2005 and 10 September 2004.

The police have the copies of all these documents and if we don't already have them, or the GMC is not able to provide them, a further request for copies can be made to the police.

attendance

Code A told me that the documents submitted fall in to two categories;

1. Documents which relate to the investigation generally.

2. All the evidence specifically relating to each of the ten case referred to above.

With regard to the general evidence, Code A told me that we have been provided with everything which the police consider we will need with one exception - a report prepared by Code A on behalf of the Chief Medical officer - Commission for Health and Improvement. The full title is "Report for Commission of Health and Improvement dated July 2002, dealing with an investigation in to the Portsmouth Health Care NHS Trust at Gosport, War Memorial Hospital". The report was given to the police in confidence. The police have asked for permission to disclose to us. The police are still waiting for a reply. However Code A indicated that a copy of the report was already in the public domain and could be downloaded from the internet. Apparently the commission for Health and Improvement were not prepared for the police to rely on the report as part of the police investigation. This is because the report had been prepared with the cooperation of staff members and the commission has no wish to compromise its position in any further enquiry. Therefore a careful decision has to be made before they consent to the release of the report.

Code A is not aware of any other investigation carried out by third party - specifically he is not aware as to whether the NHS Trust itself conducted an investigation in to Code A

Code A explained that the police had conducted three investigations in all. These are referred to in the summary reports in the general file. The general file also contains some witness statements, a schedule of addresses of witnesses have been provided and copies of exhibits referred to in the statements have also been copied.

Code A explained how the police had come to determine the ten strongest cases from a total of ninety two cases. The police appointed a key clinical team comprised of four experts in different fields. The experts were Code A (nursing), Code A (Consultant Physician - Geriatrician), Code A (nursing) and Code A (Toxicology?). The experts reviewed patient's notes and put each case in to a category as follows;

Category

1. Where optimal care had been demonstrated by Code A

2. Where suboptimal care had been demonstrated (this includes the case of Code A and Code A, two of the five original cases).

3. Where in view of the experts there had been negligent conduct.

4. Where there had been intent to cause harm.

The cases were further classified as follows -

Category

(A) Cases where a natural death had occurred.

(B) Cases where the cause of death is unclear.

(C) Cases where the cause of death is unexplained by illness.

Explanation of how police investigation was carried out

attendance

When the experts had considered the records in respect of each patient they met at a round table discussion to agree a classification in each case. I asked whether there had been any category 4 cases. Code A told me that on three occasions one member of the expert team has classified a case as class 4 but this had been downgraded in discussion with the other experts.

The findings of the key clinical team were then "quality checked", by a further expert, Code A by going through the categorisation process which essentially filtered out all the weak cases and left the stronger ones. The 14 category 3 cases were looked at again separately by two further experts, Code A an expert in palliative care and Code A Code A, a specialist geriatrician.

Code A told me that in each of the ten cases I will have all the reports from Code A Code A and Code A The earlier reports prepared by the key clinical teams in respect of each of the ten cases have not been included in the papers. I explained that in due course a request for disclosure of these reports may be made. Code A gave me copies of the letter of instruction given by the police to Code A and also to the key clinical team (see plastic folder for copies).

Code A gave me an indication of what he believes are the strongest case in the "top ten". He said that if there had been a prosecution, in his opinion, this would have involved the following patients;

1.
2. Code A
3.

The next strongest cases in his view are as follows

4.
5.
6. Code A
7.
8.

In giving me his assessment Code A made it clear that in the case of Code A Code A it was perhaps easier to prove causation. Negligence in each case may have not been any less or more than in the other cases.

He told me that Code A had been classified as a category one case and the Code A and Code A case had both been classified at category two.

The papers provided in respect of each individual patient, include statements taken from the following;

1. Family group members.
2. Patient GPs.
3. Consultants working with Code A

4. Nursing Staff, being either senior, trained or auxiliary staff.

5.

Copies of relevant police statements (taken to produce exhibits for example) are also included.

With the exception of Code A the police have obtained consent from next of kin to disclose records to us. In the case of Code A a verbal consent has been obtained. The police have written to the relatives of Code A and Code A to inform them that the papers will be disclosed with or without their consent (presumably in the public interest).

I requested a sample letter of consent and I was given a consent form signed by Code A Code A on behalf of Code A (copy in plastic folder).

The papers provided also include copy medical notes, obtained from the Gosport and Haslar Hospital. Some of the patient's GP records are still being copied. The ones that have already been copied are included in the papers in the boxes handed over to me. With the exception of one case, Code A all the records have been photocopied from originals still held by the police. Only Code A has been copied from microfiche. I explained that in due course we may request the original records.

The individual patient files include evidence obtained by the police from Code A Code A explained that Code A was interviewed in respect of each of the "top ten" cases. There were two sets of interviews;

1. An initial interview at which Code A tendered a witness statement in each case. The transcript of the interview records that the statement was read out in each case.

2. Following the initial interviews a series of "challenge interviews" took place in eight of the ten cases. There were no challenge interviews in respect of Code A as these cases were considered to be too weak. In the "challenge interviews" the police put to Code A a series of pre-prepared questions. Code A explained in the case of three or four patients the challenge interview transcripts have been typed and will therefore record the questions that were specifically put to Code A They will also record that she made no comment in respect of each question asked. The remaining "challenge interviews" (three or four cases) have not yet been typed up. Code A is not convinced that they will be of any great assistance to us.

   Code A explained that at our request a complete list of all evidence obtained by the police during the whole of the investigation is included in the papers. If we need any particular piece of evidence, statement etc that has not already been copied then we simply have to make a request. All the statements obtained in connection with the top ten cases have been included in the papers handed over to me.

   I asked if the police looked at the possibility of prosecuting any other Doctors / Medical Staff as part of the investigation. Code A told me that Code A was a suspect. He was one of the consultants who supervised Code A in the period when Code A died. He was interviewed under caution on a voluntary basis on three occasions. The interviews deal with his general involvement as a consultant and also specifically with regard to the Code A and Code A cases. No charges were brought against Code A In addition to Code A

Code A, at different times, Code A supervised Code A
None of the other consultants fell under suspicion.

The police have sent papers to the Nursing and Midwifery council. Code A told me that some reports criticised a sister in charge of one of the wards, Code A She has provided statements. At one stage it was proposed to interview her under caution but this did not happen and no charges have been brought against her.

Code A told me that there were four further category 3 cases (where negligence had been found). The papers in respect of these cases have not been copied. The copies can be provided on request.

By way of general background information, Code A told me that over a period of time the care of patients at Gosport had become more intensive. Initially patients were referred to the hospital for rehabilitation / continuing care. Due to pressure on beds at the Queen Alexandra Hospital, from approx 1995 - 1996 onward, more serious cases had been referred to the Gosport hospital.

Code A did four sessions a week at Gosport. Code A view, the demands of the job required a full time post and when Code A left her post in 2000 a full time post was created.

I asked about the decision not to prosecute. In Code A view it was always going to be difficult to bring a prosecution in this case after the CPS had made a decision not to prosecute in 2002.

Code A thinks that Code A is now aged about 60. At the time that she was working as a Code A at Gosport she was also the practice manager at a surgery. She took on far too much work. As practice manager she would never have had enough time to also cover work at the Gosport Hospital properly. She should have known this. Query whether her decision to take on the extra workload was made on a financial basis.

Code A

Code A mentioned that Code A was responsible for two wards at Gosport, there was a further ward - Code A (ward?) where patients were referred by their own GP's and their own GP's were responsible for looking after them whilst they were in hospital. Code A prepared a report on behalf of the Commission for Health improvement, which includes a statistical analysis of deaths on the two wards covered by Code A and the third ward covered by other GP's.

Code A

NOTES OF MEETING

Code A

19/10/07

ed docs to CPS

have everything except

from Code A

d by Chief medical

dice – it is proof of

Code A

– his report open to police

ecipient – no reply as yet

to request for disclosure.

3x files Cervical cancer file +

two email files

[Whole of investigation ≈ 1997–2006

x3 Investigations in total – all

referred to in Serving.

→ Cleared docs to CPS

— We have evidence except report from **Code A** commissioned by Chief Medical Officer — it is property of

Code A

— his report given to police & referred — no copy as yet to request for disclosure.

3x files Generic case file + two exhibit files

[Whole of investigation ~~as~~ 1997–2006

x3 Investigations in total — all referred to in Summary.

Further Evidence – Core files

– 0 Dec 2004 evidence in from Cmmd Ltr

→ Evidence after Dec 2004 in further evidence file

Code A Files retain written statements, exhibits + evidence of interviews]

Individual Patients

eg. Cemyplan

Code A

[critical exams will involve
reading - new exams
need a late invitation]

[or x3 previous exams
in the discipline and where
appr is knowledge/procedural
x2 main exams]

— In all x10 cases.
Both graded x11 students
— Typed turned into
caution - at each she
tendered a repeat student

what she read —
Schools who no better
Council

— Question put to her of
all 10 interviews —
Still made no comment

— Only 4 college interviewed
re x 8 Cases. [left

Code A

— they
were week cases]

— College interviews for ~~xx~~ x 3/4
cases are in the papers —
to date 3/4 have been
typed up [ ] we wait
on d tapes — ash]
— Re they bring anything to the

→ Inquiry →

→ In respect of each

patient there are 6 or 7
colleges
(minimum of about 45 min.

=

Whether

— ① Family Group
members
② Patient GP
③ Consultant
④ Nursing staff
- senior
- trained
- auxiliary
⑤ police officers (eg to
produce exhibits)

→ Patient records - from hospital
Gastro + if applic. ITAS etc. hospital
→ Copies from medical
- only care in **Code A**

* [We still have original records - will keep in custody]

→ Family carers - also have written to all relatives - request to consent to our papers - all consented apart from

Code A then

Code A - only relevant]

- Police have write to **Code A**

Code A - ~~text~~ to whom

test pipes will be checked
with / w/o cement.

* Colour of cement not in
pipes provided to us
- we have simple cement from

- Code A for the
make cement

- 1-10 - All deaths
999

opinion

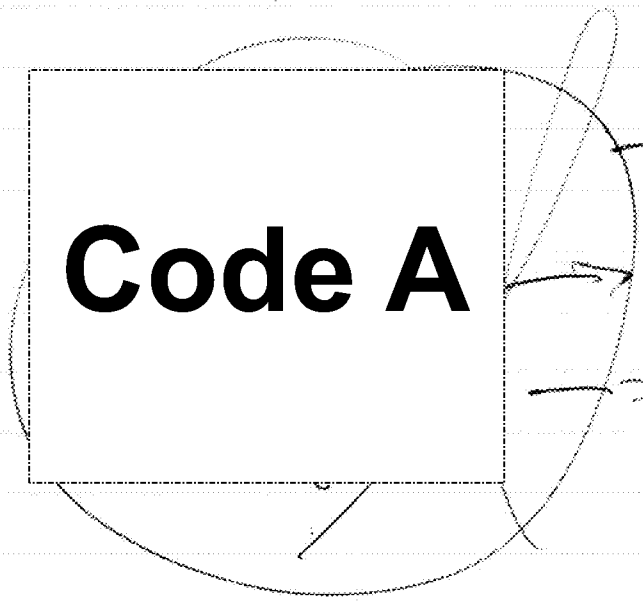
Intervention
Level
give wit
Item 3

Code A

→ Focus to share counting
a little cards - but
responses may not have been
any more i data cards.

⇌

→



→ All type **Code A** does
send to Core Network

Code A - key check
team - to export i check
fields - they reviewed with +
put case into

categories - Code

Code A ↔ [Quality assured the findings of the experts

- filtering process - 92 cases ⇒ 10 cases

↔ Code A / Blue provided detailed reports.

Code A report + reports from Key Clinical team not in our papers]

→ Cert. 1 +2 cases

papers → GMC → included the clinical team findings and Code A quality assurance, if applicable

- Where to direct report by case.

→ All types of Cat 1 + 2 - 82 Hep → GMC → submitted to GMC

→ GMC have picked up reports from events & Key Guard Tea

[Nursing]

Code A

[Nursing assessment, documentation.]

[Toxicology?]

→ 16/12/04 eg. Apes sent to GMC

- include review of experts

→ phs police officer expert

→ Report by **Code A**

→ ∴ All expert evidence submitted to GMC

→ We can write - police still have item.

→ Key chief been independently reviewed

- Now take discussion / joint agreement 1, 2, 3 by

- Per device structure & [illegible] in quick succession

- [illegible] agreed

Where to [1, 2 +]
and A, B, C [cause of death]

→ 1 = optimal care

2 = sub-optimal care (includes poor + useless)

3 = neglect

4 = intent to cause harm
[none in this category]

A = Natural death
B = Unclear
C = Unexplained by illness.

[on X3 occasions she
needed to have closed
[illegible] a case of a gloss
4 – when need table
X3 cases ended up as class 3.]

GMC101181-0103

Code A

— Experts & Medical Records.

* [Cut note for 10 are put in boxes - this will be provided]

— We asked for a list of surgeries + procedures

— Index of all patients taken in the whole surgery + exhibits.

→ If there is anything of these we can request copies.

→ NB. Any student re the 10 cases is in our papers.

→ Mr

→ Qualified Midwife = Code A

- day to day care

→ Supervised by consultant

(varied are due)

Code A

Code A

Supervised by

Code A

Code A are obtained via

caution a a [illegible] basis a

X 3 Code A - generally +

with epid

Code A

[M his typed [illegible]

at a [illegible] bridle]

- no [illegible] bright again

Code A

→ Form criticism of
sister i charge of
ward by one Expert

→ **Code A**

the mode + Student
in majority of cases
- a no of two records
the doctor - purpose
to identify the underlying
→ MSR identified under
Code A → no
cleaner

Code A = 16/12 Dec 04

Code A

a note of cases for the
Chief Medical officer →
Report prepared by **Code A** on
behalf of Chief Medical Officer

- This is the only report not submitted to us.

Code A

10 Sept 2004
- 29 Sept 2005.

→ police and nurses &
Nursing & midwifery
Council re Cat. 1 + 2
cases - They were at
Strike Ballot meeting

→ No date given when
suspicion

Other consultant? -
visits weekly - consultant
may not have seen patient
before he/she died

- Conduct - walk and round

Code A

are 4 years the conduct is clear.

→ Apart from need no dens ride suspicia.

Other 4 cases referred to as Class 3, - i.e. registered included in bundle

→ DJ we want details —
ask he report

→ what training to key
Acute Team?

=

Care d patients d respond
become more intensive
are c need — more
severe mental conditions
— Initially — rehabilitation
coming care — but to
do to prove a bed
at Queen Alexandra hospital
from 95/96 (?) — more
severe care offered

— She had a ... ms x 4
Sessions a week i 90
but due to demand —
it really varied.
2M time post — the
she left i 2000 ...
the post was created

→ CPS — desire in 2002
— having made this change
going to be a challenge to
persuade them to change their
mind

→ Some print production is
available in addition to
briefing note to network
Experts (key channel
team).

- Briefly upto Jan
Black [redacted] Code A

↔ Code A - now aged
about 60:

→ At one time she was
practising a range of
practice - hospital
work, shared care

→ Transplant/
Surgery

"Word of mouth"

D+D [redacted] Code A
Scalia work - talking
upto patients - were patients own
GP's

Code A

report
analysis

Covering the 3 words

Commission for Health Improvement Report

Bolam Report

Report into co-operation of staff - compromised position of CHI if police had relied on it in their investigation

Report for Commission of Health Improvement July 2002

Investigation into the
Partnership Healthcare
NHS Trust & Gosport
War Memorial Hospital

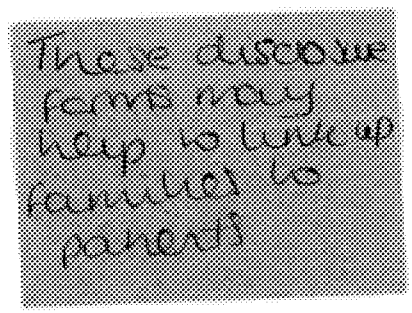
→ Not aware of Trust
chair/CEO investigation /
report.

XIO aware investigation started
in Sept 02 i.e. after
the publication of the CHI
report.

→

Code A

GP not provided at end of week — ~~at~~ for 7 of the 10.


These discourse
forms may
help to tune up
formulas to
patients

Docs received from Code A at meeting on 18 Jan. 2007.

SHIRE JULARY

SURE OF MEDICAL RECORDS

I HEREBY AUTHORISE HAMPSHIRE CONSTABULARY TO DISCLOSE:-

1) MEDICAL RECORDS
2) ANY OTHER RELEVANT INFORMATION

THAT HAS BEEN OBTAINED DURING THE COURSE OF THE POLICE INVESTIGATION TO RECOGNISED OFFICIAL REGULATORY BODIES. I UNDERSTAND THAT HIS INFORMATION WILL ONLY BE DISCLOSED IF IT MAY BE OF USE TO ANY SUBSEQUENT INVESTIGATION.

I FURTHER AUTHORISE THE POLICE TO DISCLOSE THIS INFORMATION TO ANY PERSON ACTING ON BEHALF OF ANY OFFICIAL REGULATORY BODY.

AS NEXT OF KIN I AUTHORISE THE POLICE TO MAKE DISCLOSURE IN RESPECT OF:-

MR/MRS/MS Code A [a]

(PLEASE PRINT THE FULL NAME OF THE FAMILY MEMBER)

Code A

DATED 12 December 2006

PRINT NAME

Code A

HAMPSHIRE CONSTABULARY

WRITTEN CONSENT TO DISCLOSURE OF MEDICAL RECORDS

I HEREBY AUTHORISE HAMPSHIRE CONSTABULARY TO DISCLOSE:-

1) MEDICAL RECORDS
2) ANY OTHER RELEVANT INFORMATION

THAT HAS BEEN OBTAINED DURING THE COURSE OF THE POLICE INVESTIGATION TO RECOGNISED OFFICIAL REGULATORY BODIES. I UNDERSTAND THAT HIS INFORMATION WILL ONLY BE DISCLOSED IF IT MAY BE OF USE TO ANY SUBSEQUENT INVESTIGATION.

I FURTHER AUTHORISE THE POLICE TO DISCLOSE THIS INFORMATION TO ANY PERSON ACTING ON BEHALF OF ANY OFFICIAL REGULATORY BODY.

AS NEXT OF KIN I AUTHORISE THE POLICE TO MAKE DISCLOSURE IN RESPECT OF:-

~~MR~~./MRS./~~MS~~ ..... Code A .....

(PLEASE PRINT THE FULL NAME OF THE FAMILY MEMBER)

Code A

DATED

22 December 2006

PRINT NAME

Code A

OPERATION ROCHESTER

Guidance for Medical Experts

Overview.

Operation ROCHESTER is an investigation by Hampshire Police into the circumstances surrounding the deaths of elderly patients at Gosport War Memorial Hospital.

Nine such cases are subject to ongoing investigation. The brief to medical experts in this respect is to examine the medical records and to comment upon the standard of care afforded to those patients in the days leading up to their death. If the care falls below what were then the acceptable standards of the day, the opinion sought would be, how far below the acceptable standards or practice did the care fall?

It may be the case however that the experts determine that the standard of care afforded was acceptable.

Any opinion should be limited to for example, stating that it would have been obvious to the reasonably prudent and skilful doctor in the defendant's position that their actions would hasten or end life.

Whatever the view of the experts, their statements of evidence/reports should be constructed with the following principles in mind:-

1) What treatment should have been proffered in each individual case? Experts should cover in their report the basic conditions of a particular disease and how the symptoms present themselves. They can then go on to describe how the condition would ***normally*** be treated in their own experience, referencing to recognised protocols of the day.

2) When creating reports the experts must bear in mind 'plain speak'. Whilst it is important to be professionally correct, opinions are likely to be challenged by defence experts. Equally reports should be set out in a way that allows for the police/counsel etc to dissect the report and ask for further work or clarification.

3) Experts should have an understanding of the terms Criminal Gross Negligence, and Unlawful Act within the context of Homicide. Language used to describe negligence should be consistent, and if appropriate able to demonstrate why one act is more negligent than another and the level of negligence.

4) When reading the statements of the experts the prosecutor will be looking to apply the criminal standard of proof namely, the evidence to prove any element of the offence must be sufficient to satisfy the jury so that they are sure, or satisfied beyond reasonable doubt. Experts should bear this in mind when expressing opinions or findings so that it is clear as to the level of certainty they can give. Is it for example, only to the level of more likely than not (i.e. on the balance of probabilities), or to the higher level, of being sure so that other reasonable possibilities can be excluded

5) Consideration must be given to explaining the use of statistical information in reports and what the statistics are seeking to establish.

6) Referenced documentation supporting any report must be included.

7) Analysis of supplementary paperwork such as prescription charts/fluid charts/observation charts needs to be undertaken. Paperwork differs from ward to ward let alone hospital to hospital. Ensure that if experts are commenting on procedures that have been carried out and are critical that they have already documented what procedures should have been in place and carried out in ***their*** experience. They cannot assume that the practices they follow are the same as the ones used by the staff at this hospital. They must spell things out.

8) Expert will be supplied with copies of relevant hospital protocols / procedures.

In order to assist experts with an understanding of the law the following passages may be relevant during their determinations.

UNLAWFUL ACT MANSLAUGHTER

'Unlawful act' manslaughter requires that:

(a) the killing must be the result of the accused's unlawful act, though not his unlawful omission. It must be unlawful in that it constitutes a crime. A lawful act does not become unlawful simply because it is performed negligently. The act must be a substantial (more than minimal) cause of death, but not necessarily the only operative cause (see "Causation" below);

(b) the unlawful act must be one, such as an assault, which all sober and reasonable people would inevitably realise must subject the victim to, at least, the risk of some harm resulting there from, albeit not serious harm;

(c) it is immaterial whether or not the accused knew that the act was unlawful and dangerous, and whether or not he intended harm; the mental state or intention required is that appropriate to the unlawful act in question; and

(d) "harm" means physical harm.

(Church [1966] 1 QB 59, DPP v Newbury [1977] AC 500, Goodfellow (1986) 83 Cr App R 23)

GROSS NEGLIGENCE MANSLAUGHTER

"Gross negligence" manslaughter requires the satisfaction of a four stage test:

(a) The existence of a duty of care owed by the defendant to the deceased;

(b) A breach of that duty of care, which

(c) Causes (or significantly contributes to) the death of the victim (see "Causation" below);

(d) And the breach should be characterised as gross negligence and therefore a crime.

(Adomako [1994] 3 All ER 79)

The standard and the breach are judged on the ordinary law of negligence. Those with a duty of care must act as the reasonable person would do in their position. The test is objective. It does not matter that the defendant did not appreciate the risk, provided that such a risk would have been obvious to a reasonable person in the defendant's position. The risk in question is a risk of death.

MURDER

Murder is the unlawful killing of a person with the intention to kill or cause grievous bodily harm. Nothing less will suffice. Foresight that a consequence is almost certain to result is not the same as intention, though it may be evidence of it. There is some legal authority for the proposition that, where the sole, bona fide intention of a doctor is the relief of pain through the administration of drugs, knowledge that those drugs will, as an unwanted side effect, also inevitably hasten the patient's death, that is not murder.

CAUSATION

When prosecuting for an offence of homicide, there are a number of elements the Crown has to prove, and has to prove them to the criminal standard i.e. 'beyond reasonable doubt.' One of those is the element of 'causation'. In simple terms this means that the prosecution must prove that the death was 'caused' (wholly or in part) by the defendant and ought to be straightforward but, '(W)here the law requires proof of the relationship between an act and its consequences as an element of responsibility, a simple and sufficient explanation of the basis of such relationship has proved notoriously elusive.' - *R v Cheshire* [1991] 3 All ER 670.

Recent experience has identified causation as a difficult element to prove in certain types of cases. These are typically, but not exclusively, cases involving medical negligence.

The classic statement on causation in manslaughter was provided by the present Code A Code A in *R v HM Coroner for Inner London, ex parte* Code A 998) 1 All ER 344:

"...that the unlawful act caused death in the sense that it more than minimally, negligibly or trivially contributed to the death.

"In relation to both types of manslaughter it is an essential ingredient that the unlawful or negligent act must have caused the death at least in the manner described. If there is a situation where, on examination of the evidence, it cannot be said that the death in question was [not] caused by an act which was unlawful or negligent as I have described, then a critical link in the chain of causation is not established. That being so, a verdict of unlawful killing would not be appropriate and should not be left to the jury."
(There is an additional 'not' [now in brackets] in the penultimate sentence, otherwise the sentence does not make sense.)

It can be seen from this that the prosecution **must** be able to link the act to at least **an** operative cause of death. It is not sufficient to say that it **may have been** a cause of death.

Hastening/acceleration of death

This can be one of the most difficult aspects of causation. The 'hastening' or 'acceleration' of death and whether depriving a person of the opportunity to live can be a cause of death.

Death is inevitable. Any **action** that brings that day forward can therefore be said to have hastened or accelerated death and will itself be a cause of death. The case most often cited for such a proposition is Code A [1909] 1 Cr App R 13. There the defendant had assaulted a child in November 1906 and December 1907. The child died in March 1908 but the charge of manslaughter did not specify the date of the assault (the 'year and a day' rule was then in force.) The child's condition had deteriorated as a result of the 1906 assault but the court said that the judge should have directed the jury to consider 'whether the appellant accelerated the death by his injury of December 1907'. In allowing the appeal the court said that 'it was not absolutely certain that the death had been accelerated' by the second assault as 'death may have been due to a fall'.

This is not a controversial proposition as it is simply a question whether the later act of the defendant brought about the death. Even if the deceased is dying (subject to the *de minimis* rule in *Sinclair*), if the defendant's act shortens life, causation is proved.

De minimis

It would not be sufficient to prove causation if the Crown could only show that the victim would have survived 'hours or days in circumstances where intervening life would have been of no real quality.' It is this meaning that is taken when referring to the *de minimis* rule. For example, if 'V' is dying, is in a coma, on life support and the defendant's act or omission brings forward the date of that inevitable death by hours or even days, if it can be said that there was 'no real quality' of life in that intervening period, the *de minimis* rule would apply. This is to be contrasted with a situation whereby the act or omission caused the coma and ensuing death or where there was a significant period between the act or omission and the ensuing death. It is not possible to be more definite as to the duration here but if 'V' survived in that state for more than a few days, *de minimis* would not apply and the ordinary rule of causation would do so instead.

Multifactorial

The insuperable difficulty comes when the doctors cannot say when or even if he may have died even if treated appropriately. This may be because they do not know the underlying cause of the illness or there are numerous factors present at death and it is not possible to identify which, if any had an operative influence on the death. In instances such as these, the death may be certified as 'multifactorial'. Although such a term should provide a warning to a prosecutor as to proof of causation, it does not necessarily mean that we cannot prove causation. If we can prove that one of the operative causes of death was due to the act or omission of the defendant, then this is sufficient to prove causation. Causation does not require that the particular cause would have caused death on its own, provided it is sufficient to be an operative **contribution** to the cause of death. Therefore, if the doctor in citing 'multifactorial' says that death was caused by a combination of factors and that factor 'X' was a more than minimal **contribution** to death (even if on its own it would not have caused death), if 'X' was caused by the act or omission of the defendant, we can show causation. This is so even if any one of the other factors would have been sufficient to have caused death on their own. This is an area that needs to be carefully analysed. What will not be sufficient to prove causation is a statement that, death was caused by any one or more of a number of causes and it cannot be said for sure that the relevant one was an operative cause, only that it might have been.

Code A

OPERATION ROCHESTER

Guidance for Medical Experts

Overview.

Operation ROCHESTER is an investigation by Hampshire Police into the circumstances surrounding the deaths of elderly patients at Gosport War Memorial Hospital.

Nine such cases are subject to ongoing investigation. The brief to medical experts in this respect is to examine the medical records and to comment upon the standard of care afforded to those patients in the days leading up to their death against the acceptable standards of the day. Where appropriate, if the care is found to be sub optimal comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

It may be the case that the experts determine that the standard of care afforded was acceptable.

Conversely it may be determined that the standard of care delivered to those patients was either sub optimal, negligent or intended to hasten or end life.

Whatever the view of the experts, their statements of evidence/reports should be constructed with the following principles in mind:-

1) What treatment should been proffered in each individual case? Experts should cover in their report the basic conditions of a particular disease and how the symptoms present themselves. They can then go on to describe how the condition would ***normally*** be treated in their own experience, referencing to recognised protocols of the day.

2) When creating reports the experts must bear in mind 'plain speak'. Whilst it is important to be professionally correct, opinions are likely to be challenged by defence experts. Equally reports should be set out in a way that allows for the police/counsel etc to dissect the report and ask for further work or clarification.

3) Experts should have an understanding of the terms Criminal Gross Negligence, and Unlawful Act within the context of Homicide. Language used to describe negligence should be consistent, and if appropriate able to

demonstrate why one act is more negligent than another and the level of negligence.

4) Experts need to be clear from the outset that the language to be used in these cases will apply to the criminal standard of proof 'sure beyond all reasonable doubt' 'causative' etc, not 'balance of probabilities.'

5) Consideration must be given to explaining the use of statistical information in reports and what the statistics are seeking to establish.

6) Referenced documentation supporting any report must be included.

7) Analysis of supplementary paperwork such as prescription charts/fluid charts/observation charts needs to be undertaken. Paperwork differs from ward to ward let alone hospital to hospital. Ensure that if experts are commenting on procedures that have been carried out and are critical that they have already documented what procedures should have been in place and carried out in ***their*** experience. They cannot assume that the practices they follow are the same as the ones used by the staff at this hospital. They must spell things out.

8) Expert will be supplied with copies of relevant hospital protocols / procedures.

In order to assist experts with an understanding of the law the following passages may be relevant during their determinations.

MANSLAUGHTER BY UNLAWFUL ACT.

The following statements in respect of manslaughter resulting from an unlawful act are established:-

a. Death must be the result of an unlawful act, not omission.

b. The unlawful act must be one which all sober and reasonable people would inevitably realise must subject the victim to at least the risk of some harm resulting there-from even though it may not be serious harm.

c. It is immaterial whether or not the accused knew that the act was unlawful and dangerous and whether or not harm was intended.

d. Harm means physical harm.

The House of Lords have approved the following for the meaning of unlawful act.

"Where the act which a person is engaged in performing is unlawful, then if at the same time it is a dangerous act, that is, an act which is likely to injure another person, and quite inadvertently the doer of the act causes the death of that other person by that act, then he is guilty of manslaughter."

MANSLAUGHTER BY GROSS NEGLIGENCE

The court in the case of R v Adomako (1993) created the following test for such manslaughter:

(a) Was there, in the circumstances, a duty of care owed by the defendant to the deceased (assuming the Judge has ruled that on the facts such a duty was capable of arising)?

(b) Was there a breach of that duty?

(c) Did that breach cause the death of the deceased or was there a foreseeable risk of death by reason of it (R v Singh, 19/2/99)?

(d) Should the breach of duty be characterised as gross negligence and therefore characterised as a criminal act?

This ruling has become the standard test for such cases and it is important therefore that it is taken into account when reports are compiled.

This criminal offence can be complicated to prove. In medical based enquiries clinical experts can assist the authorities in assessing whether an offence has been committed by addressing certain key areas in their reports. The most important area for a clinician to comment upon is causation. With this point in mind consideration needs to be given as follows:-

For causation to be proved, the unlawful actions of the potential defendant need not be the only cause of death, nor the main cause provided they amount to a more than minimal cause of, or contribution to death. '

For any homicide, the burden is on the Crown to prove beyond reasonable doubt that the act (or omission) 'caused death in the sense that it more than minimally, negligibly or trivially contributed to the death' (the 'de minimis' rule). Unless the crown can establish that the act or omission was a cause of or a substantial contribution to the death, an essential link in the chain of causation is not established.

Murder.

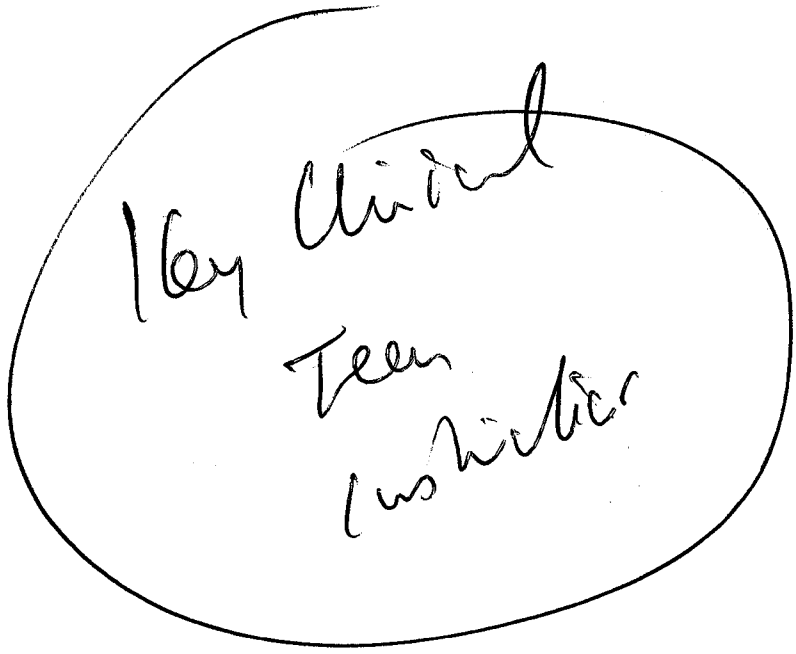
Murder is defined at common law as 'where a person of sound mind and discretion unlawfully kills any reasonable creature in being with intent to kill or cause grievous bodily harm.'

Unlawfully means without legal justification or excuse.

Lawful conduct would be bona fide surgical or medical treatment.

The defendants Act must be the substantial cause of death. Must not be so insignificant as to be dismissed by the court on the deminimus principle.

27th July 2004.


16y Clinical
Teen
Psychiatrist

EVERSHEDS

attendance

Client General Medical Council
Matter Code A
Attendees

Date 17 January 2007
F/E Code A

Code A

The case involving Code A has already been referred to the PCC.

Code A wanted to know if I would see all the expert evidence that has been prepared in this case. I explained to her that I am due to go to meet the Hampshire police tomorrow to collect all their paperwork. I also explained that on receipt of this I would have to analyse all the material, I will then be giving advice to the GMC as to which are the strongest cases to take forward. She hoped that her mothers case would not be dropped in the process. I could not make any comment one way or the other in connection with this. I simply retreated that we need to analyse each case very carefully and advise the GMC as to the strength of each case. I also explained it would take a little time to do this.

She told me that the police had not got all the evidence in respect of her mothers case. She referred in particular to a witness who she claimed had told her that a false death certificate had been prepared in her mothers case but the police had not interviewed the witness in connection with this.

She also told me that she had heard a rumour that a police officer had interviewed an expert witness - Code A and allegedly told the expert not only how he should write his report but what should be included in it. I said I would make a note of this but I cautioned against information being distorted by the "Bush Telegraph" effect in which information can be passed around. I said that we would be looking at all the expert evidence very closely.

We would also be seeking to identify any further evidence - expert or factual, where necessary in each case.

She told me that she had made a complaint against one of the nurses involved in her mothers case and that she does not know what is happening in connection with that.

She was polite throughout the conversation and thanked me for listening.

Code A

Code A

From: Code A
Sent: 17 January 2007 08:39
To: Code A
Subject: FW: TRIP TO FAREHAM ON THURS 18 JANUARY

From: Code A
Sent: Wednesday, January 17, 2007 8:39:10 AM
To
Cc Code A
Subject: FW: TRIP TO FAREHAM ON THURS 18 JANUARY
Auto forwarded by a Rule

Please see attached. I did ask that any response be made direct to Code A but I don't think he will have received it.

From: Code A
Sent: 17 January 2007 08:36
To: Code A
Subject: RE: TRIP TO FAREHAM ON THURS 18 JANUARY

Code A
Booked in diary, will use the 6 seater Merc and depart at 08:00.
Regards
Code A

-----Original Message-----
From: Code A
Sent: 15 January 2007 10:24
To: Code A
Subject: TRIP TO FAREHAM ON THURS 18 JANUARY

**** Before acting on this email or opening any attachment you are advised to read the Eversheds disclaimer at the end of this email. ****

THIS EMAIL HAS BEEN SENT ON BEHALF OF Code A PLEASE REPLY DIRECT TO ROB AT THE EMAIL ADDRESS GIVEN BELOW.

Dear Code A

I refer to our telephone conversation today and confirm that I need someone to collect me from Colwinston and take me to Fareham in Hampshire for a meeting with the Police. The address is Quay Street, Fareham, PO16 0NA.

The meeting is scheduled to start at 11.30 am and will last for one to two hours.

As explained on the telephone, I will be collecting approximately 8 archive boxes of documents, so we will need a 'people carrier' or one of the large Mercedes cars.

Please confirm that you are able to arrange transport and let me know the pick up time from Colwinston.

Kind regards

Code A

Associate

Code A

e:mail: Code A

EVERSHEDS

telephone

Client	General Medical Council	Date	15 January 2007
Matter	Code A	F/E	Code A
Attendees			

I telephoned Code A at the Hampshire Police in Fareham. He confirmed that the photocopy documents will be ready for collection this week. We arranged that I would go down to Fareham to collect them on Thursday. I will be there at 11.30. He said that either he and/or Code A would be able to meet me to go through the documents. He confirmed that there are about 8 banker's boxes of documents to be collected. He gave me the following directions:-

Head for Portsmouth along the M2. Take Junction 11. Then over a roundabout. Stay in the right hand lane. Drop down a hill onto another roundabout. From there you will see a large public car park. (He suggested that I park there.) There is a huge cinema and the police station is to the right of the cinema.

I then telephoned Code A to make the necessary travel arrangements.

Code A

4013

attendance

EVERSHEDS

Client General Medical Council
Matter Code A
Attendees

Date 10 January 2007
F/E Code A

Code A received a telephone call from Code A She said that she had heard a snippet of information this morning which she felt she needed to pass on to us although she appreciates that we will be unable to comment. She said that she has been reluctant to engage with any of the other Gosport families as she noticed at a very early stage that shortly after she had relayed the events of what happened to her mother, the other families would report similar incidents having happened to their family member a short time afterwards. However, she has heard today that Code A of FFW who was advising the police refused to sign something off. She is not sure if he was refusing to sign off for the evidence relating to her mother to be forwarded to the CPS or whether he was refusing to sign off for the case to be closed. Code A said that it was not appropriate for her to comment on another solicitors conduct but thanked Code A for the information.

Code A

From: Code A
Sent: 05 January 2007 11:29
To: Code A
Subject: RE: Operation Rochester

Code A
Many thanks.I will call you on the 15th January as suggested so that we can make the necessary arrangements.
Regards
Code A

From: Code A
Sent: 05 January 2007 10:47
To:
Cc: Code A
Subject: RE: Operation Rochester

Code A

You are more than welcome to collect the paperwork once it has been completed. We can also arrange a date and time when either myself or the case officer will be able to explain what we are presenting and hopefully address any questions that you may have.

In respect of the amount of material. I would estimate around 8 large boxes which you could get in an estate vehicle with the back seats down.
If you would like to contact me again on the 15th the papers should be complete and I can give you a better idea of the size of vehicle needed if you are hiring one.

Regards

Code A

From: Code A
Sent: 05 January 2007 10:09
To: Code A
Subject: Operation Rochester

**** Before acting on this email or opening any attachment you are advised to read the Eversheds disclaimer at the end of this email. ****

Dear Code A

Thank you for your e-mail on 2 January.

On reflection, I think it would probably be best if we arranged to come and see you when all the photocopying

has been completed. It would be helpful to have a short meeting with you or someone else who is involved in the investigation who is fully familiar with all the paperwork. We can collect the photocopied documents at the same time. I understand there is a large volume of material. Would this fit into a car or would we need to arrange special transport facilities?

I look forward to hearing from you.

Regards

Code A
Associate

Code A
International: +44 20 7497 9797

www.eversheds.com

seen by employees other than the intended recipient.

****

Code A

From: Code A
Sent: 05 January 2007 10:09
To: Code A
Subject: Operation Rochester

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Wader please check to see if this has been filed. Thanks 4/1/3

attendance

Client General Medical Council
Matter Code A
Attendees

Date 2 January 2007
F/E Code A

Telephone call to Code A LM explained she had a message from Code A who is confused as to why we are writing to her as she had been informed in 2002 that the matter had already been investigated.

Code A explained she could not find volume 2 of the correspondence files relating to the PPC decision so was unsure as to what Code A had been informed. PH found the letter sent to Code A following the PPC decision and it confirmed that the case had been referred to the PCC. Code A advised that Code A acts very much as a spokesperson for the family members, and that he has been in regular contact with her.

Code A therefore telephoned Code A She was confused by our letter as she was not sure that Code A appreciated that the case had already been referred to the PCC. Code A reassured Code A that she was aware of this, and that the purpose of the letter had been twofold, first to explain that whilst the police are not prosecuting, this does not prevent the GMC continuing and secondly to introduce ourselves as there will now be further contact from us as we are now investigating as the police investigation is over.

Code A asked if we had seen her statement. Code A confirmed that she had seen her police statement and also a statement from her sister, Code A informed Code A that she and her sister are estranged. Code A asked if we had seen Code A second statement. Code A said that she did not believe she had but that we were awaiting the police material. Code A said that there were several issues regarding Code A evidence. Code A saw Code A the nurse, administer two injections that were not written up in the notes. Code A also was told that there were no signs of a haematoma, yet this was recorded as the cause of death on the death certificate. Code A had informed the police that she was aware that the death certificate was incorrect, but was advised by the police not to include this detail in her witness statement. Code A said that she believed her sister had committed an offence in accepting an incorrect death certificate. A further statement was taken from Code A in 1999. Code A was concerned that this statement was never passed to the CPS. Code A said that our investigation is entirely separate and if she had issues with the police investigation she should raise those in writing with the police.

Code A explained that we are conducting an entirely separate and thorough investigation which whilst we will begin by looking at the police material. Code A said that once we had read the material from the police, it is likely we will be in touch to possibly take further evidence from her if there is further information to be added. Code A said that she was sure that there were gaps. Code A explained that if there are gaps we will endeavour to fill those. Code A explained however, that we are looking at an entirely different test from that of the police, we are looking at whether there are failures to meet the standards in Good Medical Practice which may include failure to record in notes, improper care, wrong treatment decisions etc. Code A said that we may also need to take a further statement from her sister. Code A has said from the very beginning that she

wanted nothing to do with the investigation and Code A does not even have an address for her.

Code A was concerned that Code A was not solely to blame, that the nurse, Code A was also responsible. Code A explained that the GMC can only look at conduct of practitioners registered with them, and therefore any concerns she has in this regard should be raised with the Nursing and Midwifery Council.

Code A explained that there had been 5 separate investigations been carried out by the police over time, and that she has complained to the IPCC about the police conduct of the case. Code A gave details of each of the police investigations dating back to 1999. Her first complaint predated the Code A Inquiry, yet she now believes that there has been a cover up to ensure that the public is never aware of another Code A She explained that the investigation had been reopened when complaints regarding the treatment of other patients had been made through for example the Ombudsman. She also said that the Commission for Healthcare Improvement had carried out an investigation and produced a report, but they did not interview her. She said that many of the relatives had emerged. when the Health Authority printed a request for anyone with any concerns to come forward, and she was aware that there were 92 patients involved in total. She asked whether all 92 would be involved in the GMC case. LM said that she would have thought that the GMC case will consist of a sample of the cases, but she has no instructions on this from the GMC as yet but 92 would be a very large number.

Code A warned that she did not believe the material will be as quickly in arriving as Code A expects as she is aware that the last meeting with the relatives and the CPS is not taking place until 13 January and that the police are holding on to their papers until after then. She criticised the fact that these meetings are taken place after the decision not to prosecute has been made.

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Code A

From: Code A
Sent: 02 January 2007 15:16
To: Code A
Subject: FW: Operation Rochester

Hi Code A

I've received the attached reply from Code A

Ta
Code A

Code A

Code A
International: +44 20 7497 9797
www.eversheds.com

From: Code A
Sent: 02 January 2007 14:20
To:
Cc: Code A
Subject: RE: Operation Rochester

Mr Code A
I'm not sure whether we can assist you any further at the present moment. The files are being prepared on a case by case basis. I hope that by next Monday there will be two or three cases complete. The case papers will include not only the medical notes but also copies of witness statements and expert reports. Each component part of the case will be required to enable a full assessment to be made.
I have provided similar information for analysis to GMC IOC panels in respect of a number of investigations during the last 7 years. I'm sure that no decision will be made in respect of a hearing until all the papers have been considered for every case. With this in mind we will supply a full set for each case as they are ready.
I'm more than happy to release the papers to you on a case by case basis if this would allow you to speed up your own processes. Please feel free to contact me at anytime either with this email address or on the below number
Regards

Code A

From: Code A
Sent: 02 January 2007 12:57

To: Code A
Subject: FW: Operation Rochester

**** Before acting on this email or opening any attachment you are advised to read the Eversheds disclaimer at the end of this email. ****

From: Code A
Sent: 02 January 2007 11:07
To: Code A
Subject: FW: Operation Rochester

From: Code A
Sent: 22 December 2006 14:08
To: Code A
Subject: Operation Rochester

Dear Code A

I refer to your email sent to my colleague, Code A yesterday in response to our request for copies of documents relating to the 14 category 3 cases.

I note that given the volume of documents the copying process will not be complete until the middle of January 2007. In view of this I wonder whether it would be possible to prioritise copying of the medical evidence in each of the 14 cases, in the hope that this may be ready for collection at an earlier date.

The information is required by the GMC to assist in the consideration of an interim orders panel hearing in this case.

Regards.

Code A
Associate

Direct Dial: Code A
International: +44 20 7497 9797
www.eversheds.com

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EVERSHEDS

attendance

Client General Medical Council
Matter Code A
Attendees

Date 2 January 2007
F/E Code A

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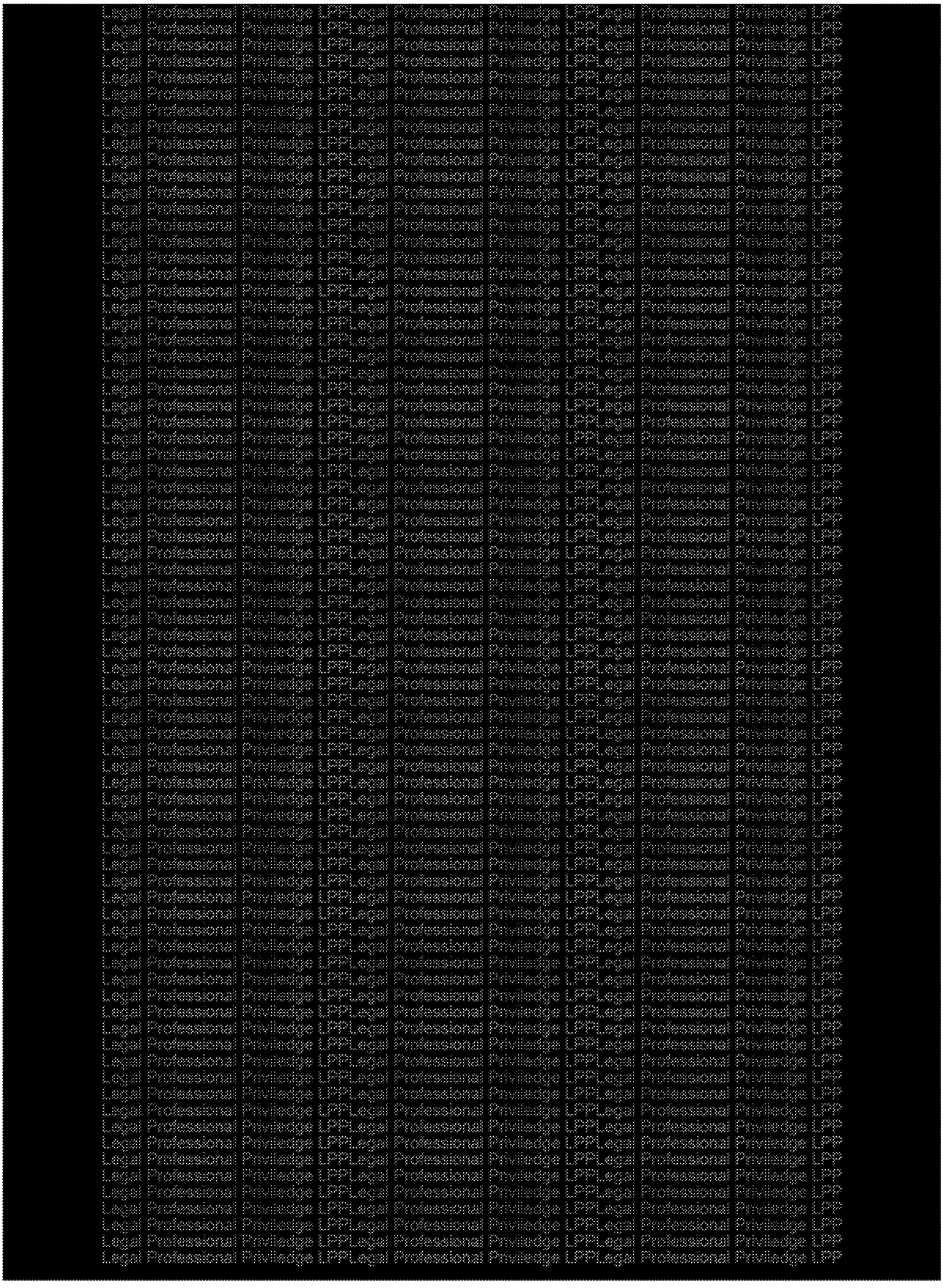
Legal Professional Privilledge LPP

Code A

From: Code A
Sent: 22 December 2006 14:08
To: Code A
Subject: Operation Rochester

Dear Code A

I refer to your email sent to my colleague, Code A yesterday in response to our request for copies of documents relating to the 14 category 3 cases.

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Regards,

Code A
Associate

Direct Dial: Code A
International: +44 20 7497 9797
www.eversheds.com

22/12/2006

Code A

From: Code A
Sent: 22 December 2006 09:57
To: Code A
Subject: FW: letter to Code A
Attachments: Code A

Code A
could you do me a favour please and print off this e mail and all the attachments
thanks
Code A

From: Code A
Sent: 21 December 2006 10:26
To: Code A
Subject: FW: letter to Code A

Code A these are the cat 3 cases which did not form part of the police 10. Cat 3 are where there was real concern. These weren't included in the 10 though as there was no causation

From: Code A
Sent: 20 December 2006 17:39
To: Code A
Cc: Code A
Code A
Subject: FW: letter to Code A

Code A
4 summary documents attached. Code A

From: Code A
Sent: 20 December 2006 17:29
To: Code A
Subject: RE: letter to Code A

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Thank you.The note states that there are 14 Cat 3 cases, but in 4 of those cases death was from natural causes although there were negligence issues to be explored. Please could you confirm the identities of those 4.
Kind regards
Code A

From: Code A
Sent: 20 December 2006 17:11
To:
Cc: Code A
Subject: FW: letter to Code A

Apologies..
Code A

From: Code A
Sent: 20 December 2006 17:06
To: Code A
Subject: RE: letter to Code A

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Thank you, unfortunately the summary was not attached, please could you resend it?
Kind Regards
Code A

From: Code A
Sent: 20 December 2006 16:59
To:
Cc: Code A
Subject: FW: letter to Code A

Dear Code A
I have forwarded your request to Code A who will deal with the disclosure issues..
Please find attached a summary of the 10 cases.
Regards
Code A
Detective Superintendent.

From: Code A
Sent: 20 December 2006 16:21
To: Code A
Subject: letter to Code A

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Please see attached letter following our meeting yesterday.
Yours sincerely
Code A
FOR EVERSHEDS LLP

****** Eversheds is supporting both Unicef and Breast Cancer Campaign as an alternative to sending Christmas cards and E-cards. We wish all our clients and contacts a Happy Christmas and prosperous New Year. ******

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********* This email is sent for and on behalf of Eversheds LLP *********

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Operation Rochester.

Medical assessment in respect of Category 3A cases.

Overview Code A

Code A was a widower living alone in Fareham. He had a Code A Code A who were his main carers. He had a home help who would visit once a week.

He was in good health until early 1999 during which he slowly declined over the course of the year probably due to the onset of leukaemia. In June 1999 Code A moved to The Red House Residential Home when according to his son and daughter in law he was unable to cope at home and had been diagnosed with Hairy cell leukaemia in May he also suffered from Alzheimer's disease.

Code A was admitted to the Queen Alexander Hospital and then transferred to Gosport War Memorial Hospital on 27th October 1999 with bronchopneumonia, septicaemia and a stroke from which he had made no real physical, functional or mental recovery for continuing care and rehabilitation.

He deteriorated over the four weeks of his admission and died on 10th November 1999.

Cause of death was recorded as bronchopneumonia and hairy cell leukaemia.

When admitted to Daedalus Ward there existed a summary in the notes of his recent problem but no clinical examination was recorded. The notes state:- "in view of poor prognosis, not for 999. I am happy for any nurse to verify his death. Mainly for TLC."

Code A was distressed and unwell on 7th November, as a result a decision was made (not clear if this was purely a nursing decision or whether there was medical involvement) to prescribe the 'as required Oramorph'

When this had little effect a decision was made to start Midazolam alone in a syringe driver.

Finally Diamorphine was added to the syringe driver at 0010 on the 8th November 1999. Code A received a medical review during that day and was found to be frail but comfortable though further deteriorating.

On 9th November an increased dose of Diamorphine was required, this being justified in the nursing cardex as he does not appear comfortable (despite receiving 30 mgs of Diamorphine currently in the syringe driver) and with increased agitation.

It would appear at this stage that 60 mgs of Diamorphine was started in the syringe driver together with the Hyoscine and 2 mgs of Haloperidol. Later Code A Code A is recorded as being much more comfortable.

On 10th November a new prescription of Diamorphine, Hyoscine and Haloperidol was written up regularly and 100 mgs placed in the syringe driver at 09.45hrs.

Code A died at 14.50hrs the same day. It is not clear why this new prescription was written up, or why a dose of 100 mgs was chosen, nor is it clear whether this was chosen by the medical or nursing staff.

This case was brought to the attention of Operation ROCHESTER in 2002 by Code A

As a consequence the case was examined by a team of medical experts in geriatrics, palliative care, toxicology, general medicine and nursing. They took the view that whilst the care afforded to Code A was potentially negligent that he died of natural causes.

This view was independently quality assured and agreed by a legal/ medical lawyer who had access to all of the papers.

Finally an expert Geriatrician was assigned to this case to make a further independent medical and evidential assessment.

He examined in detail the circumstances surrounding the care and treatment of Code A

The expert concluded that Code A was an extremely frail and elderly gentleman when he entered the Gosport War Memorial Hospital and was not going to recover from his various problems. It was inevitable that he was going to deteriorate and die in hospital.

Recording of the medical notes seemed very poor and the justification for writing up various medications was not made clear in the medical notes.

The Geriatrician thought it reasonable that he received doses of Oramorph on 7th November when he was distressed and deteriorating. It was also appropriate that he was started on a syringe driver including 20 mgs of Diamorphine on 8th November as well as the Haloperidol and Midazolam to help his agitation.

He commented that Midazolam is widely used subcutaneously in doses from 5 – 80 mgs in 24 hours and is particularly used in terminal restlessness. The

dose of Midazolam used was 20 mgs per 24 hours which was within current guidance; although many believe that elderly patients may need a dose of 5 – 20 mgs per 24 hours.

The dose of Diamorphine was raised to 30 mgs on 9th November and then apparently doubled up to 60 mgs because he showed continual stress and agitation. As Code A settled following this medication change the geriatrician concluded that it was a reasonable change in dosage.

Whilst there was nothing recorded as to why Code A Diamorphine was re-written on 10th November, or any information about the decision to give him a 100 mgs from 09.45 on 10th November, it was the experts view that this was probably an unnecessary step up in dosage as there was nothing to suggest he was not still settled on the 60 mgs in 24 hours dose. It was possible that this may have had the effect of very slightly shortening Code A life by no more than a few hours.

Operation Rochester.

Medical assessment in respect of Category 3A cases.

Overview Code A

Code A was a frail 92 year old widower with a son and lived in a rest home in Southsea. He was a retired civil servant for the Department of Health. He had multiple medical problems over a number of years. His health started to more rapidly decline and enter a final phase from July 1993. A probable (and likely) diagnosis of carcinoma of stomach was made and he received palliative care in hospital until the time of his death on 24th December 1993.

Cause of death was recorded as cancer of the stomach and bronchopneumonia.

On 20th July, 1993 Code A had an emergency admission following a domiciliary visit. The GP had referred on the 7th July because he was deteriorating generally with episodic vomiting with altered blood. The domiciliary visit letter documents vomiting and weight loss, feeling fed up and being depressed but he was mobilising indoors. He was discharged on 30th July where as he had not been noted to vomit on the ward a Barium Meal had been undertaken. The report of the Barium Meal documents an abnormality in the gastric fundus with mucosal irregularity. It was difficult to undertake the procedure because of patient immobility. A gastroscopy to take biopsies is recommended. It was also noted on the abdominal x-ray, that he had abnormal trabecula pattern in the right hemi-pelvis suggestive of Paget's disease. The report of the Barium Meal is suggestive but not diagnostic of gastric cancer.

A letter from the GP, August 1993 notes that Code A is very frail, that there was no question that he could have a gastric operation should cancer be confirmed, that actually undertaking further investigations would be difficult and unpleasant and he suggests that Code A should be just managed symptomatically. The consultant Code A agrees and offers palliative care, if and when, it is needed.

On 25th October he is admitted as an emergency to St Mary's General Hospital with vomiting and severe back pain. The GP states in his letter that he had already started regular Diamorphine. However it is not clear from the GP's letter when it was started and how much the patient was currently on. The GP believes that the patient now needs a syringe driver.

Subsequently Code A is transferred to John Pounds Ward for pain control and is recorded as being on Diamorphine pump.

On the 2nd November he is noted to have his pain controlled, however he is now completely dependent with a Barthel of 1. His notes state that his son is aware of the prognosis and agrees to Palliative Care. He is switched to oral morphine for pain control.

On 5th November his family agree to long term care at Gosport War Memorial and it is recorded his pain is well controlled by the oral morphine slow release. He is then admitted on 8th November to Gosport War Memorial for long stay care. He is in no pain and does not want to be examined.

The nursing and medical notes then record between 8th November and 20th December, apart from bouts of nausea, retching, and occasional pyrexia, his pain seems mostly controlled but he is clearly, slowly physically deteriorating. On 20th December it is noted that he was deteriorating further and that sub-cut Diamorphine might be needed.

On 23rd December he is noted to be rapidly deteriorating and that sub-cut analgesia had been commenced the day before (80mgs diamorphine). The family were aware and happy with the management. On 24th December he is recorded as having died peacefully at 12.05 hours.

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He examined in detail the circumstances surrounding the care and treatment of Code A.

The expert concluded that Code A was a frail 92 year old gentleman who had had multiple medical problems over a number of years. His health started to more rapidly decline and enter a final phase in July 1993. A probable (and in my view likely) diagnosis of carcinoma of stomach was made and he received palliative care in hospital until the time of his death on 24th December 1993.

The dose of Diamorphine and Midazolam started in the syringe driver on 22nd December might be considered to have been excessive, however I believe

that this made a negligible contribution to the death of Code A

Operation Rochester.

Medical assessment in respect of Category 3A cases.

Overview Code A

Code A lived with Code A in a bungalow in Gosport. They had Code A Code A They lived independently with no outside help. Code A Code A had poor mobility and had been admitted several times to Gosport War Memorial Hospital for respite care to give his wife a break after suffering a stroke in 1991.

Following a further event (stroke) and decline at the end of January 2004, he is readmitted to the Gosport War Memorial Hospital where he deteriorates and dies over 6 days.

Cause of death was recorded as cerebrovascular accident and senile dementia.

On 31st January 1994 he was readmitted as an emergency and the history was that he had a Transient Ischemic Attack (Mini stroke) on the Friday lasting 20 minutes and since then he had been sleeping excessively.

On 3rd February the medical notes record that his overall condition has deteriorated and he was short of breath and restless, he was not feeding or drinking. The notes suggested that he might have had a further CVA (stroke) but no examination is recorded. No plan is made apart from a chat with the wife. The nursing cardex had noted that he was very variable in condition on 2nd February and very drowsy at times. The nursing notes also record that his condition deteriorated on 3rd February with breathlessness and some distress and he had been seen by Code A and was for a syringe driver "if and when needed". The medical record on 4th February states that he is still unwell and eating and drinking very little.

On 6th February 1994 he is reported to be Cheyne-Stoking (respiratory problem) in the nursing notes and that a syringe driver was started at 7.45. The nursing notes then record the patient was restless, agitated and distressed at 11 am and that a Dr was contacted who arranged for a further one off dose of 5 mgs of Diamorphine to be given. He was then seen by a Dr who arranged for the Diamorphine in the syringe driver to increase to 60 mgs. The medical notes also document these events, that he was very restless on the 40 mg Diamorphine of in 24 hours and that he was given 5 mgs intramuscularly and thereafter Diamorphine 60 mgs in 24 hours was given in the syringe driver. Code A died at 20.50 on 6th February 1994.

The case was brought to the attention of Operation ROCHESTER in 2002 by Code A via the NHS helpline.

As a consequence the case was examined by a team of medical experts in geriatrics, palliative care, toxicology, general medicine and nursing. They took the view that whilst the care afforded to Code A was potentially negligent that he died of natural causes.

This view was independently quality assured and agreed by a legal/ medical lawyer who had access to all of the papers.

Finally an expert Geriatrician was assigned to this case to make a further independent medical and evidential assessment.

He examined in detail the circumstances surrounding the care and treatment of Code A

The expert concluded that Code A was a 71 year old gentleman at the time of his death, he had ischaemic heart disease, hypertension then suffered a devastating stroke in 1991, leaving him severely dependent and disabled with a right hemiplegia and severe communication problems. He was cared for at home by his wife but started to decline during the autumn of 1993 and had several admissions to the Gosport War Memorial Hospital, mainly to support his wife. Following a further event (a Transient Ischemic Attack) and decline at the end of January 2004, he is readmitted to the Gosport War Memorial Hospital where he deteriorates and dies over 6 days.

A starting dose of Diamorphine of 10 – 20 mgs in 24 hours in the syringe driver might be more commonly used and many would consider that 40 mgs was an excessive starting dose. Despite this, the doses used fail to manage his symptoms and a further dose of intramuscular sedation is required, given at 11 am. The syringe driver is then restarted with 60 mgs of Diamorphine in 24 hours. This appears to provide adequate symptom control and he dies at 20.10. The evidence in the notes suggests that this was an appropriate therapeutic response to the distressing symptoms being suffered by Code A Code A

This admission marked the culmination of a progressive decline in his health and it is unlikely that any active or invasive measures would have made a significant difference to the eventual outcome of his care

Although the expert Geriatrication also states that :-The lack of detail in the medical notes, in particular, lack of a recorded clinical assessment at the time of his readmission on 31st January and at the time of a significant deterioration on 3rd February 1994 make it difficult to fully assess the problems suffered by Code A and the reasons for his final decline and death. However, I

believe that the symptomatic response to his terminal illness was appropriate and that his death was by natural causes.

Operation Rochester.

Medical assessment in respect of Category 3A cases.

Overview Code A

Code A lived with her husband in a house in Gosport. They had just sold this and were hoping to move to a bungalow. They had 3 daughters. Code A Code A was deaf in her left ear and wore a hearing aid.
Code A was admitted to the EWGH for respite care and gastroenteritis after collapsing. She was transferred to the Gosport War Memorial Hospital on 27th April 2000 for 'build up' and was then transferred to the St Mary's General Hospital where she died on 7th May 2000.

Cause of death was recorded as Cardiogenic Shock, Ischaemic Heart Disease, and Chronic Lymphatic Leukaemia.

Code A had a history going back to an operation in 1979 for duodenal ulcer disease. In 1998 she was noted to have an abnormal blood count with lymphadenopathy, was referred for a haematological opinion and an original diagnosis of chronic lymphatic leukaemia was made. In 1998 she had been admitted to hospital acutely with a myocardial infarction, had a positive exercise test and was referred for an angiogram in May 1999. In the meantime she had a bone marrow which confirmed chronic lymphatic leukaemia with lymph node involvement.

In 2000 a cardiologist decided that despite her severe coronary artery disease, she was not fit for surgery because of "a high chance of thrombosis and stroke". In 2000 she is diagnosed to have a post nasal drip.

In early 2000 she was seen in the Gastrointestinal clinic having been referred from the haematologist because of a fall in haemoglobin. It is decided to do further investigations for possible blood loss and an upper GI endoscopy and colonoscopy are booked. Around the same time, she has further haematological investigation and a second bone marrow and she is now thought to have a follicular lymphoma rather than pure chronic lymphatic leukaemia. In March 2000 she is on Prednisolone and Chlorambucil and is noted to be significantly more cheerful. On the 18th April the booked upper and lower gastro intestinal investigations are performed. Her blood pressure is 135/70 prior to the investigations and the two documented blood pressures after are 85/48 and 100/60. She is also noted to be breathless at rest but discharged home. The investigations are reported as showing no significant abnormality, apart from a hiatus hernia. Finally her creatinine on 22nd March was normal at 100 micro mls per litre.

She is admitted into a GP bed by her Code A on 27th April and the medical notes state that she has weakness, exhaustion and depression and a recent bout of diarrhoea and vomiting (514). Her previous past medical history is noted as is her medication of Citalopram, Isosorbide Mononitrate, Aspirin, Nitrolingual Spray, Quinapril and Atenolol. No examination is recorded and the plan is stated to be two weeks to help regain her usual state of health.

On 28th April she is seen by the Code A and her blood pressure is to be monitored. However, there are no medical notes that day and no further medical notes to the 2nd May. The nursing notes on 29th May document a blood pressure of 100/60 and that there had been diarrhoea 3 times that morning. On 30th she continued to have offensive stools, feeling unwell, cold, clammy to the touch, feels hot. She was light headed and standing blood pressure of 90/50, a pulse of 68 and temperature of 36.

On 5th May she is unwell at 10.30 am, cold and clammy, blood pressure unrecordable, weak and thready pulse, her GP is called and comes at 11.50 am. He records that her blood pressure is low at between 80-90/40-50 and asks for her to be transferred to St. Mary's Hospital. However it is not until 17.39 that a bed becomes available.

She arrives at St Mary's Hospital at 18.45 is cold, clammy and dyspnoeic. The on-call medical team is asked to see her urgently at 19.30; the examination finds that she is in extremis, pulse 120, no recordable blood pressure and signs of a large right pleural effusion. A chest x-ray confirms a massive right pleural effusion. The diagnosis is thought to be a combination of septic shock and a large pleural effusion; she is in acute renal failure. She is severely acidotic and passes a large mucus stool, is resuscitated and finally a decision is made for transfer to ITU.

During the course of 6th May she is treated with very intensive medical treatment and at first there is a small improvement in cardiac output. However, she deteriorates later in the day, the family are spoken to at 10.30 and she is then put on a ventilator for respiratory distress.

She finally dies of cardiogenic shock at 02.55 on 7th May.

This case was brought to the attention of Operation Rochester in October 2002 by Code A via the NHS Helpline.

As a consequence the case was examined by a team of medical experts in geriatrics, palliative care, toxicology, general medicine and nursing. They took the view that whilst the care afforded to Code A was potentially negligent that she died of natural causes.

This view was independently quality assured and agreed by a legal/ medical lawyer who had access to all of the papers.

Finally an expert Geriatrician was assigned to this case to make a further independent medical and evidential assessment.

He examined in detail the circumstances surrounding the care and treatment of Code A and concluded that at the time of her death she was a 69 year old lady who suffered from ischaemic heart disease with a proven myocardial infarction, follicular lymphoma and chronic lymphatic leukaemia, problems with her gastrointestinal symptom and finally a massive pleural effusion developing shortly before her death.

Her GP admits her to the Gosport War Memorial Hospital on the 24th April 2000 where a clinical examination is either not undertaken or not recorded. She is recorded as being persistently hypotensive and unwell by the nursing staff over a number of days until her final admission on 5th May to St. Mary's Hospital. At that time she is very seriously ill and despite active and appropriate intensive care dies shortly after. A major problem in assessing this case is the poor documentation in Gosport Hospital, in particular in the medical notes making a retrospective assessment of her progress difficult. The lack of documentation of examination possibly undertaken at the Gosport War Memorial Hospital or accurate information on changes in her clinical status represents poor clinical practice. However, I believe her death was by natural causes.

Code A

Code A

From: Code A

Sent: 21 December 2006 10:00

To: Code A

Subject: Operation Rochester

Code A

With regards to your request for information in respect of the 10 outstanding cases.

The information that you have requested in your letter of the 20th December is available. It will run to approximately 45 arch lever files. I will have my officers start the copying process next week after xmas. I anticipate that the material will be available to you and the GMC around the middle of January once the family meetings with CPS have concluded.

I will let you know the date when you can arrange to come and collect the material.

If you have any further requests please contact me

Regards

Code A

Review Team

Code A

Code A

Operation Rochester.

Medical assessment in respect of Category 3A cases.

Overview Code A

Code A was a widower living alone in Fareham. He had a Code A Code A who were his main carers. He had a home help who would visit once a week.

He was in good health until early 1999 during which he slowly declined over the course of the year probably due to the onset of leukaemia. In June 1999 Code A moved to The Red House Residential Home when according to his son and daughter in law he was unable to cope at home and had been diagnosed with Hairy cell leukaemia in May he also suffered from Alzheimer's disease.

Code A was admitted to the Queen Alexander Hospital and then transferred to Gosport War Memorial Hospital on 27th October 1999 with bronchopneumonia, septicaemia and a stroke from which he had made no real physical, functional or mental recovery for continuing care and rehabilitation.

He deteriorated over the four weeks of his admission and died on 10th November 1999.

Cause of death was recorded as bronchopneumonia and hairy cell leukaemia.

When admitted to Daedalus Ward there existed a summary in the notes of his recent problem but no clinical examination was recorded. The notes state:- "in view of poor prognosis, not for 999. I am happy for any nurse to verify his death. Mainly for TLC."

Code A was distressed and unwell on 7th November, as a result a decision was made (not clear if this was purely a nursing decision or whether there was medical involvement) to prescribe the 'as required Oramorph'

When this had little effect a decision was made to start Midazolam alone in a syringe driver.

Finally Diamorphine was added to the syringe driver at 0010 on the 8th November 1999. Code A received a medical review during that day and was found to be frail but comfortable though further deteriorating.

On 9th November an increased dose of Diamorphine was required, this being justified in the nursing cardex as he does not appear comfortable (despite receiving 30 mgs of Diamorphine currently in the syringe driver) and with increased agitation.

It would appear at this stage that 60 mgs of Diamorphine was started in the syringe driver together with the Hyoscine and 2 mgs of Haloperidol. Later Code A Code A is recorded as being much more comfortable.

On 10th November a new prescription of Diamorphine, Hyoscine and Haloperidol was written up regularly and 100 mgs placed in the syringe driver at 09.45hrs.

Code A died at 14.50hrs the same day. It is not clear why this new prescription was written up, or why a dose of 100 mgs was chosen, nor is it clear whether this was chosen by the medical or nursing staff.

This case was brought to the attention of Operation ROCHESTER in 2002 by Code A

As a consequence the case was examined by a team of medical experts in geriatrics, palliative care, toxicology, general medicine and nursing. They took the view that whilst the care afforded to Code A was potentially negligent that he died of natural causes.

This view was independently quality assured and agreed by a legal/ medical lawyer who had access to all of the papers.

Finally an expert Geriatrician was assigned to this case to make a further independent medical and evidential assessment.

He examined in detail the circumstances surrounding the care and treatment of Code A

The expert concluded that Code A was an extremely frail and elderly gentleman when he entered the Gosport War Memorial Hospital and was not going to recover from his various problems. It was inevitable that he was going to deteriorate and die in hospital.

Recording of the medical notes seemed very poor and the justification for writing up various medications was not made clear in the medical notes.

The Geriatrician thought it reasonable that he received doses of Oramorph on 7th November when he was distressed and deteriorating. It was also appropriate that he was started on a syringe driver including 20 mgs of Diamorphine on 8th November as well as the Haloperidol and Midazolam to help his agitation.

He commented that Midazolam is widely used subcutaneously in doses from 5 – 80 mgs in 24 hours and is particularly used in terminal restlessness. The

dose of Midazolam used was 20 mgs per 24 hours which was within current guidance; although many believe that elderly patients may need a dose of 5 – 20 mgs per 24 hours.

The dose of Diamorphine was raised to 30 mgs on 9th November and then apparently doubled up to 60 mgs because he showed continual stress and agitation. As Code A settled following this medication change the geriatrician concluded that it was a reasonable change in dosage.

Whilst there was nothing recorded as to why Code A Diamorphine was re-written on 10th November, or any information about the decision to give him a 100 mgs from 09.45 on 10th November, it was the experts view that this was probably an unnecessary step up in dosage as there was nothing to suggest he was not still settled on the 60 mgs in 24 hours dose. It was possible that this may have had the effect of very slightly shortening Code A life by no more than a few hours.

Operation Rochester.

Medical assessment in respect of Category 3A cases.

Overview Code A

Code A was a frail 92 year old widower with a son and lived in a rest home in Southsea. He was a retired civil servant for the Department of Health. He had multiple medical problems over a number of years. His health started to more rapidly decline and enter a final phase from July 1993. A probable (and likely) diagnosis of carcinoma of stomach was made and he received palliative care in hospital until the time of his death on 24th December 1993.

Cause of death was recorded as cancer of the stomach and bronchopneumonia.

On 20th July, 1993 Code A had an emergency admission following a domiciliary visit. The GP had referred on the 7th July because he was deteriorating generally with episodic vomiting with altered blood. The domiciliary visit letter documents vomiting and weight loss, feeling fed up and being depressed but he was mobilising indoors. He was discharged on 30th July where as he had not been noted to vomit on the ward a Barium Meal had been undertaken. The report of the Barium Meal documents an abnormality in the gastric fundus with mucosal irregularity. It was difficult to undertake the procedure because of patient immobility. A gastroscopy to take biopsies is recommended. It was also noted on the abdominal x-ray, that he had abnormal trabecula pattern in the right hemi-pelvis suggestive of Paget's disease. The report of the Barium Meal is suggestive but not diagnostic of gastric cancer.

A letter from the GP, August 1993 notes that Code A is very frail, that there was no question that he could have a gastric operation should cancer be confirmed, that actually undertaking further investigations would be difficult and unpleasant and he suggests that Code A should be just managed symptomatically. The consultant Code A agrees and offers palliative care, if and when, it is needed.

On 25th October he is admitted as an emergency to St Mary's General Hospital with vomiting and severe back pain. The GP states in his letter that he had already started regular Diamorphine. However it is not clear from the GP's letter when it was started and how much the patient was currently on. The GP believes that the patient now needs a syringe driver.

Subsequently Code A is transferred to John Pounds Ward for pain control and is recorded as being on Diamorphine pump.

On the 2nd November he is noted to have his pain controlled, however he is now completely dependent with a Barthel of 1. His notes state that his son is aware of the prognosis and agrees to Palliative Care. He is switched to oral morphine for pain control.

On 5th November his family agree to long term care at Gosport War Memorial and it is recorded his pain is well controlled by the oral morphine slow release. He is then admitted on 8th November to Gosport War Memorial for long stay care. He is in no pain and does not want to be examined.

The nursing and medical notes then record between 8th November and 20th December, apart from bouts of nausea, retching, and occasional pyrexia, his pain seems mostly controlled but he is clearly, slowly physically deteriorating. On 20th December it is noted that he was deteriorating further and that sub-cut Diamorphine might be needed.

On 23rd December he is noted to be rapidly deteriorating and that sub-cut analgesia had been commenced the day before (80mgs diamorphine). The family were aware and happy with the management. On 24th December he is recorded as having died peacefully at 12.05 hours.

This case was brought to the attention of Operation ROCHESTER in November 2002 by Code A

As a consequence the case was examined by a team of medical experts in geriatrics, palliative care, toxicology, general medicine and nursing. They took the view that whilst the care afforded to Code A was potentially negligent that he died of natural causes.

This view was independently quality assured and agreed by a legal/ medical lawyer who had access to all of the papers.

Finally an expert Geriatrician was assigned to this case to make a further independent medical and evidential assessment.

He examined in detail the circumstances surrounding the care and treatment of Code A.

The expert concluded that Code A was a frail 92 year old gentleman who had had multiple medical problems over a number of years. His health started to more rapidly decline and enter a final phase in July 1993. A probable (and in my view likely) diagnosis of carcinoma of stomach was made and he received palliative care in hospital until the time of his death on 24th December 1993.

The dose of Diamorphine and Midazolam started in the syringe driver on 22nd December might be considered to have been excessive, however I believe

that this made a negligible contribution to the death of Code A

Operation Rochester.

Medical assessment in respect of Category 3A cases.

Overview Code A

Code A lived with his wife Code A in a bungalow in Gosport. They had a Code A They lived independently with no outside help. Code A Code A had poor mobility and had been admitted several times to Gosport War Memorial Hospital for respite care to give his wife a break after suffering a stroke in 1991.

Following a further event (stroke) and decline at the end of January 2004, he is readmitted to the Gosport War Memorial Hospital where he deteriorates and dies over 6 days.

Cause of death was recorded as cerebrovascular accident and senile dementia.

On 31st January 1994 he was readmitted as an emergency and the history was that he had a Transient Ischemic Attack (Mini stroke) on the Friday lasting 20 minutes and since then he had been sleeping excessively.

On 3rd February the medical notes record that his overall condition has deteriorated and he was short of breath and restless, he was not feeding or drinking. The notes suggested that he might have had a further CVA (stroke) but no examination is recorded. No plan is made apart from a chat with the wife. The nursing cardex had noted that he was very variable in condition on 2nd February and very drowsy at times. The nursing notes also record that his condition deteriorated on 3rd February with breathlessness and some distress and he had been seen by Code A and was for a syringe driver "if and when needed". The medical record on 4th February states that he is still unwell and eating and drinking very little.

On 6th February 1994 he is reported to be Cheyne-Stoking (respiratory problem) in the nursing notes and that a syringe driver was started at 7.45. The nursing notes then record the patient was restless, agitated and distressed at 11 am and that a Dr was contacted who arranged for a further one off dose of 5 mgs of Diamorphine to be given. He was then seen by a Dr who arranged for the Diamorphine in the syringe driver to increase to 60 mgs. The medical notes also document these events, that he was very restless on the 40 mg Diamorphine of in 24 hours and that he was given 5 mgs intramuscularly and thereafter Diamorphine 60 mgs in 24 hours was given in the syringe driver. Code A died at 20.50 on 6th February 1994.

The case was brought to the attention of Operation ROCHESTER in 2002 by Code A via the NHS helpline.

As a consequence the case was examined by a team of medical experts in geriatrics, palliative care, toxicology, general medicine and nursing. They took the view that whilst the care afforded to Code A was potentially negligent that he died of natural causes.

This view was independently quality assured and agreed by a legal/ medical lawyer who had access to all of the papers.

Finally an expert Geriatrician was assigned to this case to make a further independent medical and evidential assessment.

He examined in detail the circumstances surrounding the care and treatment of Code A

The expert concluded that Code A was a 71 year old gentleman at the time of his death, he had ischaemic heart disease, hypertension then suffered a devastating stroke in 1991, leaving him severely dependent and disabled with a right hemiplegia and severe communication problems. He was cared for at home by his wife but started to decline during the autumn of 1993 and had several admissions to the Gosport War Memorial Hospital, mainly to support his wife. Following a further event (a Transient Ischemic Attack) and decline at the end of January 2004, he is readmitted to the Gosport War Memorial Hospital where he deteriorates and dies over 6 days.

A starting dose of Diamorphine of 10 – 20 mgs in 24 hours in the syringe driver might be more commonly used and many would consider that 40 mgs was an excessive starting dose. Despite this, the doses used fail to manage his symptoms and a further dose of intramuscular sedation is required, given at 11 am. The syringe driver is then restarted with 60 mgs of Diamorphine in 24 hours. This appears to provide adequate symptom control and he dies at 20.10. The evidence in the notes suggests that this was an appropriate therapeutic response to the distressing symptoms being suffered by Code A Code A

This admission marked the culmination of a progressive decline in his health and it is unlikely that any active or invasive measures would have made a significant difference to the eventual outcome of his care

Although the expert Geriatrication also states that :-The lack of detail in the medical notes, in particular, lack of a recorded clinical assessment at the time of his readmission on 31st January and at the time of a significant deterioration on 3rd February 1994 make it difficult to fully assess the problems suffered by Code A and the reasons for his final decline and death. However, I

believe that the symptomatic response to his terminal illness was appropriate and that his death was by natural causes.

Operation Rochester.

Medical assessment in respect of Category 3A cases.

Overview Code A

Code A lived with her husband in a house in Gosport. They had just sold this and were hoping to move to a bungalow. They had 3 daughters. Code A Code A was deaf in her left ear and wore a hearing aid.
Code A was admitted to the EWGH for respite care and gastroenteritis after collapsing. She was transferred to the Gosport War Memorial Hospital on 27th April 2000 for 'build up' and was then transferred to the St Mary's General Hospital where she died on 7th May 2000.

Cause of death was recorded as Cardiogenic Shock, Ischaemic Heart Disease, and Chronic Lymphatic Leukaemia.

Code A had a history going back to an operation in 1979 for duodenal ulcer disease. In 1998 she was noted to have an abnormal blood count with lymphadenopathy, was referred for a haematological opinion and an original diagnosis of chronic lymphatic leukaemia was made. In 1998 she had been admitted to hospital acutely with a myocardial infarction, had a positive exercise test and was referred for an angiogram in May 1999. In the meantime she had a bone marrow which confirmed chronic lymphatic leukaemia with lymph node involvement.

In 2000 a cardiologist decided that despite her severe coronary artery disease, she was not fit for surgery because of "a high chance of thrombosis and stroke". In 2000 she is diagnosed to have a post nasal drip.

In early 2000 she was seen in the Gastrointestinal clinic having been referred from the haematologist because of a fall in haemoglobin. It is decided to do further investigations for possible blood loss and an upper GI endoscopy and colonoscopy are booked. Around the same time, she has further haematological investigation and a second bone marrow and she is now thought to have a follicular lymphoma rather than pure chronic lymphatic leukaemia. In March 2000 she is on Prednisolone and Chlorambucil and is noted to be significantly more cheerful. On the 18th April the booked upper and lower gastro intestinal investigations are performed. Her blood pressure is 135/70 prior to the investigations and the two documented blood pressures after are 85/48 and 100/60. She is also noted to be breathless at rest but discharged home. The investigations are reported as showing no significant abnormality, apart from a hiatus hernia. Finally her creatinine on 22nd March was normal at 100 micro mls per litre.

She is admitted into a GP bed by her GP Code A on 27th April and the medical notes state that she has weakness, exhaustion and depression and a recent bout of diarrhoea and vomiting (514). Her previous past medical history is noted as is her medication of Citalopram, Isosorbide Mononitrate, Aspirin, Nitrolingual Spray, Quinapril and Atenolol. No examination is recorded and the plan is stated to be two weeks to help regain her usual state of health.

On 28th April she is seen by the GP Code A and her blood pressure is to be monitored. However, there are no medical notes that day and no further medical notes to the 2nd May. The nursing notes on 29th May document a blood pressure of 100/60 and that there had been diarrhoea 3 times that morning. On 30th she continued to have offensive stools, feeling unwell, cold, clammy to the touch, feels hot. She was light headed and standing blood pressure of 90/50, a pulse of 68 and temperature of 36.

On 5th May she is unwell at 10.30 am, cold and clammy, blood pressure unrecordable, weak and thready pulse, her GP is called and comes at 11.50 am. He records that her blood pressure is low at between 80-90/40-50 and asks for her to be transferred to St. Mary's Hospital. However it is not until 17.39 that a bed becomes available.

She arrives at St Mary's Hospital at 18.45 is cold, clammy and dyspnoeic. The on-call medical team is asked to see her urgently at 19.30; the examination finds that she is in extremis, pulse 120, no recordable blood pressure and signs of a large right pleural effusion. A chest x-ray confirms a massive right pleural effusion. The diagnosis is thought to be a combination of septic shock and a large pleural effusion; she is in acute renal failure. She is severely acidotic and passes a large mucus stool, is resuscitated and finally a decision is made for transfer to ITU.

During the course of 6th May she is treated with very intensive medical treatment and at first there is a small improvement in cardiac output. However, she deteriorates later in the day, the family are spoken to at 10.30 and she is then put on a ventilator for respiratory distress.

She finally dies of cardiogenic shock at 02.55 on 7th May.

This case was brought to the attention of Operation Rochester in October 2002 by Mrs Margaret WARD (daughter) via the NHS Helpline.

As a consequence the case was examined by a team of medical experts in geriatrics, palliative care, toxicology, general medicine and nursing. They took the view that whilst the care afforded to Code A was potentially negligent that she died of natural causes.

This view was independently quality assured and agreed by a legal/ medical lawyer who had access to all of the papers.

Finally an expert Geriatrician was assigned to this case to make a further independent medical and evidential assessment.

He examined in detail the circumstances surrounding the care and treatment of Code A and concluded that at the time of her death she was a 69 year old lady who suffered from ischaemic heart disease with a proven myocardial infarction, follicular lymphoma and chronic lymphatic leukaemia, problems with her gastrointestinal symptom and finally a massive pleural effusion developing shortly before her death.

Her GP admits her to the Gosport War Memorial Hospital on the 24th April 2000 where a clinical examination is either not undertaken or not recorded. She is recorded as being persistently hypotensive and unwell by the nursing staff over a number of days until her final admission on 5th May to St. Mary's Hospital. At that time she is very seriously ill and despite active and appropriate intensive care dies shortly after. A major problem in assessing this case is the poor documentation in Gosport Hospital, in particular in the medical notes making a retrospective assessment of her progress difficult. The lack of documentation of examination possibly undertaken at the Gosport War Memorial Hospital or accurate information on changes in her clinical status represents poor clinical practice. However, I believe her death was by natural causes.

Code A

From: Code A
Sent: 20 December 2006 17:29
To: Code A
Subject: RE: letter to Code A

Thank you.The note states that there are 14 Cat 3 cases, but in 4 of those cases death was from natural causes although there were negligence issues to be explored. Please could you confirm the identities of those 4.

Kind regards

Code A

From: Code A
Sent: 20 December 2006 17:11
To:
Cc: Code A
Subject: FW: letter to Code A

Apologies..
DW.

From: Code A
Sent: 20 December 2006 17:06
To: Code A
Subject: RE: letter to Code A

**** Before acting on this email or opening any attachment you are advised to read the Eversheds disclaimer at the end of this email. ****

Thank you, unfortunately the summary was not attached, please could you resend it?
Kind Regards
Code A

From: Code A
Sent: 20 December 2006 16:59
To:
Cc: Code A
Subject: FW: letter to Code A

Dear Code A
I have forwarded your request to Code A who will deal with the disclosure issues..
Please find attached a summary of the 10 cases.
Regards
Code A

From: Code A
Sent: 20 December 2006 16:21
To: Code A
Subject: Code A

HAMPSHIRE
CASE SUMMARY
FROM POLICE

...STER.
...evidence.
...d negligence.
6th June 2006.

Overview.

Operation ROCHESTER is an investigation into 92 deaths of elderly Gosport War Memorial Hospital patients between 1988 and 2000.

It follows allegations initially made in 1998 that the death of patients was being hastened through the inappropriate and excessive administration of Diamorphine in many cases delivered by way of syringe driver.

Recent expert evidence raises further significant concerns in a small number of cases that the care afforded to patients was 'negligent' to a point that it contributed 'more than minimally' towards the death of the patient. These matters continue to be investigated as potential homicides.

Following police investigation in 2001/2 files of evidence were placed before the Crown Prosecution Service in respect of the death of five patients, Code A the common denominator being that prior to death Diamorphine was prescribed by Code A CPS determined on 28th November 2002 that there was 'no reliable evidence that the named patients were unlawfully killed'.

The police investigation was resurrected in September 2002 following concerns raised by nursing staff around similar issues (the alleged excessive use of Diamorphine)

Subsequent enquiries revealed concerns raised by family members and healthcare professionals in respect of the standard of care afforded to 92 patients.

The patients medical case notes were recovered and reviewed by a team of medical experts (known as the key clinical team) in the fields of toxicology, general medicine, palliative care, geriatrics and nursing.

The cases were effectively 'categorised' as follows.

Category 1. (19 cases) No concerns. Optimal care delivered. The family members in respect of these cases have been informed that no further police action will be taken.

Operation ROCHESTER.
Summary of expert evidence.
Ten cases of alleged negligence.
6th June 2006.

Overview.

Operation ROCHESTER is an investigation into 92 deaths of elderly Gosport War Memorial Hospital patients between 1988 and 2000.

It follows allegations initially made in 1998 that the death of patients was being hastened through the inappropriate and excessive administration of Diamorphine in many cases delivered by way of syringe driver.

Recent expert evidence raises further significant concerns in a small number of cases that the care afforded to patients was 'negligent' to a point that it contributed 'more than minimally' towards the death of the patient. These matters continue to be investigated as potential homicides.

Following police investigation in 2001/2 files of evidence were placed before the Crown Prosecution Service in respect of the death of five patients, Code A the common denominator being that prior to death Diamorphine was prescribed by Code A CPS determined on 28th November 2002 that there was 'no reliable evidence that the named patients were unlawfully killed'.

The police investigation was resurrected in September 2002 following concerns raised by nursing staff around similar issues (the alleged excessive use of Diamorphine)

Subsequent enquiries revealed concerns raised by family members and healthcare professionals in respect of the standard of care afforded to 92 patients.

The patients medical case notes were recovered and reviewed by a team of medical experts (known as the key clinical team) in the fields of toxicology, general medicine, palliative care, geriatrics and nursing.

The cases were effectively 'categorised' as follows.

Category 1. (19 cases) No concerns. Optimal care delivered. The family members in respect of these cases have been informed that no further police action will be taken.

Category 2. (59 cases) 'Concerns' exist in that the medical team of experts assessed the care of these patients as 'sub optimal'. However, these cases have not been raised to the status of 'negligent', and as such it is highly unlikely that there will be any further police investigation into the particular circumstances. The family members have been informed of the category of the deceased and a summary of the care provided and attendant circumstances of death, by a legal/medico lawyer quality assuring the findings of the clinical team. Additionally the relevant category 2 case-file papers and medical notes have been forwarded to the GMC and Nursing and Midwifery counsel for their attention. Family members have been informed that these cases have been released from police investigation upon the basis that the criminal standard of proof could not be met.

Category 3. (14 cases) The medical team have assessed the care delivered in these cases as 'negligent.'

In four of the cat/3 cases however the death of the patients has been confirmed to be through 'natural causes'. These cases are shortly (June 2006) to be released from criminal investigation and forwarded to the GMC and NMC who no doubt will look to explore the potential 'negligence' issues.

There remain ten category 3 cases that have been assessed as 'negligent care' with the cause of death being 'unclear'. It is in these cases that a full police investigation has been conducted including the statementing of all relevant healthcare staff involved in the care of the patient prior to death, expert witness review of medical notes and geriatric and palliative care assessment, family group member statements, and interviews with healthcare staff under criminal caution.

It is anticipated that case-files in respect of all of these cases will have been passed to the CPS for their final consideration by 9th June 2006 or thereabouts (files have been submitted incrementally since December 2004).

This document provides an overview of these cases by summarising the initial findings of the multi-disciplinary team and the expert 'evidential' witnesses.

1. **Code A**
   - Clinical team assessment - Negligent, medication possibly contributing towards cause of death bronchopneumonia.
   - Palliative expert - Appropriate levels of medication under the circumstances.
   - Geriatric expert - Appropriate management for terminal illness.

2. **Code A**
   - Clinical team assessment - Negligent, cause of death unclear and use of opioids questionable.
   - Palliative expert - Doubt that patient had entered terminal phase, drugs excessive in any event. Recommends renal expert to assess whether terminal.

- Geriatric expert - Suggests irreversible kidney pathology. Drugs administered at a level higher than conventional guidance however terminally ill and appeared to receive good palliation for symptoms.
- Consultant Nephrologist - Worsening severe renal failure, possible to stabilise but prognosis death inevitable.

3. **Code A**
   - Clinical team assessment - Negligent care, admitted for rehab for fractured neck of femur, no antibiotics given for chest infection.
   - Palliative expert - Natural decline into terminal phase dose of diamorphine unlikely to be excessive.
   - Geriatric expert - Admitted with a number of serious chronic diseases, satisfied death of natural causes.

4. **Code A**
   - Clinical team assessment - Suffered head injury or brain stem stroke, forms of analgesia other than diamorphine may have helped. A worrying five fold escalation when converting from morphine to diamorphine might have contributed towards death.
   - Palliative expert - Excessive doses of diamorphine and midazolam administered ultimately could have contributed more than minimally towards death. Reasonable doubt that patient had reached terminal phase and decline may have been reversible with appropriate treatment.
   - Geriatric expert - Failure to make proper assessment of multiple medical problems but likely to be entering terminal phase of life. Excessive doses of diamorphine and midazolam likely to cause respiratory depression. Cannot say beyond all reasonable doubt that life shortened.

5. **Code A**
   - Clinical team assessment - Admitted following fractured hip, very high starting dose of diamorphine probably contributing towards death. No evidence of specialist consultation.
   - Palliative expert - **Code A** not anticipated to be dying, doctors failed to adequately assess condition, symptoms in keeping with potentially reversible septicaemia/toxaemia. Exposed to inappropriate doses of diamorphine and midazolam that would have contributed more than minimally towards death.
   - Geriatric expert - Prognosis generally poor for fractures in the elderly. A number of areas of poor clinical practice in this case including lack of medical assessment, poor documentation and considering alternative analgesic regimes. High starting dose of diamorphine however unable to satisfy that death hastened by anything other than a short time (hours).
   - Orthopaedic expert - Suffered relatively complex hip fracture, significant bleed into thigh post operatively, of grave concern

that no further action can be identified in relation to a potentially serious and reversible diagnosis.

6. Code A
   - Clinical team assessment - Admitted fracture left humerus, liver and kidney problems due to alcohol. Death presumably from an overdose of opiates in a man with poor opiate metabolism and reduced tolerance.
   - Palliative expert - Multiple alcohol related problems, increases in diamorphine difficult to justify and likely to be excessive for needs, however difficult to state with certainty whether doses contributed more than minimally towards death.
   - Geriatric expert - Oramorphine dose not an appropriate clinical response to pain. Formed a major contribution toward clinical deterioration, the treatment negligent and more than minimally contributed towards the death of Code A
   - Clinical governance expert - Code A suffered liver dysfunction and probably heart failure but the initiation of opiate medication an important factor leading to death. Might have left hospital alive had he not been commenced on opiate medication.
   - Gastroenterology expert - An unwell man whose life expectancy short but no attempt appears to have been made to justify the use of opiates in this 'at risk' patient group. Died of acute chronic (but reversible) liver failure precipitated by opiate medication.

7. Code A
   - Clinical team assessment - deteriorating physical and mental health, probably opiate toxic; cause of death unclear, opiates could have contributed.
   - Palliative expert - medical notes inadequate, pain not appropriately assessed, Opioids not appropriate to alleviate anxiety and agitation. Diamorphine excessive to need may have contributed more than minimally to death
   - Geriatric expert - Code A frail and dependent, at the end of chronic disease process of depression drug related side effects lasting 20 years. Starting dose of diamorphine 3 times greater than dose conventionally applied. Combination of drugs likely to have caused excessive sedation and may have shortened life by hours/days, but not beyond all reasonable doubt. Care sub-optimal but could not be proved negligent or criminally culpable.

8. Code A
   - Clinical team assessment – Old lady with many medical problems, diabetes, heart failure, confusion. Upon transfer was placed on sedation via syringe driver became less well and

diamorphine added, the need unclear and could have contributed towards her death.

- Palliative expert – Code A did not appear to be experiencing significant pain although opioids are used for breathlessness in end stage heart failure. Seek view of cardiologist. Not obviously in terminal stage, diamorphine dose excessive.
- Geriatric expert – Patient recorded as having long standing congestive heart failure. Cause of death multi-factorial. Drug doses higher than necessary and may have shortened life by hours, but not beyond all reasonable doubt.

9. Code A

- Clinical team assessment – died of gastrointestinal bleed, not taken seriously and treated with opioids. Cause of death natural but potentially treatable and medical care terrible.
- Gastroenterology expert – Limited medical assessment to bleed, managed by escalating doses of opiate analgesia. Transfer for endoscopic therapy should have been considered. Apparently no attempt to ascertain why patient had become so unwell.
- Palliative expert – Transferred to dryad ward for rehabilitation. Inappropriate management of gastrointestinal haemorrhage together with exposure to unjustified and inappropriate doses of diamorphine and midazolam contributed more than minimally to death.
- Geriatric expert – High risk patient, further bleed does not lead to medical attention, difficult clinical decision made without involvement of senior medical opinion, higher than conventional starting dose of diamorphine used without justification in notes. Despite the above deficiencies probably made little difference to outcome and died of natural causes.

10. Code A

- Palliative expert - Code A was a frail 84 year old who was admitted to hospital having fallen and fractured her left hip on 5th August 1998. This was surgically repaired and she had a difficult post-operative course due to events associated with her pre-existing heart and kidney problems, leading to heart failure, atrial fibrillation and renal impairment, along with a chest infection and episodic confusion/agitation at night. Apart from these episodes of pain, Code A appeared to be progressing rather than deteriorating whilst awaiting transfer to Gosport War Memorial Hospital and had begun to mobilise. I Code A not provided a good standard of care, poor notes make it difficult to understand her rapid deterioration. It is possible that her physical state had deteriorated in a temporary or reversible way and that with appropriate medical care she would have recovered. Reasonable doubt exists that she had entered her terminal

phase, and she was exposed to doses of midazolam and diamorphine that could have contributed more than minimally towards her death.

- Geriatric expert - Code A was an 84-year-old lady with a number of chronic diseases, she suffered a fall and a fractured neck of femur in August 1998. She was admitted to hospital and had operative treatment but developed post-operative complications including chest infection, chest pain and confusion at night and subsequently deteriorated and died in the Gosport War Memorial Hospital. The combination of a lack of a documented clinical examination, the lack of prescription of appropriate oral analgesia on admission to Gosport, the decision to start a syringe driver without documentation of a clinical diagnosis or the reason for it in the medical notes, together represent a negligent standard of medical care. It is impossible from the notes to determine the cause of death and a Coroner's Post Mortem should have been held. Without a proven diagnosis, it is possible that the combination of Diamorphine and Midazolam together with the Hyoscine in a syringe driver contributed in part to Code A Code A death. However the expert is unable to satisfy himself to the standard of beyond reasonable doubt that it made more than a minimal contribution.

Wider expert case summaries.

Clinical Team assessment.

Code A 79. Died Code A five days after admission to Gosport War Memorial Hospital, suffering Parkinson's disease, dementia, myelodysplasia, admitted from a nursing home with 'difficult behaviour'.

Admitted from day hospital with a large necrotic sacral sore which 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 and a rapid escalation of Diamorphine and high doses of Midazolam were administered.

Palliative expert - There appears little doubt that Code A was 'naturally' coming to the end of his life. His death was in keeping with a progressive irreversible physical decline, documented over at least 10 days by different clinical teams, accompanied in his terminal phase by a bronchopneumonia. Code A could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Code A a peaceful death, albeit with what appears to be an apparent lack of sufficient knowledge, illustrated, for example, by the reliance on large dose range of diamorphine by syringe driver

rather than a fixed dose along with the provision of smaller 'as required' doses that would allow Code A needs to guide the dose titration.

Code A could also be seen as a doctor who breached the duty of care she owed to f Code A by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Code A by unnecessarily exposing him to potentially receiving excessive doses of diamorphine.

In the event, however, such large doses were not administered, and in the experts opinion, the use of diamorphine, midazolam and hyoscine in these doses could be seen as appropriate given Code A circumstances.

Geriatric expert - Code A a 79 year-old gentleman, suffered from long-standing Parkinson's disease with multiple complications followed by a fairly rapid decline in health leading to his first admission to the Gosport War Memorial Hospital on 21st July, 1998 and a final admission 21st September, 1998.

He received terminal care including subcutaneous Diamorphine and Midazolam through a syringe driver and died on 26th September 1998. The expert opinion is:

Code A is an example of complex and challenging problems in geriatric medicine. He suffered from multiple chronic diseases and gradually deteriorated with increasing medical and physical dependency. It is always a challenge to clinicians to identify the point at which to stop trying to deal with each individual problem or crisis, to an acceptance that the patient is dying and that symptom control is appropriate.

Code A was managed appropriately, including the decision to start a syringe driver for managing his symptoms and agitation as part of his terminal illness in September 1998.

The experts one concern is the increased dose of Diamorphine in the syringe driver on 25th and 26th September 1998. The expert was unable to find any justification for this increase in dosage in either the nursing or the medical notes. This increase in medication may have slightly shortened life for at most no more than a few hours to days. However the expert was not able to find evidence to satisfy that this is to the standard of 'beyond reasonable doubt'.

Clinical team assessment.

2. Code A 88 died 21st November 1999 32 days after admission to Gosport War Memorial Hospital. She had suffered multi-infarct dementia, moderate/chronic renal failure and paraproteinaemia. She had been occasionally aggressive and restless being 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 (chronic renal failure) is not clear and the use of opiods questionable, especially when considering doses. An issue over whether or not she was dying before given Fentanyl which was inappropriately prescribed for sedation.

Palliative expert-

Code A was a frail 88yr old with significant medical problems.

A fentanyl transdermal patch was commenced for an unspecified reason. The following day Code A became more confused and agitated. An injection of chlorpromazine was given and a syringe driver started one hour later containing diamorphine and midazolam. She died 2 days later.

The medical care provided by Code A was sub optimal, there was a failure to keep clear accurate and contemporaneous patient records, there was an inadequate assessment of Code A condition, treatment's were prescribed that appeared excessive for her needs.

In particular the prescription of fentanyl and diamorphine appear unjustified and/or excessive for Code A needs.

The use of chlorpromazine and midazolam appears justifiable on the grounds of Code A confusion, but the doses used were excessive for her needs.

There is a reasonable doubt that she had definitely entered her terminal stage.

If it were that Code A had naturally entered the terminal phase of her life at best Code A could be seen as a doctor who whilst failing to keep clear accurate and contemporaneous patient records had in good faith been attempting to allow a peaceful death, albeit with what appears to be inappropriate and excessive use of medication due to a sufficient lack of knowledge.

At worst Code A could be seen as a doctor who breached the duty of care she owed to Code A by failing to provide treatment with a reasonable amount of skill and care.

This was to a degree that disregarded the safety of Code A by unnecessarily exposing her to inappropriate and excessive doses of medications as with the fentanyl which could have resulted in a worsening of her agitation and confusion.

Code A response to this was to further expose Code A to inappropriate and/or excessive doses of midazolam and diamorphine that could have contributed more than minimally negligibly or trivially to her death.

As a result Code A lays herself open to the accusation of gross negligence.

Code A death was not typical of patients dying from chronic renal failure.

Code A was incorrectly labelled as having 'myeloma' in the admission notes, this mistake is important if it influenced how the patient was managed eg deterioration could be incorrectly considered an 'expected' irreversible terminal event due to her cancer like condition.

It is difficult to endorse prescribing action morphine on the day of transfer that results in the use of an above average dose of a strong opioid as a first line analgesic in a frail elderly patient(against company prescribing advice). Medication was excessive even if it were considered she was dying of natural causes.

Increasing doses of opioids excessive to a patients needs are also associated with an increasing risk of delirium, nausea and vomiting and respiratory depression. Once unresponsive and not drinking Code A renal function would decline further.

In the absence of pain shortness of breath or cough in my view there is no justification for the use off diamorphine by syringe driver.

A starting dose of 5-10mg a day would have been more appropriate.

Geriatric expert-

This case presents as an example of the most complex and challenging problems in geriatric medicine.

Physicians including a renal physician and a haematologist all conclude that she suffered from a progressive problem with no easily treatable or remedial cause, the small kidneys shown on ultrasound usually suggest irreversible kidney pathology.

The mental health team describe increasing confusion and mental deterioration over the course of the year.

The major problem in deciding whether care is sub –optimal is the lack of documentation.

The drug management was sub-optimal, there was no apparent justification for the Diamorphine to be written up prn on admission to Gosport.

The logic for the prescription of Fentanyl is not explained.

There was a three hour overlap, between the prescription of the subcutaneous Diamorphine and Midazolam and the removal of the Fentanyl patch.

The starting doses of both Midazolam and Diamorphine were higher than conventional guidance, which may have shortened her life by a short period of time, this would have no more than hours to days (but she was also out of distress for the last 58hrs)

However she was terminally ill and appeared to receive good palliation of her symptoms.

It is not clear whether any advice was sought (by Code A) from the consultant legally responsible for the care of this patient (Code A) in respect of the administration of Fentanyl on 18th November 1999.

In my opinion on 19th November patient was terminally ill, on balance many clinicians would come to the same conclusion after a month in hospital.

In my view the death certificate would appropriately say acute renal failure, chronic glonerulonephritis, paraproteinemia and dementia.

The prediction of how long a terminally ill patient will live is virtually impossible, and even palliative experts show an enormous variation.

Whilst her care was sub-optimal I cannot prove it to be negligent or criminally culpable.

I am not able to say that the use of Fentanyl, Diamorphine and Midazolam were prescribed with the intention of deliberately shortening her life or had the definite effect of shortening her life in more than a minor fashion.

Expert Consultant Nephrologist-

Code A was admitted as an emergency to hospital with an acute confusional state for which no other cause other than multi-infarct dementia and severe renal impairment could be found.

After a period of stabilisation, her clinical condition worsened with severe renal failure and worsening agitation and restlessness.

Although it may have been possible to stabilise her condition with relatively simple measures, this would not have materially changed her prognosis as death was inevitable.

Clinical team assessment.

3. Code A 91 died 22nd November 1999 81 days after admission to Gosport War Memorial Hospital, she had suffered a 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 (recorded as Bronchopneumonia) Should they have tried antibiotics or explained why they were not used? She probably would have died whatever was done from 15.11.1999.

Palliative expert - Code A decline was noted over a number of weeks and this would be in keeping with a natural decline into a terminal phase. Further, whatever the reason was for the use of diamorphine the physical findings on the day of Code A death would suggest that the dose she was receiving was unlikely to have been excessive to the degree that it rendered her unresponsive or was associated with respiratory depression.

Geriatric expert - Code A a 91 year old lady with a number of serious chronic diseases suffers a fall and fractured neck of femur in August 1999. She is admitted to the Haslar Hospital and making little rehabilitation progress, with a very poor prognosis she is transferred to the Gosport War Memorial Hospital.

There is some weakness in the documentation of her condition in particular on her admission to the Gosport War Memorial Hospital and on the 18th November when her definitive final clinical deterioration is documented. If clinical examinations were undertaken they have not been recorded. General Medical Practice (GMC2001) states that "good clinical care must include adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to patient's and any drugs or other treatment prescribed". The lack of clinical examination both on admission and more important Code A Code A care, deteriorated represents poor clinical practice to the standards set by the General Medical Council.

Despite the above the expert is satisfied that Code A death was of natural causes and that her overall clinical management in Gosport was just adequate.

Clinical team assessment.

4. Code A 83. Died Code A 14 days after admission to Gosport War Memorial Hospital, she had been suffering 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 (cerebovascular accident) and the dose escalation might have contributed.

Palliative expert-

The medical notes were inadequate and the cause and treatment of Code A Code A urinary tract infection was not properly assessed/ treated.

The Morphine may have been inappropriate or excessive to the type of pain experienced and the possible role this played in her deterioration was not considered. Treatments were continued that may have aggravated her condition ie the diuretic.

Excessive doses of diamorphine/ midazolam were administered from 26th February 1996.

Blood tests of 27th February 1996 revealed low platelet count and deteriorating kidney function, not reflected in the notes and no action taken, not discussed with a consultant or specialist advice.

On 29th February 1996 no mention made of high blood sugar requiring high doses of insulin. No mention of pain in medical notes therefore inconsistent with nursing notes.

No pain assessment recorded against increase in morphine of 4th March 1996.

The reported deterioration mentioned in the notes of 5th March is not explained.

There is reasonable doubt that Code A had reached her terminal phase. Causes of her decline may have been reversible with appropriate treatment.

Ultimately excessive doses of diamorphine and midazolam could have contributed more than minimally trivially or negligibly towards her death, Code A Code A leaves herself open to the accusation of gross negligence.

Cause of death registered as cerebrovascular accident, validity difficult to comment upon but final deterioration does not seem typical of cerebrovascular accident, more likely immobility from fall leading to infection.

Geriatric expert-

Patient suffered long standing multiple medical problems, after admission found to be doubly incontinent, totally dependent, suffering constant pain to shoulders and arms and found to have serious abnormalities in various blood tests.

Increasing physical dependency and increased patient distress.

Doctors and consultants failed to make adequate medical assessment and diagnosis of her condition.

A belief that Code A was misdiagnosed and had suffered a quadriplegia from a high cervical spinal cord injury secondary to her fall.

Abnormal blood tests could have represented systemic illness such as cancer of the bone marrow, the test should have been commented upon by the doctor in charge of the case as to their relevance.

The lack of examination and comment on abnormal blood tests make it impossible to assess the care as sub optimal, negligent or criminally culpable.

It was likely that Code A had several serious illnesses and was entering the terminal phase of her life.

Code A received a 'negligent' medical assessment both at Haslar and Gosport War Memorial Hospital, in particular she was not examined on admission to Gosport. No medical diagnosis made for pain, which would fit with spinal cord fracture. Without appropriate assessment impossible to plan appropriate management.

The two options were to either get further specialist opinion or provide palliative care it would have been wise to obtain specialist opinion, probably from the consultant in charge of the case. There is no evidence that this was done.

Unusually large dose of diamorphine written up on 26th February 1996, and subsequent excessive dose reported on 5th March 1996, together with high dose of Midazolam likely to cause excessive sedation and respiratory depression.

However this expert cannot say beyond all reasonable doubt that Code A Code A life was shortened.

Clinical team assessment.

5. Code A 92. Died Code A eighteen days after admission to Gosport War memorial hospital. She had suffered a fractured hip which had

been 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 was 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 mg 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 the 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.

Palliative expert-

Code A was a relatively fit and independent 92 year old widow who lived alone. Whilst walking her dog, she fell and fractured her right hip which was surgically repaired using a dynamic hip screw on the 20th March 1999. Within hours of the surgery there was leakage from the wound and swelling of her right thigh to twice its normal size, causing discomfort and pain on palpation. It was considered most probable that she had developed a haematoma due to a bleeding vessel in the wound. Pain in Code A hip/thigh on movement continued to be a problem noted by Code A when he reviewed Code A on the 24th March 1999. Code A reviewed Code A but no specific comment was recorded in the medical notes regarding Code A pain, no changes were made to her analgesia and on the 26th March 1999 she was transferred to Dryad Ward, Gosport War Memorial Hospital. With regards to the standard of care proffered to Code A in Haslar Hospital, the report of expert orthopaedic surgeon raises several concerns.

During her admission to Dryad Ward, the medical care provided by Code A Code A was suboptimal: there was a lack of clear, accurate, and contemporaneous patient records; inadequate assessment of Code A Code A condition; a lack of consultation with colleagues to seek appropriate advice and support; the use of diamorphine and midazolam was in doses excessive to Code A needs.

When Code A became less well, increasingly drowsy, dehydrated, agitated, spilling things and had a nightmare there was no medical assessment or even simple observations documented.

Code A was not anticipated to be dying and her symptoms and signs were in keeping with a potentially reversible septicaemia/ toxaemia arising from an infection (the wound had become tender and inflamed despite the antibiotics) ± the effects of increasing blood levels of morphine metabolites

due to dehydration. Potentially beneficial treatments (e.g. intravenous hydration, reduction in the dose of morphine, different antibiotics) were not proffered nor advice obtained from the orthopaedic team or a microbiologist.

Instead a syringe driver containing diamorphine (equivalent to a 4–6 fold increase in her morphine dose) and midazolam was commenced. On a subsequent review by Code A as a result of finding Code A unresponsive, the diamorphine dose was halved, however the midazolam dose was doubled.

In short, Code A in particular, but also Code A could be seen as doctors who breached the duty of care they owed to Code A by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Code A by failing to adequately assess her condition and taking suitable and prompt action when she complained of pain that appeared excessive to her situation and when her physical state deteriorated in what was a potentially reversible way. Instead the actions of Code A Code A and Code A exposed Code A to the use of inappropriate doses of diamorphine and midazolam that would have contributed more than minimally, negligibly or trivially to her death. As a result Code A leave themselves open to the accusation of gross negligence.

Geriatric expert-

Code A presents a common problem in geriatric medicine. A very elderly lady with a number of chronic conditions is becoming increasingly frail and has a fall leading to a proximal femoral fracture.

The prognosis after such a fracture, particularly in those with impairments of daily living before their fracture is generally poor both in terms of mortality or morbidity and returning to independent existence. Up to 25% of patients in such a category will die shortly after their fracture from many varied causes and complications.

A significant problem in Code A case is the apparent lack of medical assessment and lack of documentation at Gosport. Good medical practice, '(GMC 2001) states that " good clinical care must include an adequate assessment of the patients condition, based on the history and symptoms and if necessary, an appropriate examination"..... "in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drug or other treatments provided". "Good clinical care must include – taking suitable and prompt action when necessary"..... "referring the patient to another practitioner, when indicated"..... "in providing care you must recognise and work within the limits of your professional competence"..... "prescribe drugs or treatments including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs.

The expert comments that there are a number of areas of poor clinical practice in this case to the standards set by the General Medical Council. The lack of a medical assessment, or documentation of that assessment on admission to Gosport, the failure to address the cause of this lady's pain or to consider any other actions from 26th March until 7th April, the use of Oramorphine on a regular basis from admission without considering other possible analgesic regimes.

Subsequent management of Code A pain was within current practice with the exception of the starting dose of Diamorphine (80mg in the syringe drive is at best poor clinical judgement). However, the expert was unable to satisfy beyond reasonable doubt that this high dose of Diamorphine hastened death by anything other than a very short period of time (hours).

Consultant Orthopaedic Surgeon-

Code A suffered a relatively complex hip fracture as a result of her fall on March 19th 1999. The decision to operate and the implants and operative technique employed were appropriate. The expert was unable to comment on the quality of the fixation of the fracture in the absence of radiographic record or post mortem findings.

The patient had a significant bleed into her thigh in the early stages post-operatively, and the possibility of compartment syndrome was raised. It is of grave concern that no further action can be identified in relation to this potentially serious and reversible diagnosis. Consequently, it is not possible to confirm that she had a compartment syndrome from the medical record.

Due consideration of the significance of her symptoms of pain and her inability to mobilise was not given consistently at either Haslar or at Gosport War Memorial Hospital. Specifically she did not undergo a further x-ray examination at either hospital, and she was not referred back to Haslar from Gosport War Memorial Hospital. The differential diagnosis should have included implant failure and uncontrolled infection. These complications would have been reversible.

Clinical team assessment.

6 Code A 74. Died Code A four days after admission to Gosport War memorial Hospital, he is recorded as having a high alcohol intake and poor nutritional status. He was admitted with a fracture of the left humerus.

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. The initial dose of Morphine was inappropriate in a person with known alcoholic liver disease. A rapid increase in body weight was documented in notes, with no apparent clinical response.

Palliative expert –

Code A was a 74 year old man who was admitted to hospital after falling over and fracturing the greater tuberosity of his left humerus. He had multiple serious medical problems; alcohol-related cirrhosis leading to liver failure and encephalopathy, heart failure and kidney failure. Other problems included early dementia, depression and a high level of dependency.

Although the care he received at Queen Alexander Hospital led to Code A being mentally more alert and returned his kidney function to normal, he continued to become increasingly oedematous despite the re-introduction of his diuretic therapy which was considered due to heart failure. The pain he experienced from his fracture progressively improved as anticipated and during his time at Queen Alexander Hospital, his daily analgesic requirements reduced from the equivalent of 20mg to 3mg of oral morphine. Nevertheless, given the time it takes for a fracture to heal, it was not surprising that pain on movement was still present at the time of his transfer.

There are no concerns regarding the care proffered to Code A at the Queen Alexander Hospital.

On transfer to Dryad Ward, the care proffered to Code A by Code A and Code A fell short of a good standard of clinical care as defined by the GMC (Good Medical Practice, General Medical Council, July 1998 pages 2–3) with particular reference to a lack of clear note keeping, adequate assessment of the patient Code A and providing treatment that could be excessive to the patients needs Code A

No pain assessment was carried out on Code A but his only regular analgesic, paracetamol, was discontinued and prescribed p.r.n. (as required). Instead of his usual codeine 15–30mg p.r.n., approximately equivalent to morphine 1.5–3mg, he was prescribed morphine 5–10mg p.r.n. for pain relief. He received two doses of 10mg (a total of 20mg/24h) and the next day commenced on regular morphine 10mg every 4h and 20mg at night. In total he received 50mg of morphine in this 24h period, representing a larger dose

than that he received in the initial 24h after his fracture. This is against the general expectation that pain from a fracture would have been improving over time and, without a clearly documented pain assessment, it is difficult to justify. However, the impact of this dose of morphine on Code A is impossible to judge because he deteriorated rapidly in the early hours of the 16th October 1998.

The nature of his rapid decline and subsequent death were in keeping with worsening heart failure with or without a sudden event such as a heart attack. This, combined with his liver failure, could easily have precipitated his terminal decline. His reduced level of consciousness could have been due to a hepatic coma precipitated by the morphine or by a reduced level of blood oxygen secondary to the excess fluid on the lungs (pulmonary oedema) due to the heart failure. Later that day a syringe driver was commenced containing diamorphine 20mg/24h and increased over the next 48h to 60mg/24h, equivalent to oral morphine 120–180mg/24h. This increase in dose appears difficult to justify, as Code A was not reported to be distressed by pain, breathlessness or the secretions and was likely to be excessive for his needs. However, because heart and liver failure could also have led to a reduced level of consciousness, in my opinion, it is difficult to state with any certainty that the doses of morphine or diamorphine he received would have contributed more than minimally, negligibly or trivially to his death.

Geriatric expert-

Code A a 74 year old gentleman with known severe alcoholic liver disease who was admitted with a complex and painful fracture of the left upper humerus. His physical condition deteriorates at first in hospital, with alteration in mental state, renal impairment and subsequent gross fluid retention. He then starts to improve and is transferred to the Gosport War Memorial Hospital for further assessment and possible rehabilitation or continuing care. He is started on regular oral strong opiate analgesia for pain in his left arm and rapidly deteriorates and dies within 5 days of admission.

There is weakness in the documentation of his condition, in particular on the admission to the Gosport War Memorial Hospital on 14th October, and on the15th October when the regular oral strong opiate analgesia is commenced. If clinical examinations were undertaken they have not been recorded. General Medical Practice (GMC2001) states that "good clinical care must include adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must provide clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to the patient and any drugs or other treatments provided". The lack of clinical examination on admission and on the day of 15th October when the decision was made to start regular strong oral opiate analgesia represents poor clinical practice to the standards set by the General Medical Council.

It is the expert's belief that the prescription of a total of 50 mgs of Oramorphine on the 15th October following the 20 mgs that were given on the 14th October was not an appropriate clinical response to the pain in [Code A] left arm.

This dose of analgesia formed a major contribution to the clinical deterioration that occurred over the 15th-16th October, in particular, his rapid mental state deterioration. In the experts view this treatment was negligent, and more than minimally contributed to the death of [Code A] on 19th October.

Clinical governance expert.

Studied the records provided by Hampshire Constabulary in order to consider three issues – the certified cause of death, the prescription of opiates and sedatives, and whether [Code A] fell into the category of patients who might have left hospital alive.

With respect to death certification the expert concluded that the certificate was inaccurate in that [Code A] did not have renal failure, and had liver dysfunction but not failure. He probably did have heart failure, although the expert believed the initiation of opiate medication was an important factor in leading to death.

With respect to the prescription of opiate drugs the expert concluded that on evidence available, that the initiation of opiate medication on transfer to Dryad ward was inappropriate. The expert also concluded that the starting dose was too high. The prescription of hyoscine and midazolam was justified by the use of opiates.

With respect to leaving hospital alive, it was concluded that [Code A] was in the category of patients who might have left hospital alive if he had not been commenced on opiate medicate on transfer to Dryad ward.

In the experts opinion, [Code A] had liver dysfunction but not full blown failure. His liver dysfunction did not cause death. In the presence of other life-threatening conditions, the liver dysfunction may impair the ability to recover, and it would have been reasonable to mention on the death certificate that [Code A] had chronic liver disease. The cause of his liver disease – alcohol – was not mentioned on the certificate.

[Code A] did not have renal failure. He did have abnormal blood test results after his admission to hospital, but these improved with re-hydration. [Code A] probably did have cardiac failure. There may have been other conditions as well. Haemoglobin estimations during his admission to Queen Alexandra Hospital had indicated mild anaemia. If this condition had deteriorated, the heart failure would also have become worse. However this was rather unlikely since he was being closely observed in Queen Alexandra Hospital and signs of increasing anaemia would almost certainly have been recognised. Evidence of bleeding would have been noted if it had occurred. There is no convincing evidence in the

records to confirm a diagnosis of myocardial infarction such as history of chest pain, raised cardiac enzymes or ECG evidence. One could also speculate about possible occurrence of some unsuspected condition.

However, despite all these speculations, it has to be acknowledged that his decline was associated with the regular administration of morphine, and was responded to by administration of diamorphine by syringe driver.

The reason for commencing Oramorph is not recorded in the medical notes [179]; in particular, the reasons for not using a non-opiate drug for pain relief are not given. Even if Code A did have pain from the fracture that was not controlled by paracetamol, regular does of 10mg of oral morphine would not have been the appropriate treatment. Other non-opiate or weak opiate medication should have been used first. If these medications had failed to adequately reduce the pain, a low dose of morphine (2.5-5mg) as had been used in the early days of his admission might have been reasonable. Although Code A did have congestive cardiac failure, therefore his death would have been hastened by opiate administration and the path to death may well have been initiated by the commencement of Oramorph on 14/10/98.

It is important to note that the general standard of completion of death certificates is unsatisfactory. For example, in a review of 1000 counterfoils of certificates in one teaching hospital in 1999-2000, only 55% of certificates had been completed to a minimally accepted standard (Swift and West, 2002). Of the remaining certificates, 25% had incomplete data, in 11% the part II section had been used inappropriately, and 9% were illogical or inappropriate. In her third report from the Code A Inquiry, Code A observed: *A further problem with the current system is that the quality of certification is poor. Doctors receive little training in death certification.* (paragraph 17, page 4, Code A nquiry). The standard of completion of the death certificate in Code A case should therefore be regarded as fairly typical. Although Code A did not have renal failure, the history of recent abnormal renal function tests prompted use of this diagnosis; the mention of liver failure was probably a convenient way of describing the impaired liver function.

Consultant Gastroenterologist.

The management of Code A liver condition following the time of initial admission was not perfect but reasonable. He should have received Pabrenex to prevent *Wernickes'* encephalopathy in addition to lactulose to treat *hepatic* encephalopathy.

Code A was assessed by a psychogeriatrician who did not detect any of the classical signs of Wernickes' encephalopathy. During most of his admission as well Code A was generally alert and so the omission of lactulose or other anti-encephalopathy treatment cannot be cited as a major omission. In real-life I suspect Code A would have refused to take lactulose for presumed encephalopathy because of its taste and laxative effects.

Code A was clearly an un-well man whose life expectancy was short. His previous record demonstrates that he would have been likely to return to drinking on discharge from hospital. The administration of high doses of morphine whilst an in-patient on Dryad however must be considered reckless. Warnings about morphine usage in the context of liver disease are readily available in standard prescribing guides such as those cited from the BNF. No attempt appears to have been made to justify the use of opiates in this at risk patient group. There also does not appear to have been any attention paid to appropriate dose reduction and/or monitoring in Code A case. The outcome was predictable in the clinical context of cirrhosis and escalating opiate dosage that Code A could not have survived.

Code A cause of death is given as (1) Congestive Cardiac Failure (2) Renal failure and (3) Liver failure. The experts understanding was that this was a clinical diagnosis as opposed to a post-mortem finding.

Congestive cardiac failure was unlikely to be the primary cause of death in Code A Code A case. Code A had oedema and the *commonest* cause for oedema is as a consequence of heart failure. However oedema also occurs in cirrhotic liver disease and in the experts view this was far more likely cause of oedema and ultimate demise than heart failure.

Code A had cirrhosis and therefore cause of death (3) 'liver failure' was reasonable. Code A had signs of *chronic* liver failure throughout his hospital stay including oedema and probable hepatic encephalopathy. The experts view is that he died of *acute chronic* liver failure precipitated by opiate medication.

Renal failure is a common secondary consequence of liver failure.

While there is limited evidence to support a diagnosis of 'renal failure' it is a common complication of liver disease. Code A is likely to have had the 'hepatorenal syndrome.' This means reversible renal failure as a direct consequence of the liver failure. If the liver injury can in some way be reversed then the renal failure will correct.

Clinical Team assessment.

7. Code A Died Code A 15 days after admission to 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. A 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.

Palliative expert.

Medical case-notes inadequate and pain not appropriately assessed. Opioids were not appropriate as administered to alleviate anxiety and agitation.

It was not necessary to use a syringe driver (unless the patient unwilling or unable to take medicines orally)

Doses of diamorphine 40-120mgs were excessive to needs of the patient (far exceeding appropriate starting dose of 10-15mgs.

There was little doubt that Code A was naturally coming to the end of his life.

At best Code A had attempted to allow a peaceful death, albeit with excessive use of diamorphine.

Experts opinion was that Code A breached her duty of care, by failing to provide treatment with skill and care, it was difficult to exclude completely the possibility that a dose of diamorphine that was excessive to his needs and may have contributed more than minimally negligibly or trivially to his death. Code A leaves herself open to the accusation of gross negligence.

Given the nature of Code A decline, Bronchopneumonia appears to be the most likely cause of death.

Geriatric expert.

Reports that Code A was extremely frail and dependent, and at the end of a chronic disease process of depression and drug related side effects spanning 20 or more years.

There was a problem in the expert assessing care due to lack of documentation.

The lack of notes represented poor clinical practice, no written justification for high doses of Diamorphine and Midazolam.

Drug management afforded to the patient was sub-optimal.

The starting dose of 80mgs of diamorphine was approximately 3 times the dose that would conventionally be applied.

A combination of higher than standard doses of drugs, Diamorphine, and Midazolam combined with Nozinan is likely to have caused excessive sedation and may have shortened life by a short period of time, hours to days. Whilst care was sub-optimal it could not be proved to be negligent or criminally culpable.

Predictions of how long terminally ill patients live are impossible, even palliative care experts show enormous variation.

Medication is likely to have shortened life but not beyond all reasonable doubt.

Clinical Team assessment.

8. Code A 99. Died Code A two days after admission to Gosport War Memorial Hospital. This lady was very old, and had many medical problems including diabetes, heart failure, confusion and sore skin.

She was 'agitated' in the Queen Alexandra hospital but they accepted it and used thioridazine orally. Upon transfer to Gosport War Memorial Hospital, she was placed on sedation via a syringe driver at night. She became 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). Code A died the following day.

Medication could have contributed towards her death, the need for such medication was not clear.

Palliative expert.

Code A did not appear to be experiencing significant pain although opioids are use for breathlessness in end stage heart failure.

The opinion of a cardiologist should be sought on Code A likely prognosis, scope for optimising her heart failure therapy and the role of opioids in chronic heart failure in 1997.

On Code A first night on Dryad ward she was commenced on a syringe driver containing midazolam in a dose sufficient to sedate an elderly patient. This in the experts opinion appeared to be an excessive reaction to what is a well recognised understandable response of a confused patient to new surroundings. Code A was not obviously at her terminal stage but was elderly, hard of hearing, confused/prone to confusion, spending her first night in a new environment with new staff and her usual night sedation was not given.

Subsequently the increase in midazolam to 40mg and the addition of diamorphine 20mg over 24hrs are without justification in the medical and nursing notes.

Blood tests on 4th June 1997 show Code A was dehydrated a reversible problem treated previously on F.1 ward (Queen Alexandra Hospital)

There is no comment in the notes about these results and why it was not felt appropriate to act on them. If it were considered that Code A was actively dying then it would have been reasonable not to have re-hydrated her and the use of diamorphine and midazolam could be justified, albeit that the dose of diamorphine was excessive for her needs.

If it were that Code A were not actively dying as the notes on her transfer to Dryad ward suggest then the failure to re-hydrate her together with the use of midazolam and diamorphine would have contributed more than minimally, negligibly or trivially to her death.

However, given that elderly frail patients with significant medical morbidity can deteriorate with little or sometimes no warning it could be argued that it would be difficult to ultimately distinguish which of the above was most likely without any doubt.

Geriatric expert.

Admitted to Queen Alexandra Hospital on 17th May 1997 at the age of 99 at the request of her GP to hospital with confusion, disorientation and progressive failure for the rest home to be able to cope with.

Diagnosed to have a combination of dehydration and left ventricular failure.

Recorded as having long standing congestive cardiac failure.

Transferred to Gosport War Memorial Hospital on 3rd June, confused, diabetes and heart failure.

The cause of death in the view of the expert was 'multi-factorial'. The dose of 20mg of diamorphine combined with the 40mg dose of midazolam was higher than necessary in this very elderly and frail lady's terminal care and the medication may have slightly shortened life although this opinion was not reach the standard of proof of beyond all reasonable doubt. The expert would have expected a difference (of survival) of at most no more than a few hours or days had a lower dose been used.

Clinical team member assessment (Geriatrician.)

9. Code A 67 years died Code A thirteen days after transfer to Gosport War Memorial hospital.

'I have more concerns with this case than the other members of the team. This man was treated for a myocardial infarction but died of a gastrointestinal bleed. I have been told that this was considered as the diagnosis in Queen Alexandra Hospital and the decision was made not to treat it. I have not found this and I believe they did not take this seriously in GWMH and treated him with opiates. I consider the cause of death to be natural (although potentially treatable) and the medical care terrible.

Quality assurance comment.

Code A was admitted to Gosport War Memorial Hospital in July 1999 with 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 23rd August 1999 Code A was noted as remaining very poorly with no appetite. It was noted in Code A nursing records that he was passing fresh blood per rectum on 25th August 1999.

On 26th 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 Code A and following rapidly increasing doses of Diamorphine he died on 3rd September 1999.

There is a variation in the view taken of this case by the experts reviewing the notes. Concern is expressed by the geriatrician that although the death was natural the gastrointestinal bleed was potentially treatable.

An expert report from a gastrointestinal surgeon/physician is to be sought.

Expert Gastroentorologist.

Code A did not experience a significant life threatening gastrointestinal bleed while an in patient at Portsmouth Hospital. He developed a mild anemia of chronic disease secondary to his underlying medical problems during that part of his admission. His medical state was stable and there was no medical reasons to delay transfer to a 'step down' care facility from an acute hospital.

Code A is likely to have suffered a significant gastrointestinal bleed while an out patient at Gosport War Memorial Hospital (approx 3 days after transfer) Medical assessment at that time was limited and was managed with escalating doses of opiate analgesia before he died on Code A

His main problems recorded throughout his stay were obesity, leg oedema, cellulites, poor mobility, arthritis and pressure sores. His mental state was very good and he had no pain. Overall he doesn't look ill and it was mainly a nursing problem.

During the admission period at the previous hospital the only analgesia he received was paracetamol.

Following the passing of rectal blood a non urgent sigmoidoscopy examination would have been desirable to confirm haemorrhoids and exclude bowel cancer. Transfer for endoscopic therapy should have been considered.

There is no attempt apparently made to ascertain why Code A had become so acutely unwell.

Code A was obese. He would represent a high risk for surgery. It would be difficult to justify the potential mortality of elective surgery in a morbidly obese patient.

Palliative expert.

Code A was a 67 year old man with obesity impairing his mobility, swelling of his legs and leg ulcers admitted to the Queen Alexander Hospital because of cellulitis (infection of the skin) affecting his left leg and groin. He also had pressure sores over his buttocks and thighs. He improved with treatment with antibiotics. He passed loose black stools, suggestive of melaena (blood in the stool) on a couple of occasions, but his haemoglobin was stable, excluding a significant gastrointestinal bleed. He was transferred to Dryad Ward for rehabilitation.

During his admission to Dryad Ward, the medical care provided by Code A and Code A was suboptimal; there was a lack of clear, accurate and contemporaneous patient records, inadequate assessment of Code A condition; a lack of consultation with colleagues and the use of diamorphine and midazolam in doses likely to be excessive to Code A needs.

Code A became acutely unwell on the 26th August 1999. A blood test revealed a large drop in his haemoglobin which made a significant gastrointestinal bleed likely. This is a serious and life-threatening medical emergency which requires urgent and appropriate medical care. The commonest underlying cause, a peptic ulcer, can however, be cured. Code A Code A should have been transferred without delay to the acute hospital. However, Code A was not transferred; the blood test result was not obtained or acted upon and he went on to receive doses of diamorphine and midazolam which were not obviously justified and likely to have been excessive to his needs.

In short, Code A in particular, but also Code A could be seen as doctors who breached the duty of care they owed to Code A by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Code A by failing to adequately assess his condition and taking suitable and prompt action when he became unwell with a gastrointestinal bleed. He was not appropriately assessed, resuscitated with

fluids, transferred or discussed with the on-call medical team. The use of regular morphine and subsequent use of diamorphine and midazolam in doses likely to be excessive to Code A needs were inappropriate.

It is the inappropriate management of Code A gastrointestinal haemorrhage together with his exposure to unjustified and inappropriate doses of diamorphine and midazolam that contributed more than minimally, negligibly or trivially to his death. As a result Code A and Code A leave themselves open to the accusation of gross negligence.

Geriatric expert.

Code A was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has a massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

There are a number of weaknesses in the clinical care provided to Code A Code A

Gastro-intestinal haemorrhage is suspected in Portsmouth, but although never disproven he is continued on his anticoagulant.

Despite the high risks being identified at admission, he does develop pressure sores rapidly during his admission in Portsmouth.

On assessment on 25th August 1999 a further bleed does not lead to medical attention.

On 26th August when he is identified as seriously ill, examination is either not undertaken or recorded in the notes and an investigation which is performed is never looked at or commented on. Gosport War Memorial Hospital also has communication difficulties as the laboratory simply cannot contact the hospital.

A difficult clinical decision is made without appropriate involvement of senior medical opinion.

Prescribing management and use of drug charts by both the nursing and clinical staff, in particular for controlled drugs, is unacceptably poor. A higher than conventional starting dose of Diamorphine is used without any justification for that dose being made in the notes.

Despite all of the above it is the experts opinion that Code A died of natural causes and these deficiencies probably made very little difference to the eventual outcome.

10. Code A

Palliative expert.

Code A was a frail 84 year old who was admitted to hospital having fallen and fractured her left hip on 5th August 1998. This was surgically repaired and she had a difficult post-operative course due to events associated with her pre-existing heart and kidney problems, leading to heart failure, atrial fibrillation and renal impairment, along with a chest infection and episodic confusion/agitation at night.

A combination of fluids, diuretics and antibiotics were required to support her through this period. At the time of Code A review, she summarised Code A Code A as frail and quite unwell and was uncertain as to whether there would be significant improvement. Subsequent to Code A review, Code A experienced chest pains that appeared either related to her ischaemic heart disease or were musculoskeletal in origin, for which GTN (an anti-anginal treatment) or codeine/paracetamol were effective respectively.

Apart from these episodes of pain, Code A appeared to be progressing rather than deteriorating whilst awaiting transfer to Gosport War Memorial Hospital and had begun to mobilise. On the day prior to transfer, for a period of time, she was noted to appear confused and had a temperature. However, on the day of the transfer she was reported to be well, comfortable and happy with a normal temperature.

Infrequent entries in the medical notes during her stay on Dryad Ward make it difficult to closely follow Code A progress over the last three days of her life. She apparently settled in well, but the next day complained of chest pain.

A syringe driver containing diamorphine and midazolam was commenced later that day. Code A became drowsy, her chest bubbly and the doses of drugs in the syringe driver were modified over the next two days to diamorphine 60mg, midazolam 60mg and hyoscine hydrobromide 800microgram/24h.

Code A was confirmed dead at 18.25h on the 21st August, the cause of death stated as bronchopneumonmia.

Code A does not appear to have provided Code A a good standard of clinical care as defined by the GMC; Code A was not adequately medically assessed by Code A at the time of her transfer or after her complaints of chest pain; there was no justification given for the prescription of morphine or the drugs administered in the syringe driver.
A lack of documentation makes it difficult to understand why Code A may have deteriorated in the rapid way that she did. A rapid deterioration often suggests an acute underlying medical cause. In this regard, a thorough medical assessment when she complained of chest pain (or indeed at the time of her transfer) may have identified possible contributing factors, such as a chest infection, that could have been appropriately treated. It is therefore

possible that her physical state had deteriorated in a temporary or reversible way and that with appropriate medical care she would have recovered.

If it were that Code A had naturally entered the terminal phase of her life, at best, Code A could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Code A a peaceful death, albeit with what appears to be an inappropriate use of medication due to a lack of sufficient knowledge. However, given the lack of medical and nursing records to the contrary, reasonable doubt exists that Code A had definitely entered her terminal stage.

Given this doubt, at worst, Code A could be seen as a doctor who breached the duty of care she owed to Code A by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Code A by failing to adequately assess her physical state at the time of her transfer and when she complained of chest pain, failing to take suitable and prompt action when necessary and if her physical state had deteriorated in a temporary or reversible way exposing her to the inappropriate use of diamorphine and midazolam in doses that could have contributed more than minimally, negligibly or trivially to her death. As a result Code A leaves herself open to the accusation of gross negligence.

Geriatric expert.

Code A was an 84-year-old lady with a number of chronic diseases, she suffered a fall and a fractured neck of femur in August 1998. She was admitted to hospital and had operative treatment but developed post-operative complications including chest infection, chest pain and confusion at night and subsequently deteriorated and died in the Gosport War Memorial Hospital.

Code A had a number of chronic diseases prior to her terminal admission following a fractured neck of femur. She had cardiac disease with known atrial fibrillation, aortic sclerosis and heart failure, documented in 1993. She also had not just osteoarthritis but an auto-immune arthritis that was thought variously to be either rheumatoid arthritis or variant auto-immune arthritis (the CREST syndrome). She also had problems as a result of her long-standing varicose swelling of her lower limbs, with many years of unresolved and very painful leg ulcers. Finally she had impaired renal function, developed mild acute renal failure when she was given on occasion, non-steroidal anti-inflammatory drugs.

When she is transferred to the Gosport War Memorial Hospital she is seen by Code A who fails to record a clinical examination, apart from a statement regarding her functional status.

The continuation notes of Code A then mention rehabilitation with a statement about being happy for the nursing staff to confirm death. There are no further medical notes at all and in view of the subsequent changing

clinical condition documented in the nursing cardex on 19th August and that the nurses contacted the doctor this is a poor standard of care. It also makes it very difficult to asses whether appropriate medical management was given to Code A

On admission the regular drugs being prescribed at Haslar were continued but the Paracetamol and Tramadol she had received in the Gosport War Memorial Hospital only a month before were not prescribed, nor was any other milder analgesia such as Paracetamol. The only analgesia written up was Oramorphine on the 'as required' part of the drug prescription. While it is probably appropriate for somebody who might have been having episodes of angina and left ventricular failure while in Gosport to have a Morphine drug available for nurses to give, it is very poor prescribing to write up no other form of analgesia, particularly if a doctor is not on site. The nursing staff could have no alternative but to go straight to a strong opioid analgesia.

On her first night she is documented as anxious and confused. This is then treated by giving a dose of Oramorphine despite there being no record in the medical or nursing cardex that it was pain causing this confusion. It should be noted this was probably no different from her evenings in Haslar which did not need any specific medication management. It is the experts view that this is poor nursing and medical care in the management of confusion in the evening.

On 19th August an event happened at 11.50 in the morning with the nursing notes recording that she had marked chest pain and was grey around her mouth. This could have been a heart attack, it could have been a pulmonary embolus, it could have been another episode of angina, it could simply have been some non-specific chest pain. No investigations are put in train to make a diagnosis, she does not appear to have been medically assessed, or if she was it was not recorded in the notes and would be poor medical practice. However, if the patient was seriously distressed, it would have been appropriate to have given the Oramorphine 10 mgs that was written up on the 'as required' side of the drug chart. The first aim would be to relieve distress while a diagnosis was made.

Later on 19th August a syringe driver is started containing Diamorphine 20 mgs and 20 mgs of Midazolam. The only justification for this is recorded in the nursing notes where it says pain is relieved for a short period. I am unable to find any records of observations, for example, pulse or blood pressure while the patient continues to have pain.

The syringe driver is continued the next day and Hyoscine is add and the dose of Diamorphine, Midazolam and Hyoscine all increase during the afternoon of the 20th and again when the syringe driver is replaced on 21st. Code A dies peacefully on Code A

Diamorphine is specifically prescribed for pain, is commonly used for pain in cardiac disease as well as in terminal care. Diamorphine is compatible

with Midazolam and can be mixed in the same syringe driver and is widely used subcutaneously as doses from 5 – 80 mgs per 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was 20 mgs for the first 24 hours, which is within current guidance.

The original dose of Diamorphine appeared to be for continued chest pain. It is unusual to use continuous Diamorphine for chest pain without making a specific diagnosis. It is possible the patient had had a myocardial infarction and was now in cardiogenic shock. In that case it would be very reasonable to use a syringe driver and indeed to add Midazolam and Hyoscine over the subsequent 48 hours. This can only be supposition without adequate documentation.

It is impossible from the notes to determine the cause of death and a Coroner's Post Mortem should have been held.

The combination of a lack of a documented clinical examination, the lack of prescription of appropriate oral analgesia on admission to Gosport, the decision to start a syringe driver without documentation of a clinical diagnosis or the reason for it in the medical notes, together represent a negligent standard of medical care.

Without a proven diagnosis, it is possible that the combination of Diamorphine and Midazolam together with the Hyoscine in a syringe driver contributed in part to Code A death. However the expert unable to satisfy himself to the standard of beyond reasonable doubt that it made more than a minimal contribution.

Summary prepared from medical evidence received to date.

Code A
Senior Investigating Officer.
6th June 2006.

Code A

From: Code A
Sent: 20 December 2006 16:21
To: Code A
Subject: letter to Code A
Attachments: Code A

Please see attached letter following our meeting yesterday.

Yours sincerely

Code A
FOR EVERSHEDS LLP

police consent

Code A

Code A
Hampshire Constabulary

Date 20 December 2006
Your ref
Our ref Code A
Direct dial Code A
Direct fax 0845 498 7333
Code A

Dear Code A

Operation Rochester

Further to the stakeholder meeting of yesterday, as we discussed we are keen to progress the GMC's investigation swiftly. Therefore, I would be grateful if you could provide, or make available to us to inspect at your offices:

1) the summary document that we discussed yesterday outlining the evidence in respect of the 10 cases that were identified for the CPS to consider, namely Code A

Code A

2) all witness statements, expert evidence, transcripts of police interviews and medical records relevant to the investigation of the above 10 cases together with any evidence that remains in your possession relating to Code A

3) an index of all evidence obtained to date.

I understand that you are awaiting consent from family members in respect of some of the documentation, but request that you provide such documentation as is available as soon as possible, even if that means providing the information in a piecemeal fashion. This will then enable the GMC to make an early assessment of the individual cases.

I look forward to hearing from you.

Yours sincerely

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FOR EVERSHEDS LLP

keen to go through + compile a list of achieved
Code A to put consent pr request re

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Code A

From: Code A
Sent: 20 December 2006 12:38
To: Code A
Subject: RE: Attached Files

Code A

These are fine.

I have had a couple of calls from family members of cases that have been referred to tell me that the local media has said that our investigation will take at least 15 months. I have told them that we are not able to give a specific timetable at this time and that the figure of 15 months is mere speculation.

Code A

-----Original Message-----
From: Code A
Sent: 20 Dec 2006 12:09
To: Code A
Subject: Attached Files

****** Eversheds is supporting both Unicef and Breast Cancer Campaign as an alternative to sending Christmas cards and E-cards. We wish all our clients and contacts a Happy Christmas and prosperous New Year. ******

**** Before acting on this email or opening any attachment you are advised to read the Eversheds disclaimer at the end of this email. ****

Code A

Please find attached some draft letters for you to approve. The letter is ever so slightly different for those who have already been referred by the PPC, those investigated by the police, and Code A Code A who falls into both categories. I am not sure to what extent the family members were informed of the referral to the PCC if at all, so I have remained silent on this.

There doesn't seem to have been the national news coverage that I think we were anticipating....

Code A

********* This email is sent for and on behalf of Eversheds LLP *********

Viruses: Although we have taken steps to ensure that this email and attachments are free from any virus, we advise that in keeping with good computing practice the recipient should ensure they are actually virus free.

********** [http://www.eversheds.com/] **********

General Medical Council

St James Building, 79 Oxford Street Manchester. M1 6FQ

Regents Place, 350 Euston Road, London. NW1 3JN

The Tun, 4 Jackson's Entry, Holyrood Road, Edinburgh. EH8 8AE

Regus House, Falcon Drive, Cardiff Bay. CF10 4RU

20 Adelaide Street, Belfast. BT2 8GD

Tel: 0845 357 8001
Fax: 0845 357 9001

Code A

From: Code A
Sent: 20 December 2006 16:06
To: Code A
Subject: RE: Code A

Thanks Code A

The letter seems to cover all the angles, even those "lateral" ones that they hinted at.

Code A

-----Original Message-----
From: Code A
Sent: 20 Dec 2006 15:52
To: Code A
Subject: Code A

**** Before acting on this email or opening any attachment you are advised to read the Eversheds disclaimer at the end of this email. ****

Hi Code A

Please find attached a draft letter that I propose sending to Code A Our team here has got together this morning to consider a possible strategy going forward. Of the 5 cases referred to the PCC, only 2, Code A were included in the 10 cases selected by the police. We are obliged to continue with the original 5 cases referred (unless any reason emerges for cancellation) and therefore we need any material that remains in the police possession relating to these 5. It also seems to us that we will need to consider the evidence, particularly the expert evidence in respect of the remainder of the 10 police cases, before we consider with you how many to continue with.

Kind Regards

Code A
Solicitor

Code A
International: 20 7497 9797
www.eversheds.com

****** Eversheds is supporting both Unicef and Breast Cancer Campaign as an alternative to sending Christmas cards and E-cards. We wish all our clients and contacts a Happy Christmas and prosperous New Year. ******

Code A

Code A

From: Code A
Sent: 20 December 2006 10:34
To: Code A
Cc:
Subject: RE: Family Group Member. Operation Rochester

Thanks Kate.

-----Original Message-----
From: Code A
Sent: 20 Dec 2006 10:29
To: Code A
Subject: Family Group Member. Operation Rochester

Goodmorning Code A

Just to update your records,
Code A moved on 17/12/06,
Her new address is,

Code A

Regards,
Code A

General Medical Council

St James Building, 79 Oxford Street Manchester. M1 6FQ

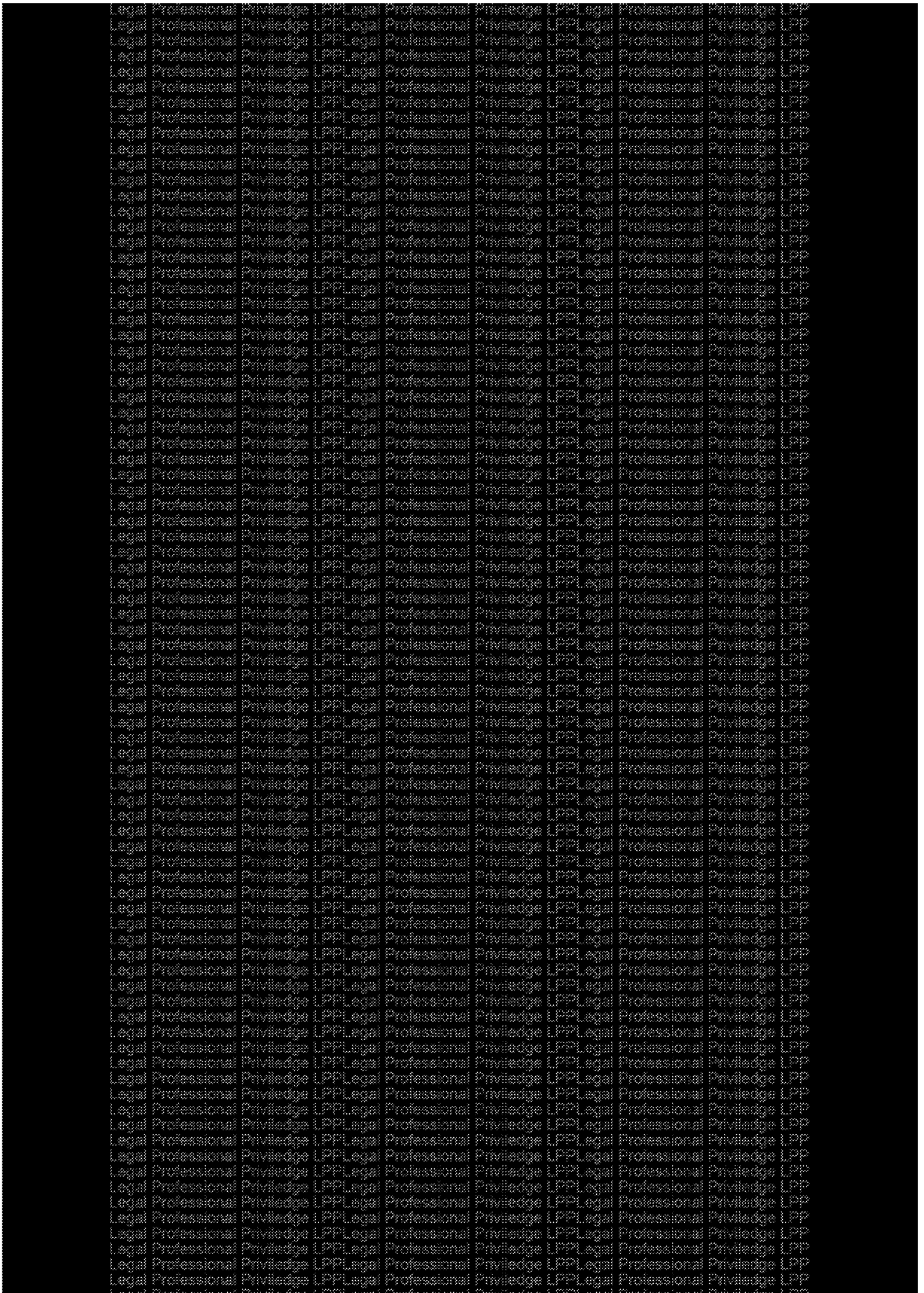
Regents Place, 350 Euston Road, London. NW1 3JN

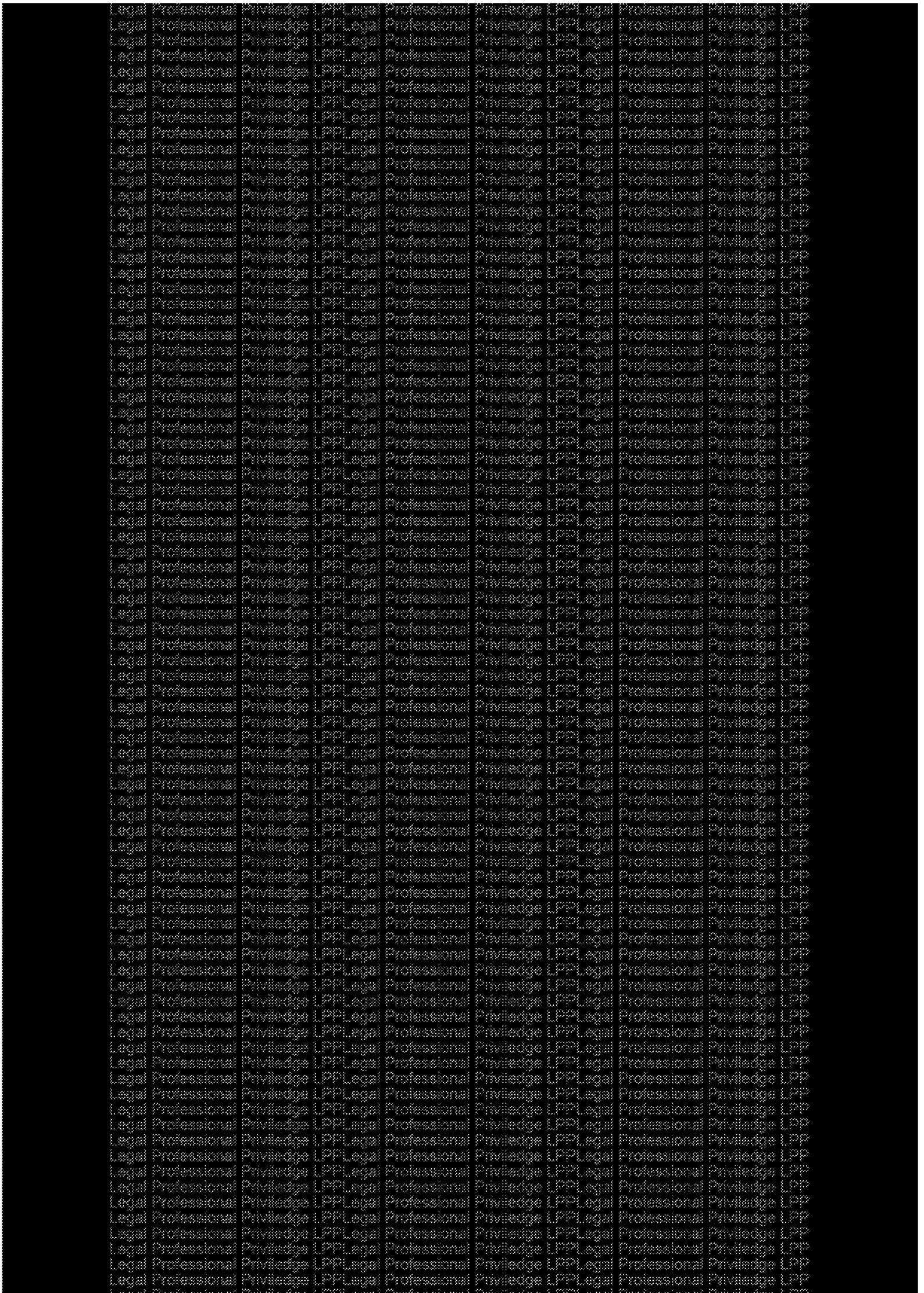
Napier House, 35 Thistle Street,Edinburgh. EH2 1DY

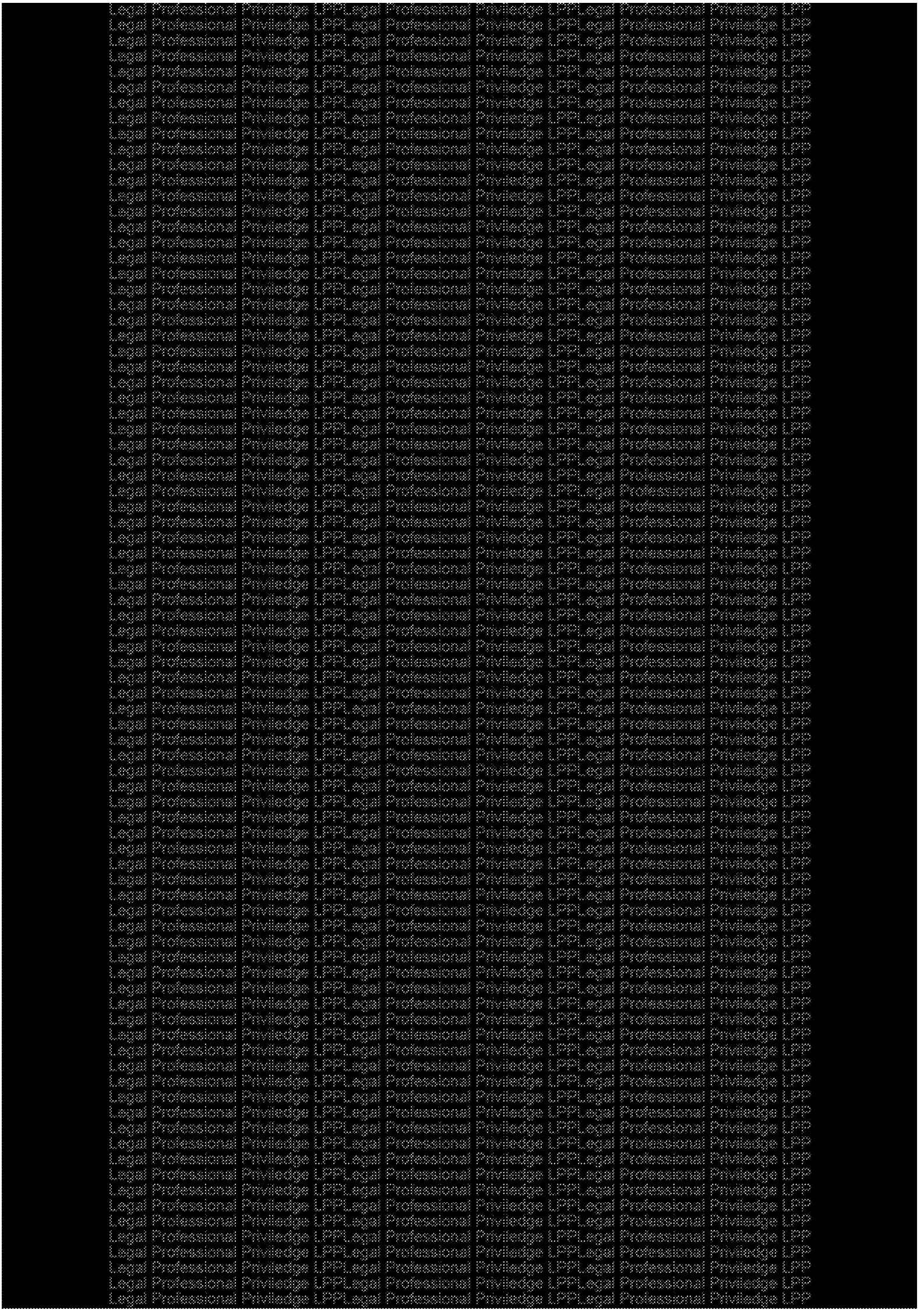
Regus House, Falcon Drive, Cardiff Bay. CF10 4RU

20 Adelaide Street, Belfast. BT2 8GD

Tel: 0845 357 8001
Fax: 0845 357 9001


Legal Professional Privledge LPPLegal Professional Privledge LPP


Legal Professional Privledge LPPLegal Professional Privledge LPP


Legal Professional Privledge LPPLegal Professional Privledge LPP

Operation ROCHESTER.

Stakeholder meeting.

Fareham Police Station Hampshire.

1530hrs Tuesday 19th December 2006.

Attendees.

Code A

Code A (General Medical Council)
Code A Solicitor for GMC)
Code A (Primary Care Trust, Strategic Health Authority)
Code A (Media for SHA)
Code A (Solicitor for NMC)
Code A (CPS)
Code A (Media Police)

Meeting objective.

To achieve multi - agency understanding in terms of organisational objectives following the NFA decision by CPS in respect of the criminal investigation into deaths at Gosport War Memorial Hospital.

Agenda.

1. Introduction/case overview. ACCSO WATTS Code A
2. General Medical Council situation report and future objectives.
3. Primary Care Trust/Strategic Health Authority situation report and future objectives.
4. Nursing and Midwifery Council situation report and objectives.
5. Hampshire CPS.
6. Media issues/approach.
7. A.O.B.

EVERSHEDS

Solicitor's Hearing File Use

attendance

Client General Medical Council
Matter Code A
Attendees See attached agenda

Date 20 December 2006
F/E Code A

Code A charged with overall strategic responsibility for the police began the meeting. He was formerly the Senior Investigating Office for Operation Rochester. He provided the following background information.

In 1998, a no of family members raised concerns regarding the deaths of their relatives at the Gosport War Memorial Hospital. The police investigated and reviewed 92 separate cases. In the last phase of the investigation, the police focussed upon 10 cases, which were referred to the CPS Special Case Division in London. Code A described a complex structured investigation with screening having been carried out to select those 10 cases where panels of experts provided their opinions, further investigations having been carried out where necessary and a Medico-legal opinion having been given by Field Fisher Waterhouse. As a result the cases were divided into different categories 1, 2 and 3. Category 3 cases were those where there was real concern that the care may have been grossly negligent.

The CPS is satisfied that the investigation that has been carried out has been thorough and appropriate. The police had tried to engage with the CPS to agree a managed approach to the release of information regarding the CPS decision. Code A said that he was convinced that everything possible had been done and that there were no further lines of enquiry open. However, what they haven't done is analyse the CPS advice and that means that there is a very small possibility of further enquiries. He had hoped to meet with the CPS to come to an agreed position in advance of this stakeholder meeting, but the CPS had refused.

The CPS had written letters to each of the family members. The police were keen to provide information as quickly as possible to the family members. It therefore did not prove possible to interrupt the process of informing the family members by returning to the CPS with queries on the advice.

Code A said that the police has kept careful records of information passed to the family members. The family members have very differing approaches to the investigation; some will be dissatisfied and undoubtedly some will be in contact with the media regarding the decision. The families have all been offered meetings by the CPS to discuss the decision.

Code A then took over. He explained that a panel of experts in geriatrics, nursing, toxicology and general medicine had screened the cases and identified 10 cases where there was significant concern. These 10 cases were then looked at by a palliative care expert, Code A from Nottingham and a Geriatrician, Code A from a Deanery in London. These experts had access to all medical notes, the responses from Code A and all witness statements (of which there are in excess of 800). They instructed a further 6/7 experts on specific medical issues. The difficulty with the investigation is that the experts have come to diametrically opposed views as to whether the patients were in the end stages of life, and whether the drugs

were properly given as palliative care. However, both experts recognised there had been negligence.

Code A said that the papers relating to 60- 80 cases have to date been passed to the NMC and the GMC.

The coroner may be holding an inquest into 3 cases, those being Code A Code A These are the only cases of the 10 that were buried. If a person is cremated, the coroner cannot hold an inquest unless he has been instructed to do so by the Lord Chancellor. The Coroner has confirmed that he has no problem with the GMC/ NMC investigation continuing in parallel. Code A family has instructed Code A

Code A then informed the meeting about the manner in which the family members have been informed. Although there are 10 cases, there are 13 family members that have been the points of contact for the police. The decision has been communicated to every family group, although not every family member. There has been an early indication that 1 or 2 families will be taking up the offer to meet with the CPS and Counsel. Code A has also provided a letter offering a meeting to discuss with the family members the investigative strategy. He has also included a form of consent for release of information to the relevant regulatory bodies. A number of families have indicated their intention to sign. The families have received a generic letter, with no reasoning on an individual basis.

Code A has been informed of the decision, as has the Minister for Health, the local MP for Hampshire, and the relevant doctors and healthcare staff. They will be informing all witnesses in due course.

It was explained that the advice from the CPS has been written on a strictly confidential basis so he cannot share it in the meeting, although he understands that some of us present may seek the advice in due course. It was explained that the relationship with Code A of the CPS is difficult and that he is rather a prickly character. However, the advice refers to R v Adomako, the principal case on negligent manslaughter. There were 2 difficulties with the cases, that of causation and also that gross negligence to a criminal standard was not made out.

Code A the Media Representative read out the CPS press release.

Code A then invited those present in the room to provide a situation report and summary of future objectives.

Code A explained that the GMC investigation had been on hold so as not to prejudice the police investigation. Code A explained that the GMC will be looking at a different test, that of serious professional misconduct so the fact that the CPS is not prosecuting poses no bar to the GMC. As for the current situation, Code A explained that 5 cases had been referred by the PPC to the PCC and therefore there will be a hearing in due course. He said that the question is to what extent the additional cases investigated by the police are to be added, and that is something we will need to consider. Code A emphasised that the clock has been ticking for some time, and that we are conscious that the Defence is likely to bring applications of delay. Code A was asked the timescale for the conclusion of the matter, and he replied that we wouldn't know until a decision had been taken as the number of cases to be put forward. In terms of the media attention, Code A Code A said that he had received calls that morning from family members, particularly Code A who has been vociferous throughout. He explained that we would not be able to say that Code A had already been referred to the PCC as under the old rules the PPC decision is taken in private, and the fact that a hearing is to take place is only made public 28 days before the hearing.

attendance

Code A solicitor for the NMC then explained that she could not provide very much in the way of a current update, having been brought in to attend the meeting at the last minute as the usual solicitor dealing with the case is in a hearing. However, she said that like the GMC they would need to take stock.

Code A of the PCT and the Strategic Health Authority stated that as a result of the Commission for Healthcare Improvement Report, there had been a review of the standard of care and it had now been brought up to a satisfactory standard. As far as he is concerned there would be no need for any shoring up. He is loathe to commence any new investigations as the GMC and NMC will now be investigating. Code A is no longer employed by the trust which means that the undertakings she gave will no longer have effect. He had some concerns about the CPS press release referring to errors. He stated that if there were errors the CPS had a duty to inform the Trust, and the Trust had a corresponding duty to ensure those errors are addressed. However, at the moment, if they are asked how the matter is being addressed he can't say as he doesn't know which errors the CPS is referring to. It was agreed that following the meeting the CPS would be contacted to see if the reference to errors could be removed from the press release prior to its circulation. There were two Trust investigations that had been suspended, he will now need to consider whether they are to be resurrected, and he will await the Chief Medical Officer's view.

The representative of the Independent Police Complaints Commission (IPCC) stated that a 4 year investigation of the police conduct in this case has already been carried out. Only if they receive complaints of a different nature will they be investigated. One low level such complaint has been received and there will be an independent investigation into this.

Code A of Hampshire CPS stated that he will be commenting privately on the way that this matter has been handled by Code A of the CPS, but all queries from professional bodies will have to be addressed to Paul Close.

Code A in subsequently read out the press release of Hampshire Police. Code A stated that he would be responding to interviews in similar terms.

Code A then provided LM with a list of the family members of the 10 cases. He advised that of these family members, Code A have been the most vociferous. Code A s represented by Code A It is therefore likely Code A Code A will push for a public inquiry. It is Code A who has complained most recently to the IPCC.

Code A stated that he had a 10 page summary of all of the cases that it would be useful for Code A to have including an outline of the expert evidence. He agreed to email this to Code A said that it would be useful to have his views on which of the 10 cases are the strongest, and he said he could provide this.

EVERSHEDS

attendance

Client	General Medical Council	Date	20 December 2006
Matter	Code A	F/E	Code A
Attendees	See attached agenda		

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The CPS had written letters to each of the family members. The police were keen to provide information as quickly as possible to the family members. It therefore did not prove possible to interrupt the process of informing the family members by returning to the CPS with queries on the advice.

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Code A then took over. He explained that a panel of experts in geriatrics, nursing, toxicology and general medicine had screened the cases and identified 10 cases where there was significant concern. These 10 cases were then looked at by a palliative care expert, Code A from Nottingham and a Geriatrician, Code A from a Deanery in London. These experts had access to all medical notes, the responses from Code A and all witness statements (of which there are in excess of 800). They instructed a further 6/7 experts on specific medical issues. The difficulty with the investigation is that the experts have come to diametrically opposed views as to whether the patients were in the end stages of life, and whether the drugs

were properly given as palliative care. However, both experts recognised there had been negligence.

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Code A has been informed of the decision, as has the Minister for Health, the local MP for Hampshire, and the relevant doctors and healthcare staff. They will be informing all witnesses in due course.

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attendance

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d

19/12/06

Code A - overall strategic responsibility. Was Senior Investigating Officer.

1998 - no of family members raised concerns. Police investigated 92 separate cases reviewed. Last phase 2001-2002. 10 cases → CPS special case division.

Complex structured screening - panels of experts, further investigation.

medico-legal expert - FFW

Cat 3 - real concern, negligent, grossly negligent

2004 - one month ago

Regular meetings ~~with~~ strategy / evidence. CPS satisfied investigation thorough / appropriate.

Had attempted to engage managed approach to release of info. Convinced everything has been done - no more lines of inquiry open.

Not been allowed by CPS to have meeting. Hoped to be able to analyse advice + come to agreed position.

Police convinced no leads, but haven't analyzed CPS advice - Small possibility further inquiries.

CPS advice on each individual case, letters to family members. Wanted to provide info asap to family. Couldn't interrupt that process + return to CPS.

Records of passing info to family. Families have different approaches to investigation, some will be dissatisfied. Some will be in contact with media.

Families have been offered meetings.

Geriatricians, Nursing, Toxicology general medicine.
Whittled down to 10 cases - significant concern
Palliative care } experts looked at 10 cases
Geriatrician.
All medical notes
Responses from Code A, all witness statements
800+ statements. Instructed further 6/7 experts on
particular medical issues.
Experts diametrically opposed as to whether in end
stages of life, whether palliative care given.
GMC + NMC provided with 60-80 cases.
Coroner may be holding an inquest 3 cases

Code A

Only required to hold inquest in burials - all rest
cremated. Only required to do inquest for even if
instructed by Lord Chancellor. Doesn't see problem
with GMC/NMC parallel.
Code A - Family instructed by Code A

10 families 13 family group members - points of
contact. Soonest practicable time. Contacted
yesterday where members were in the world. Communicated
to every family group. Received letter from CPS
invites meeting with CPS + Counsel. Early
indication from 1/2 families
Code A also provided letter offering meeting
to discuss investigative strategy. Included
form of consent for release. No of families indicated
intend to sign.

Code A

Health Minister
Local MP.
Drs + Healthcare staff.
Will be informing witnesses.

Advice from CPS - strictly confidence

Lead Case - R v Adamoko. Causation not made out. Negligence to gross negligence to criminal standard not made out. Code A of CPS invited but declined.
Relationship with Code A difficult. Close believed inappropriate to discuss advice with third parties.
Code A may be willing to impart advice

Pres Release.
~~Public confidence~~
CPS advised insufficient evidence to prosecute any person. - gross negligence / manslaughter.
-duty of care, breach, causation, gross negligence.

NMC
Code A - PCT, SHA. Have reviewed standard of care - now satisfactory. No need for sharing up.
Loathe to conduct new investigations. Code A nor practising there any more
Concerned about CPS statement referring to errors.
Recognises negligence, but not gross.
Need to know CMO's view.
Have suspended 2 investigations + whether they need to resumed.
Both experts recognised negligence

IPPC will be investigating police
Will be an independent investigation - low level complaint already made. Significant media interest. Separation between PCA + IPPC. Has to be significantly different to former complaint.

Hamps CPS
Will be commenting privately
all proj queries => CPS HQ. Code A

Media issues/approach.
Police to issue press release, respond to interviews in similar terms
most vocal as

Code A = represented by Code A

Code A already complained to IPPC.
Investigation already carried out by IPPC - no case made out. 4 yr investigation of police investigation

Code A - will push for public inquiry.

Palliative Geriatrician - Code A - Nottingham. London. Deanery. Tower Bridge.

Code A

From: Code A
Sent: 18 December 2006 17:03
To:
Cc: Code A
Subject: RE: Operation Rochester
Sensitivity: Confidential

Code A

My number is Code A

Code A

-----Original Message-----
From: Code A
Sent: 18 Dec 2006 16:58
To:
Cc: Code A
Subject: Re: Operation Rochester
Sensitivity: Confidential

**** Before acting on this email or opening any attachment you are advised to read the Eversheds disclaimer at the end of this email ****

Code A What's your mobile in case we need to contact u tomorrow? Code A

Sent from my handheld

-----Original Message-----
From
To: d
CC: Code A
Sent: Mon Dec 18 16:46:27 2006
Subject: RE: Operation Rochester

Dear Code A

I can confirm that I will be attending tomorrow's meeting. I have spoken with Eversheds Solicitors and can confirm that Code A will also be able to attend tomorrow's meeting.

Code A
General medical Council

-----Original Message-----
From: Code A
Sent: 18 Dec 2006 12:40
To: Code A
Subject: Operation Rochester

Code A

As per our conversation,

Code A is holding a Stakeholder conference in respect of Operation Rochester at 1530hrs tomorrow afternoon here at Fareham Police Station. You or your representative are invited.

The address is
Fareham Police Station
Quay st
Fareham
PO16 0NA

It is only a short taxi ride from the train station.

If you could let me know who is attending I'd be very grateful

Regards

Code A

Code A

Morris, Luisa

From: Code A
Sent: 18 December 2006 16:46
To: Code A
Cc:
Subject: RE: Operation Rochester
Importance: High
Sensitivity: Confidential

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Regards

Code A
Review Team
Code A

Code A

Code A

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Sensitivity: Confidential

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Regards

Code A
Review Team
Code A

Code A

From: Code A
Sent: 11 December 2006 11:09
To:
Cc: Code A
Subject: RE: Operation Rochester - Gosport War Memorial Investigation

Dear Code A

Thank you for your email. Code A from the GMC would wish to be in attendance, as would I as legal representative of the GMC. It is possible, that my colleague Code A may also attend, although this will depend somewhat on the date of the meeting. I would be grateful if you could let me have the date as soon as possible.

Kind Regards

Code A
FOR EVERSHEDS LLP

From: Code A
Sent: 10 December 2006 14:13
To: Code A
Cc:
Subject: FW: Operation Rochester - Gosport War Memorial Investigation

Dear Code A

Just to let you know that I spoke with the CPS attending lawyer Code A last Thursday 7th December..

He believes that he may be able to release the result towards the back end of this week..13th /14th Dec

(although previous indications have not been achieved due to CPS pressures of work)

We will be looking to hold a stakeholder meeting asap following the result..

Can you let me know who from the GMC is likely to be available?..

Thanks. Code A

From: Code A
Sent: 06 November 2006 17:03
To: Code A
Cc:
Subject: Operation Rochester - Gosport War Memorial Investigation

**** Before acting on this email or opening any attachment you are advised to read the Eversheds disclaimer at the end of this email ****

Please see attached letter.

*********** This email is sent for and on behalf of Eversheds LLP ***********

Code A

From: Code A
Sent: 11 December 2006 09:32
To:
Cc: Code A
Subject: RE: Operation Rochester - Gosport War Memorial Investigation

Code A

Can you let me know when the stakeholder meeting is, I think that I need to be there as well as yourself.

Code A

-----Original Message-----
From: Code A
Sent: 10 Dec 2006 14:13
To:
Cc: Code A
Subject: FW: Operation Rochester - Gosport War Memorial Investigation

Dear Code A

Just to let you know that I spoke with the CPS attending lawyer Code A last Thursday 7th December..

He believes that he may be able to release the result towards the back end of this week..13th /14th Dec

(although previous indications have not been achieved due to CPS pressures of work)

We will be looking to hold a stakeholder meeting asap following the result..

Can you let me know who from the GMC is likely to be available?..

Thanks Code A

From: Code A
Sent: 06 November 2006 17:03
To:
Cc: Code A
Subject: Operation Rochester - Gosport War Memorial Investigation

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Please see attached letter.

*********** This email is sent for and on behalf of Eversheds LLP ***********

Code A

From: Code A
Sent: 13 November 2006 12:33
To: Code A
Subject: RE: Operation Rochester - Gosport War Memorial Investigation
Attachments: Doc1.doc

Code A

Please find attached a list of patients whose case files still sit with CPS awaiting decision..
I am informed that counsel has completed his advice and that the papers sit with the CPS lawyer who is considering his decision..
I am awaiting confirmation of a meeting with CPS to discuss the decision week commencing Monday 20th November..

Once the decision has been made the families will be notified first..
We will then be calling a stakeholder meeting to discuss the way forward..

Code A
Detective Superintendent.

From: Code A
Sent: 06 November 2006 17:03
To:
Cc: Code A
Subject: Operation Rochester - Gosport War Memorial Investigation

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Please see attached letter.

********** [http://www.eversheds.com/] **********

****

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****

Operation ROCHESTER.

Case-file submission dates.

Code A – 24.12.2004.

Code A – 18.05.2005.

Code A – 18.05.2005.

Code A 17.11.2005.

Code A – 17.11.2005.

Code A – 14.06.2006.

Code A – 14.06.2006.

Code A – 27.06.2006.

Code A – 27.07.2006.

Code A – 27.07.2006.

+ Generic witness statements/case-file exhibits/medical note translations/glossary of terms.

Code A
Det Supt
01.08.2006.

Code A

From: Code A
Sent: 06 November 2006 17:09
To: Code A
Subject: RE: Operation Rochester - Gosport War Memorial Investigation

Thanks Code A nice letter.

-----Original Message-----
From: Code A
Sent: 06 Nov 2006 17:03
To:
Cc: Code A
Subject: Operation Rochester - Gosport War Memorial Investigation

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Please see attached letter.

********* **This email is sent for and on behalf of Eversheds LLP** *********

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General Medical Council

St James Building, 79 Oxford Street Manchester. M1 6FQ

Regents Place, 350 Euston Road, London. NW1 3JN

Napier House, 35 Thistle Street,Edinburgh. EH2 1DY

Code A

From: Code A
Sent: 06 November 2006 17:03
To:
Cc: Code A
Subject: Operation Rochester - Gosport War Memorial Investigation
Attachments: CAR_LIB1-#1698422-v1-letter_to_a Code A .DOC

Please see attached letter.

Code A
Hampshire Constabulary

Date 6 November 2006
Your ref
Code A

By email

Dear Code A

Operation Rochester - Gosport War Memorial Investigation

We are instructed by the General Medical Council ("GMC") in relation to the conduct of Code A Code A

We refer to your email of 28 July 2006 addressed to Code A of the GMC in which you advised that there were 10 remaining cases under investigation and that you were meeting with the Treasury Council on 2 August 2006 to discuss the viability of possible criminal prosecutions.

The General Medical Council has sought on numerous occasions further information to allow it to progress its own investigations. The GMC is anxious to continue its investigation and proceedings in order to properly comply with its statutory duty of protecting the public. We note from your email that further disclosure to the General Medical Council was under discussion, and that you would be in contact, post 2 August. Are you now in a position, to provide an update as to whether a criminal prosecution will proceed and what documents are to be disclosed? Please could you also provide the names of those 10 cases which remained under investigation.

Yours faithfully

EVERSHEDS LLP

Eversheds LLP
1 Callaghan Square
Cardiff
CF10 5BT

Tel 0845 497 9797
Fax 0845 498 7333
Int +44 20 7497 9797
DX 33016 Cardiff
www.eversheds.com


Legal Professional Privilege LPPLegal Professional Privilege LPPLegal Professional Privilege LPP

Code A

From: Code A
Sent: 03 August 2006 18:36
To: Code A
Subject: FW: OP Rochester..Gosport War Memorial Investigation.

From: Code A
Sent: 01 August 2006 09:41
To: Code A
Subject: FW: OP Rochester..Gosport War Memorial Investigation.

P lease find attached an update from the police on Code A

From: Code A
Sent: 28 July 2006 12:23
To: Code A
Subject: FW: OP Rochester..Gosport War Memorial Investigation.

Hi Code A

See attached in Code A absence....

Thanks
Code A

From: Code A
Sent: 28 July 2006 12:21
To: Code A
Subject: FW: OP Rochester..Gosport War Memorial Investigation.

From: Code A
Sent: Friday, July 28, 2006 12:23:29 PM
To:
Cc: Code A
Subject: RE: OP Rochester..Gosport War Memorial Investigation.
Auto forwarded by a Rule

Dear Code A
Thank you for the update.
I look forward to receiving a further update once you have met with Treasury Counsel.
Code A

-----Original Message-----
From: Code A
Sent: 28 Jul 2006 12:11
To:
Cc: Code A

Code A

Subject: OP Rochester..Gosport War Memorial Investigation.

Dear Code A

Code A

Please find attached a family group update letter that I am sending today to relatives of the 10 remaining cases under investigation.

<<Operation ROCHESTER Family Group Update 28/7/2006.>>

All files have now been forwarded to the CPS and I am meeting with Treasury Counsel next week Wednesday the 2nd August to discuss the outcome.

We have also been interviewing (under caution)a consultant Geriatrician Code A Code A in respect of 2 cases (of the 10 above) the deaths of Code A and Code A The final interview with Code A is being held on 8th August 2006.. The police investigation into these matters is then essentially complete.

Once the decision in respect of any prosecution is made (in my view not all of these cases meet the standard of evidence required to prosecute criminally and the public interest hurdle remains to be addressed) then we will need to get together to discuss further disclosure to the GMC and NMC.

I spoke with Code A legal rep Code A last week, he confirmed that Code A Code A was still adhering to the voluntary agreement not to prescribe Opiates and Benzodiazepines.. She has however now taken a senior practice partner position at her surgery..

I will be in touch post 2nd August to discuss the way forward.. It may be appropriate to pull all stakeholders together to talk this through including the local Portsmouth Coroner Code A

Regards..

Code A Det Supt..

****

General Medical Council

St James Building, 79 Oxford Street Manchester. M1 6FQ

Regents Place, 350 Euston Road, London. NW1 3JN

Napier House, 35 Thistle Street,Edinburgh. EH2 1DY

Regus House, Falcon Drive, Cardiff Bay. CF10 4RU

20 Adelaide Street, Belfast. BT2 8GD

Tel: 0845 357 8001
Fax: 0845 357 9001

4013

Code A

From: Code A
Sent: 01 August 2006 09:41
To: Code A
Subject: FW: OP Rochester..Gosport War Memorial Investigation.

GMC

Code A

P lease find attached an update from the police on Code A

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Cc: Code A

Code A

Subject: OP Rochester..Gosport War Memorial Investigation.

Dea Code A

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Regards..

Code A Det Supt..

General Medical Council

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Regents Place, 350 Euston Road, London. NW1 3JN

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20 Adelaide Street, Belfast. BT2 8GD

Tel: 0845 357 8001
Fax: 0845 357 9001


Legal Professional Privilledge LPP

Chief Constable
Hampshire Constabulary

Dear Sir,

Code A

You will doubtless recall the circumstances of this case. You will further recall that in August 2002, the Professional Purposes Committee of the Council decided to refer to the Professional Conduct Committee, the conduct of Code A in relation to five of her deceased patients, Code A Your Constabulary had already investigated whether the doctor's conduct in relation to these patients merited the bringing of criminal charges; the CPS decided in February 2002 not to proceed in any of these cases.

That decision was apparently re-considered and we agreed to defer the prosecution of the charges that we had notified to Code A in relation to these five deceased, given that we were notified in October 2002 of the police's intention to re-open their enquiries. In subsequent discussions, it appears that your Constabulary has enhanced the scope of its enquiry to cover a number of other deceased patients of Code A

The Council, in May of 2004 wrote to Code A somewhat in desperation, seeking to obtain your Constabulary's indication when the investigation would be concluded, and with what result. We also sought further information to allow us to progress our own investigations.

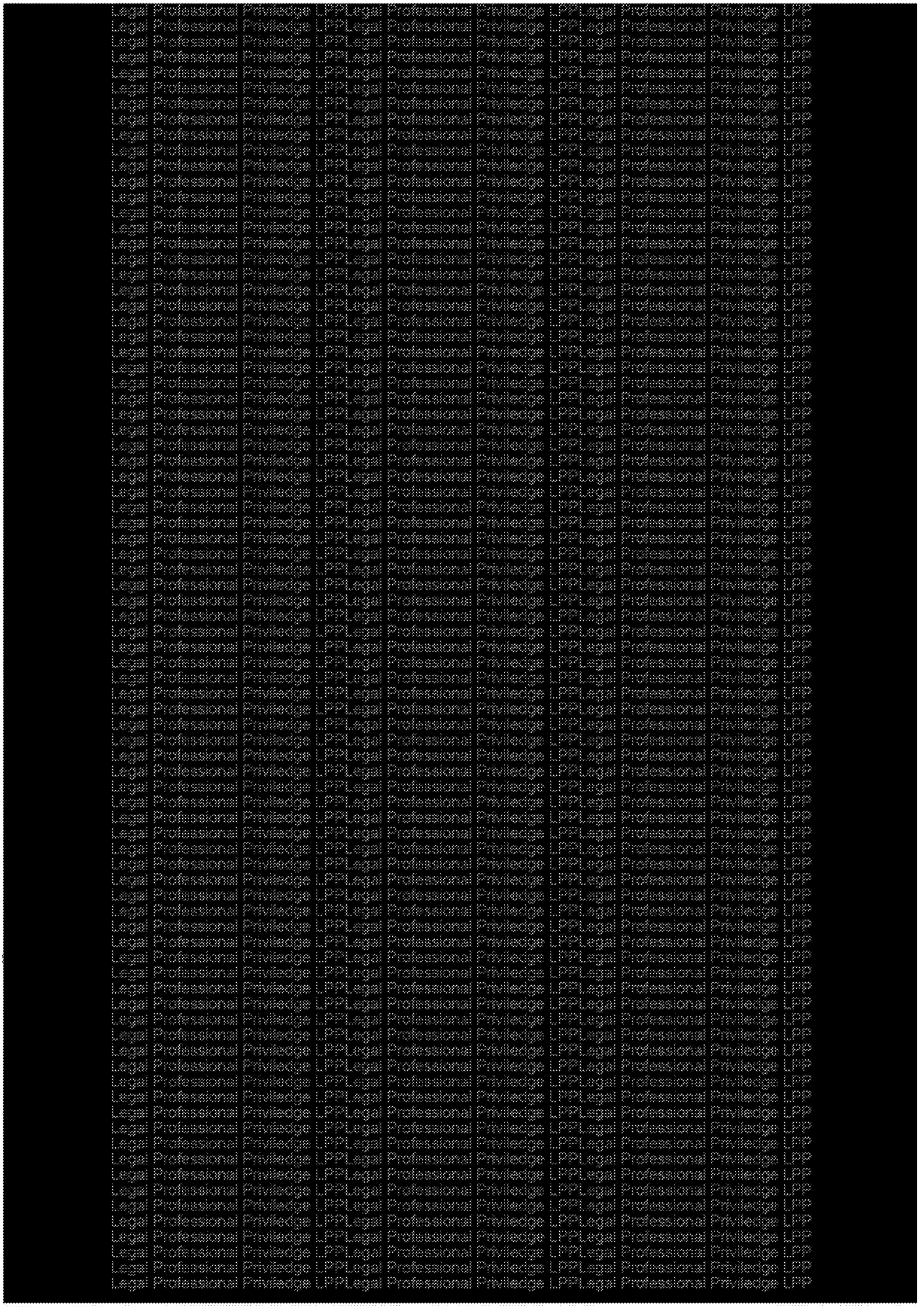
Despite that letter (copy attached), and despite a subsequent meeting with your force, we still are no further forward in obtaining such indication, or any further information that would assist us in our own investigation.

The deaths we have referred to the Professional Conduct Committee took place in 1998; it is now over four years since your investigation began. The only indication that we have from the Constabulary as to what is likely to happen is the CPS decision in February 2002 not to prosecute.

Given these facts, we are advised that we cannot wait any further with our investigation and proceedings, if we are to properly comply with our duty of protecting the public.

We therefore put you on notice that unless we hear from you by return with the positive responses sought in our letter of 5 May 2004, it is the Council's intention to proceed with the charges already notified against Code A and to proceed with its own investigation into those deaths. We further intend to exercise our powers under Section 35A of the Medical Act 1983 by seeking from you the relevant documentation in relation to further investigations you have made, both in relation to the five deceased notified to Code A already, and in relation to the further deceased that you have been investigating, as we believe that the supply of such information and production of such documents is relevant to the discharge of our functions.

Yours faithfully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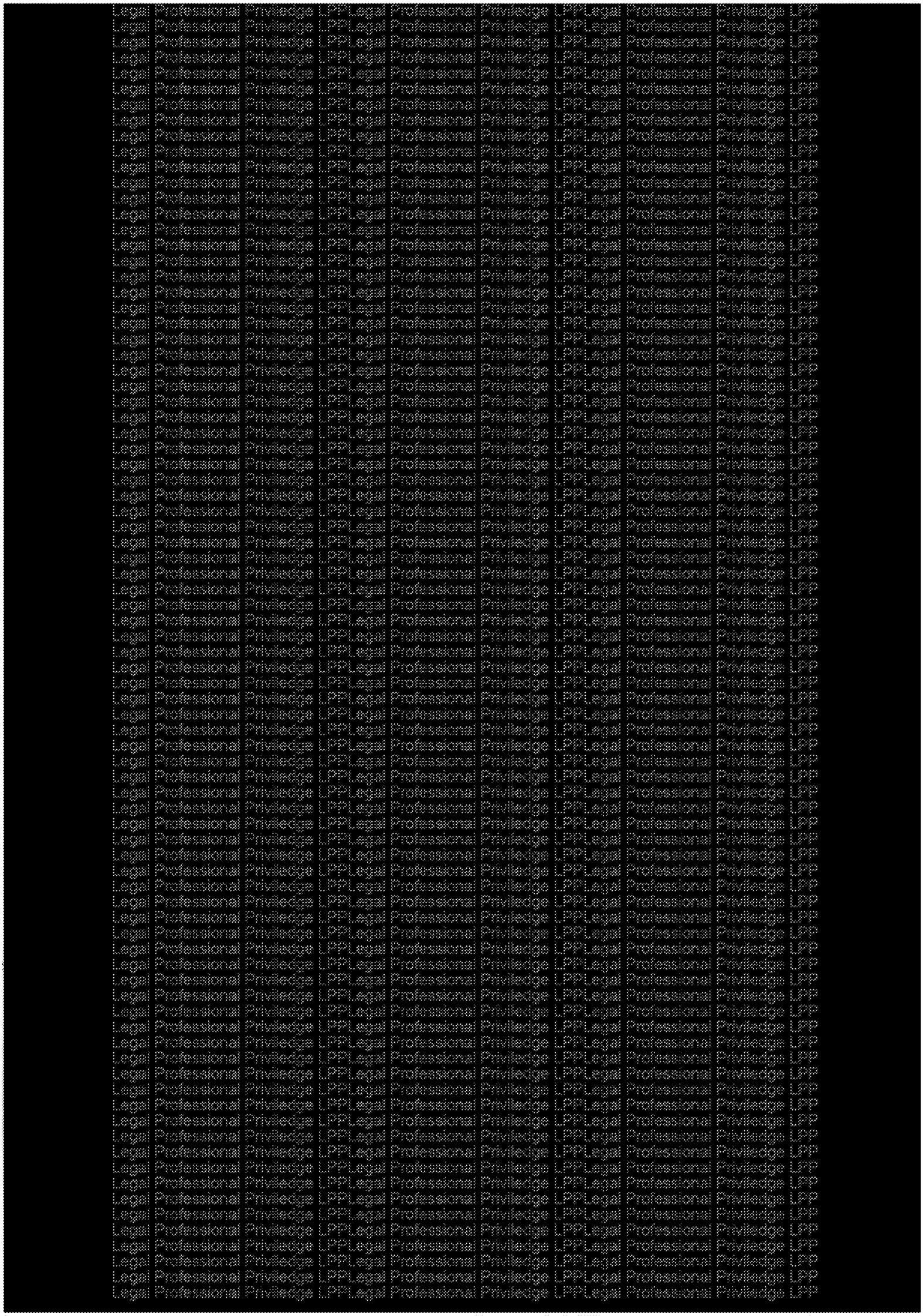
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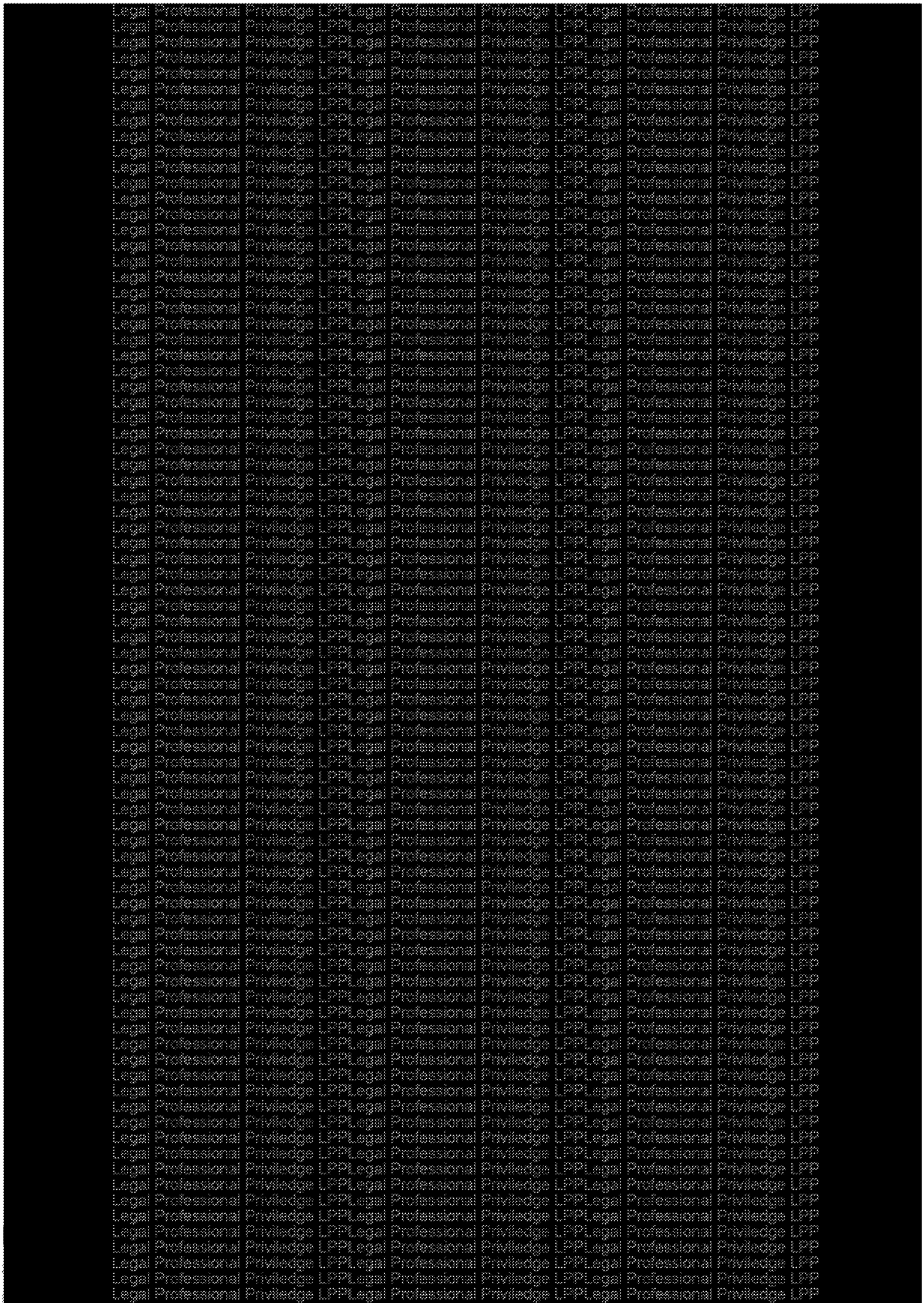
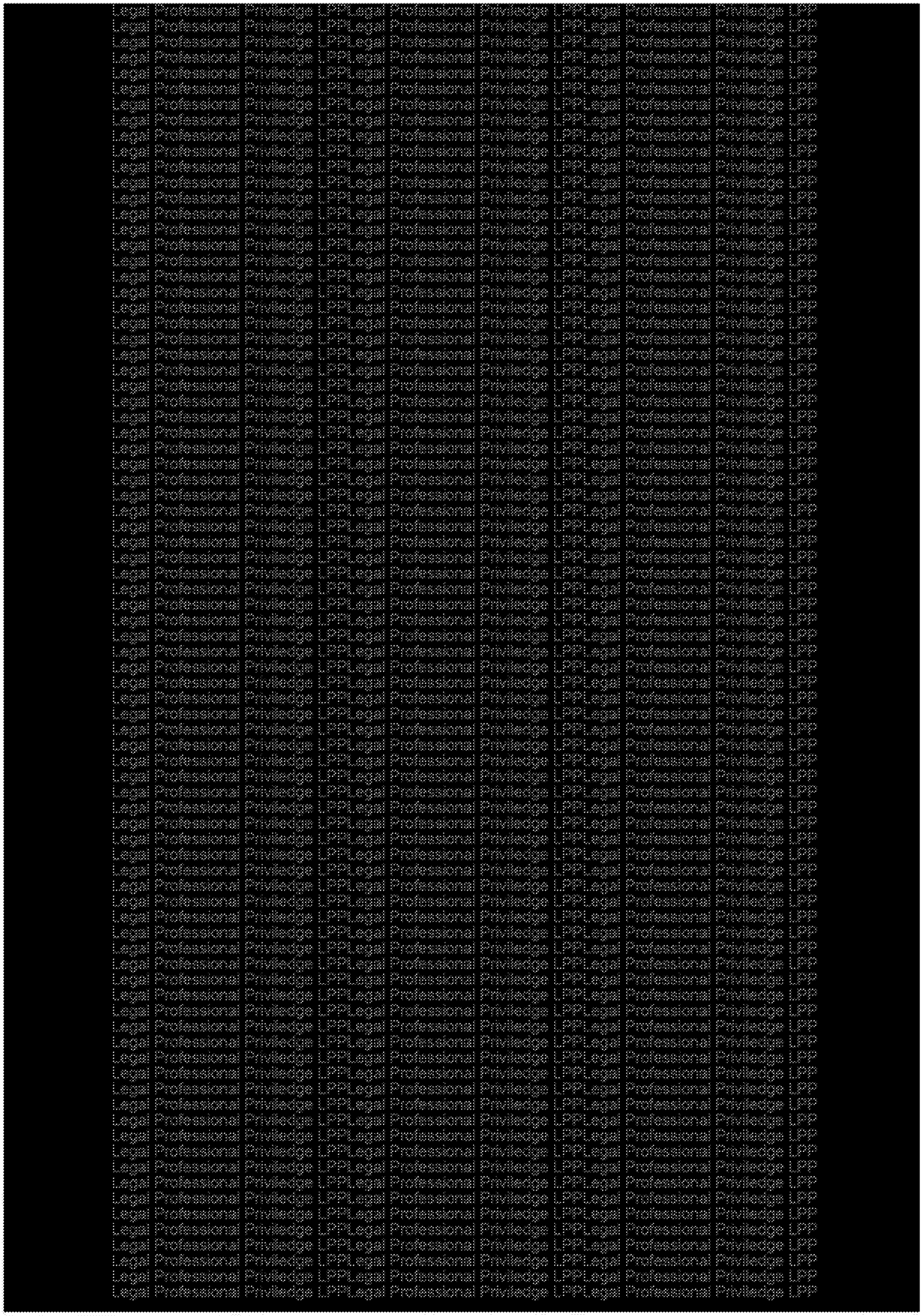

Legal Professional Privledge LPP


Legal Professional Privledge LPP


Legal Professional Privledge LPPLegal Professional Privledge LPP


Legal Professional Privledge LPP

Code A

Code A

Code A

CONTACT INFORMATION			
Client:	**General Medical Council** **Regent's Place** **350 Euston Road** **London NW1 3JN**	Tel:	**020 7189 5150**
Ref:			
Address:		Mobile:	
		Fax:	**Code A**
Contact:	**Peter Swain**	E-mail:	
Complainant	**Code A**	Tel:	
Ref:			
Address:	CHELTENHAM [illegible]		
		Fax:	
Contact:	**Code A**	E-mail:	
Counsel:		Tel:	
Ref:			
Address:		Mobile:	
		Fax:	
Contact:		E-mail:	
Expert:		Tel:	
Ref:			
Address:		Mobile:	
		Fax:	
Contact:		E-mail:	
Witness 1:		Tel:	
Ref:			
Address:		Mobile:	
		Fax:	
Contact:		E-mail:	
Witness 2:		Tel:	
Ref:			
Address:		Mobile:	
		Fax:	
Contact:		E-mail:	
Opponent's Solicitor		Tel:	
Ref:			
Address:			
		Fax:	
Contact:		E-mail:	