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Other D	ocument Form

lumber 21282

TITLE DRAFT LETTER WITH REPORT FORMAT TO DR. BLACK

(Include source and any document number if relevant)

Document registered / indexed as indicated			
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Examined - further action to be taken		O/M	SIO
irther actions no(s)		Indexer	

Code A

From: Sent:

Williams, David M 10 January 2005 11:58

To:

Code A

Subject:

FW: Operation ROCHESTE4

From: Sent:

Williams, David M

15 December 2004 16:11

To: Subject: Code A
Operation ROCHESTE4



Operation CHESTE4.doc (52 KI

Code A

As discussed.. Please proof and forward to Yvonne..

Thanks.DW.

Operation ROCHESTER. Dr BLACK 15/12.

Dear Dr BLACK

May I open this letter by thanking you for your timely response to what has clearly been a considerable body of work in the preparation of the five draft reports received from yourself between August and December 2004.

We approach a phase in this investigation where we are starting to compile case files for the Crown Prosecution Service in respect of the individual cases under investigation and using the draft expert reports to inform our ongoing investigation strategy.

Having reviewed the framework of the expert reports received from yourself and other experts we have requested that a consistency of format is applied to the process and construction of the expert reports to enable greater understanding by those reviewing the evidence contained therein.

Your terms of reference as outlined in a letter dated 14th July 2004 include a request to articulate within your expert report whether patients under review received the proper standard of care or treatment from medical staff.

It is observed that you appear to centre your reports upon whether an individual was terminally ill and consider then whether the treatment/care was appropriate.

It would be beneficial to the investigation if you were also to comment upon the standard of care afforded to these patients by healthcare professionals prior to your determination of the point where the condition became terminal. This approach will enable the investigation team and ultimately the Crown Prosecution Service to consider wider issues of culpability, particularly at Consultant and Primary Care Trust levels.

Code A has raised further issues in respect of the DEVINE case to which you have responded within a document separate to your initial draft report.

These points should be incorporated within the body of your report so that they can be read in context.

The following is the format that we would wish you to follow in preparation of your reports, commencing with the Devine case which I would ask you to complete as soon as you are able. As previously requested could you please date all draft reports, also giving version numbers.

SUMMARY OF CONCLUSIONS

Executive Summary please.

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day. Where appropriate, if the care is felt to be suboptimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

- 3.1 Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day.
- 3.2 If the care is found to be suboptimal what treatment should normally have been proffered in this case.
- 3.2 If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups.

3. BRIEF CURRICULUM VITAE

Please insert

4. DOCUMENTATION

This Report is based on the following documents:

- [1] Full paper set of medical records of Elsie Devine.
- [2] Full set of medical records of Elsie Devine on CD-ROM.
- [3] Operation Rochester Briefing Document Criminal Investigation Summary.
- [4] Hampshire Constabulary Operation Rochester Guidance for Medical Experts.
- [5] Hampshire Constabulary Summary of Care of Elsie Devine.

- [6] Commission for Health Improvement Investigation Report on Portsmouth Health Care NHS Trust at Gosport War Memorial Hospital (July 2002).
- [7] Palliative Care Handbook Guidelines on Clinical Management, Third Edition, Salisbury Palliative Care Services (1995); Also referred to as the 'Wessex Protocols.'
- [8] Portsmouth Health Care NHS Trust Policies:
- i) Control of Administration of Medicines by Nursing Staff Policy (January 1997).
- ii) Prescription Writing Policy (July 2000).
- iii) Policy for Assessment and Management of Pain (May 2001).
- iv) Compendium of Drug Therapy Guidelines, Adult Patients (1998).)
- v) Draft Protocol for Prescription Administration of Diamorphine by Subcutaneous Infusion, Medical Director (December 1999).
- vi) Final version of the Protocol for Prescription Administration of Diamorphine by Subcutaneous Infusion.
- vii) Medicines Audit carried out by the Trust referred to as Document 54 on page 52 in the Chi Report (reference 6).

Any other documentation used during the completion of the report

5. CHRONOLOGY/CASE ABSTRACT

At this point the timeline already prepared could be inserted

6. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

A number of these points have already been raised in the Devine report

Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day?

8. OPINION

Again already written but should include the points raised by Code A Could be broken down into issues raised at OA and or GWMH

9. LITERATURE/REFERENCES

10. EXPERTS' DECLARATION

- 1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
- 2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
- I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
- 4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
- 5. Wherever I have no personal knowledge, I have indicated the source of factual information.
- 6. I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
- 7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
- 8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
- 9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
- 10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

11. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature:	Date:
Once again many thanks for your continued contribution to a challeng	ging investigation.
Yours Sincerely	
David WILLIAMS	
Detective Superintendent	