Other Document Form

Number T 2657

Title EMAIL DSUPT WILLIAMS WITH IPCC REVIEW OF SIO POLICY

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further actions no(s)

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

Code A

O/M	SIO

Indexer

Code A

From: Williams, David M
Sent: 18 April 2005 12:38
To: Code A
Cc: WATTS, Steve; Niven, Nigel; Code A Grocott, David; Code A
Subject: OP ROCHESTER/IPCC review of policy.

Operation CHESTE5.doc (72 KI

Mr WATTS ..

Please find attached..

I have distilled the first 300 policies entries down to 40 key decisions in terms of investigation strategy.. To provide focus for our meeting with Laurence LUSTGARTEN of the IPCC this Wednesday 20th April 1430-1600hrs.

Code A

Would you please E mail the attached document to Mr LUSTGARTEN..

Thanks.DW.

Operation ROCHESTER.

Investigation into deaths at Gosport War Memorial Hospital 21st August 1998-....

Review of Senior Investigating Officer policy files. Briefing Note FAO ACCSO and IPCC.

15th April 2005.

Book 1 policy1. 18.8.99. DCI BURT designated SIO attaches briefing note of circumstances to date completed by Det Supt LONGMAN reviewing the investigation by DI MORGAN. Reports that Glady's RICHARDS died 21.8.1998 at Gosport War Memorial Hospital, reported to DC BETTESWORTH at Gosport Police station by daughter Gillian MACKENZIE, 27.9.1998 who effectively alleges that her mothers death was hastened through inappropriate levels of diamorhpine being administered. Investigation passed to Major Crime Department following a complaint by MACKENZIE that the matter had not been properly investigated.

Book 1 policy 15. 20.10.99. DCI BURT engages the services of Professor Brian LIVESAY to review standard of care provided (Prof LIVESAY concludes that Mrs RICHARDS unlawfully killed)

Book 1 policy 18. 12.4.2000. DCI BURT briefs head of CID providing a briefing note detailing staffing and strategy considerations.

Book 1 policy 27. 9.6.2000. DCI BURT decides to interview all healthcare staff with a duty of care towards Mrs RICHARDS under caution.

Book 1 policies 37/40. Following local news article five further reports received from members of the public expressing concerns regarding family member deaths at Gosport War memorial hospital.

Book 1 policy 43. 12.5.2001. Briefing Note DCI BURT to Det Supt JAMES. Nine fresh cases have now been reported. Refers to fresh information alleging a culture of euthanasia (Nurse SPILKA statement April 2001)

Book 2 policy 1. 21.5.2001. Det Supt JAMES now SIO. Briefs ACCSO Mr SMITH, re further complaints and statement of SPILKA, records that this substantially alters the position of 12.4.2000.

Book 2 policy 4. 21.5.01. Det Supt JAMES arranges conference with CPS and Treasury Counsel to discuss legal issues, and similarity between RICHARDS and other cases.

Book 2. Various early policy decisions 21/5-3/7/01

- Explore credibility of Prof LIVESAY
- Statistician re mortality rates
- Undertake review of individual/corporate liability
- Liaise SHIPMAN investigation management
- Brief practicing Geriatric consultant DR MUNDY
- Brief Consultant Physician/Pharmacologist Prof FORD.
- Liaise director public health.
- Enquiries DR BARTON's line management.

Book 2 policy 21. 3.7.01. Following assessment decision to investigate four further cases, PAGE, CUNNINGHAM,WILSON,WILKIE (similarities to RICHARDS case ie non life threatening conditions..syringe driver diamorphine..Death.

Letter from CPS dated 7th August 2001(not in policy file) in respect of the case of Gladys RICHARDS.

Summarised:-

- Police to decide what investigations if any to make re associated complaints.
- NFA insufficient evidence to provide a realistic prospect of conviction.
- Case discussed with Counsel David PERRY.
- Decision that no reliable evidence that RICHARDS unlawfully killed following conference with Counsel, Prof LIVESAY and Det Supt JAMES of 19.6.2001.

  Following matters emerged from conference:-

  1. Prof LIVESAY not clear as to the legal ingredients of manslaughter.
  2. Dr BARTON's decisions entitled to be afforded some respect as she was involved in Mrs RICHARDS care as a front line clinician.
  3. Dr BARTONS decisions could find support among a responsible body of medical opinion.
  4. Bronchopneumonia as a cause of death could not be contradicted.
  5. Not possible in the absence of any post mortem finding to exclude heart attack as a possible cause of death.

Book 2 policy 35.23.10.01. Commission for Health improvement investigation personally briefed by Supt JAMES.

Book 2 policy 42. 28.01.02. Supt JAMES. Wider investigation not appropriate. Reasons:- Time-lapse.. 3.5yrs since deaths further investigation 1-2yrs. Potential abuse of process. Medical experts do not met threshold of legal requirements. Conflicts between medical and expert evidence. To proceed could require investigation of up to 600 deaths, heightened public concerns, high public expectations and no certainty of outcome.
Legal issues around causation and negligence. Other regulatory bodies have a role, GMC, NMC and Trust.

Book 2 policy 43. 28.1.02. ACCSO DCS and stakeholders informed re policy 42.

(CPS eventually made NFA decision on cases 1-5 28.11.2002.

Book 3 policy 1. 19.09.2002. DCC appoints SIO D/C/S WATTS following complaint against Supt JAMES.

Book 3 policy 2. 19.9.2002. Lines of Enq:-

- Is there a causal link between administration of diamorphine and deaths at GWMHospital.
- Review papers.
- Supt STICKLER to submit 4 additional files to CPS.

Book 3 policy 3 19.9.2002. SIO meets DCC READHEAD. Papers emanating from Health Authorities re concerns in respect of diamorphine administration in 1991 at GWMH. Executives PIPER and HORNE suspended.
Review papers to assess impact on the enquiry.
Recover original papers to establish provenance.
Call critical incident management meeting to identify issues and the way forward.

Book 3 policy 4. 19.9.02. LOE incorporating review of work to date, statistical analysis of deaths, provide experts MUNDY and FORD with fresh material.

Book 3 policy 9. 26.9.02. Commit to Holmes. (Recognition of long term investigation)

Book 3 policy 10. 27.9.2002. Witness statement nurse Anita TUBRITT.

(Comment) Employed as staff nurse 1987 GWMH. Diamorphine doses occasional until Dr BARTON employed 1991. Syringe drivers introduced but initially no formal training to staff, became preferred method of administering drugs. Nurse TUBRITT raised significant minuted concerns with managers at the time. Failed to mention these concerns to the 1998 CHI investigation. However retained relevant documents from early 90's and revealed to police Sept 2002.

Book 3 policy 19. 24.10.02. Family members of deceased form action group in alliance with Alexander Harris solicitors.

Book 3 policy 32. 28.11.02. Meeting C/Supt WATTS and CPS.

- No prospect of a prosecution in respect of RICHARDS + 4 cases.
- In absence of other additional evidence no avenues to follow in respect of criminal offences.
- Agreed that additional information generated by 19.9.02 papers and by publicity may reveal evidence of criminal matters.
- Agreed to expand investigation to include those currently known to police and seek other related forensic and medical expertise.

Book 3 policy 33. 28.11.02. Draw together experts led by Prof FORREST, in Palliative Care, Geriatrics, Toxicology and review cases dating to 1991.

Book 3 policies 34-40. Dec 02. Meetings SHA, CHI CPS to determine public safety and primary interests.

Book 3 policy 41. 20.12.02. Attachments re SHA and CHI proposed investigation strategies, SIO meeting with CPS to discuss conflict of interest issues.

Book 3 policy 42. 8.1.02. 'Potential problems cannot be resolved by dogmatic legal advice (writes Paul CLOSE) we are probably in un-chartered waters and navigation will be by instinct'.

Book 3 policy 43. 13.1.02. CMO 'stays' SHA, CMO and CHI investigations.

Book 3 policy 46. 16.01.03. W.O.R.M group Ltd to copy patient records onto CD.

Book 4 policy 2. 7.3.03. Summary of the investigation to date(indicates that police are now assessing 62 cases through healthcare experts to establish whether there is justification to wider criminal investigation according to negligence criteria.

Book 4 policy 25. 14.8.03. Mathew LOHN Legal/Medico lawyer employed to quality assure the findings of the healthcare experts assessment of 62 cases.

Book 4 policy 35. 29.9.03 Professor BAKER has been commissioned by the Chief Medical Officer to conduct a statistical review of cases. He has raised significant concerns in respect of 16 cases + four further cases have been reported to police. The further 20 cases to be reviewed by the team of healthcare experts (submitted 27.10.03)

Book 4 policy 43. 7.10.03. SIO meets with CPS providing investigation update. Key issues discussed:-

- CPS felt that Prof FORREST would provide heavyweight evidence.
- Causation must be proved to a criminal standard.
- Dr BARTON emerging as a common denominator in the cases under investigation.

Book 5. policies 1-44 14.11.03 – 3.3.04.

Investigation maintenance and key stakeholder liaison:-

- Chief Medical Officer.
- Strategic Health Authority.
- Family group members and their legal representatives.
- Primary Care Trust.
- Key clinical team of reviewing experts.
- Crown Prosecution Service.
- Medical Defence Union legal reps.
- Media.
- Police Complaints Authority.
- H.M.Coroner.
- General Medical Council.
- Nursing Midwifery Council.
- Legal/medico quality assurance lawyer.

Book 5 policy 45. 4.3.04. SIO reviews lines of enquiry. Full audit to be conducted of all W.O.R.M records. KCT to complete review of 16 BAKER cases and family members to be notified. Staements to be taken from family group members in respect of category 3 cases ie.. Negligent care not meeting the standards of acceptable clinical practice.
Identify evidential experts in Palliative and Geriatric care.
Develop interview strategy.

Book 5 policy 50. 5.4.04. SIO investigation review and strategy. 12 cases to date fall into category 3 and warrant further investigation. Framework for exhibit handling and gathering of witness evidence from hundreds of healthcare professionals in

respect of the 12 cases to be investigated has been agreed to ensure common and acceptable standard of statement taking.

Book 6 policy 6. 25.5.04. Dr Andrew WILCOCK (Palliative Care) commissioned to provide evidence in respect of category 3 cases.

Book 6 policy 7. 25.4.04. Review of investigation and policy DCI WILLIAMS.

Recommendations agreed by SIO WATTS include:-

- Identify priority cases/ fast-track to CPS.
- Increase staffing by Det Sgt and 4 Detective Constables.
- Consult family liaison co-ordinator.

Book 6 policy 11. 10.6.04. Nine cases categorised 3B by key clinical team, ie ' care outside the bounds of acceptable clinical practice and cause of death unclear'. Brief case histories prepared and attached. 4 further category 3 cases whilst negligent care cause of death is natural.

Book 6 policy 34. 5.8.04. Dr David BLACK (Geriatrician) has been commissioned to provide expert evidence.

Book 6 policy 35. 12.8.04. Mathew LOHN Q/A Lawyer has raised 7 cases from the Q/A process that he wishes to discuss with the team of experts in terms of case categorisation.

Book 6 policy 37. 1.9.04. Spreadsheet attachment indicating status of all cases referred to date.

14 category 1's (natural causes optimal care released from Investigation Feb 04.
58 category 2's (sub-optimal care not extending to negligence therefore not warranting further criminal investigation)
9 category 3b's (negligence warranting further investigation).
4 category 3a's (negligence but natural cause death)
3 cases work ongoing not yet classified.

Book 6 policy 46. 17.9.04. 19 category 2 cases released to the GMC. Will form the basis of an I.O.C hearing.

Book 6 policy 50. 27.9.04. Situation report attachment.