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

Code A

O/M	SIO

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Operation Rochester
Conference at Initial Conference Centre
26th April 2003
MINUTES

Present:

Det Ch Supt Watts
DI Niven
Code A

Professor Forrest
Professor Ferner
Dr Naysmith
Dr Lawson
Mrs Waters

Det Ch Supt Watts thanked the team for their attendance and work so far then offered Dr Forrest the floor to present the findings of the Clinical Team to date.

Remunerations

The Clinical Team reported no problems with the financial arrangements and agreed that the moneys received covered the work undertaken up to current date.

DVD's

Problems with the software were highlighted by Dr Neysmith and Dr Forrest. All members of the team found difficulties with bookmarking and the 'Find' function. Dr Forrest and other members of the Clinical Team found that the application was hardware intensive, restricting which machines had the capacity to run the programme, subsequently restricting where the investigations could be carried out.
A: Dr Neysmith requested a lesson in the use of the software - which can be arranged through WORM.

Presentation of Notes

Dr Forrest pointed out that for a civil case Doctors notes are sorted, filed and tabulated making them easier to navigate. Det Ch Supt Watts explained that the practise was time intensive, that Major Crime did not possess the expertise and would rather present the evidence in an unabridged state.

E Mail Group

The Team had discussed the possibility and possible need for setting up an e mail group to maintain communications between the members. It was decided that the current arrangement of 6-8 weekly meetings was adequate.

Hierarchy and Culture

There was a lengthy discussion on the hierarchy and culture within Gosport. A comparison was drawn between the structure within the Police, where there is a more rigid hierarchical structure, and the Care professions, leading the Clinical team to conclude that the culture within Gosport wasn't what they were used to within their profession where communications are generally very good with staff working to a common cause.
The Clinical team requested a copy of the Wessex Protocol.

Screening

Dr Ferner has developed a new screening sheet using visual analogue scales with different parameters. This scale was based deemed to be more analytical than the previous which drew more on emotional analysis. Det Ch Supt Watts asked whether there was a template curve the team would be happy with. Dr Ferner agreed that there was a mark beyond which suspicion increases.

The Investigation

Dr Forrest stated that after discussing half of the material available with the rest of the team the consensus was that between 10 and 20% of cases was indicative of possible deliberate harm. Dr Ferner scored lower stating that intent to cause harm was difficult to argue. Det Ch Supt Watts reminded the team not to concern themselves with legal definitions.
The team further agreed that the standard of Nursing was poor with Nurses seemingly following orders without questioning the appropriateness, when this could possibly be called into question. There is some evidence that Nurses are requested to carry out work that does not come under their remit/they would not have received appropriate training for.
Significant parts of the records were either missing, absent or had not been completed. Irene Waters read extracts of an article on Dr Graham Pink where careers had been ruined through 'whistle blowing'.
Dr Forrest went on to say that a lot of the records had prescription sheets missing, which he deemed to be one of the most vital documents. Det Ch Supt Watts told the group that a written request would be put in to the Strategic Health Authority. Dr Neysmith mentioned that, armed with dates, details could be obtained from the Controlled Drug Register. DS Kenny stated that Dr Baker was currently in possession of this information.
Further discussion on the quality of care showed that there were omissions in note making where major medical decisions had been made, i.e. why a patient had been placed on a syringe driver. Also Doctors were giving Nurses authority to certify death as long as the Doctor was informed immediately raising the question of whether there was a cultural expectancy that when a set of events happens, is that patient expected to die.
Irene Waters stated that she would have expected Nurses to make notes of medical interventions or any concerns as this is their only defence, but this hasn't been recorded. At this point Det Ch Supt Watts requested that the team make notes of names to highlight on individual cases. Any queries over names or signatures could be cross referenced with the Controlled Drugs Register which maintained a list of

names and signatures for authenticity purposes. Dr Forrest told the group that pharmacies keep similar records.

Dr Forrest then went round the group asking if they had anything to add.
Dr Neysmith noted that the more medical records analysed, the more habitual prescribing patterns appear. She said that this was not necessarily bad, but demonstrated a definite pattern which, she said, was why the group would like to see the Wessex Protocol.
Irene Waters again questioned the level of care meted out by Nurses who, although not expected to understand, should discuss with Doctors the finer points of care. She stated that there were many instances where Nurses had gone ahead and administered drugs inappropriately without noting any concerns or queries on the patients records. The new matrix would aid with differentiating between low levels of care that may not necessarily have contributed to death and dangerously inappropriate care. Presently her scorings are clustered and not diametrically opposed, and s
he concluded that no cases could be held up as good practice and some were already raising serious concerns.

Dr Lawson said that he needed to look at the cases further in more detail. Having worked in similar practices, some of the cases, he felt, could fall within margins of error whilst others fall below that.

Dr Ferner concluded that so far results do not suggest they represent the practice of one Doctor, rather they suggest more a practice specific to the hospital.

Victimology

Det Ch Supt Watts asked whether there was a commonality in the profile of people affected. Dr Ferner replied that it was difficult to say except that those who died do not have conditions such as cancer that require this level of treatment. Dr Neysmith added that on some notes there is no mention of pain. Some notes suggested the patients were difficult, noisy or disruptive. Det Ch Supt Watts suggested a study in victimology, via a statistical analysis around certain perameters to identify any clustering. Dr Forrest stated that this was already one area the team were looking at in their analysis and would make note of any finding. Dr Forrest added that initial results suggested there was something less than random. He further suggested that there was a need to look at all patients for comparison purposes. Dr Neysmith suggested a comparative study with other hospitals.
Irene Waters also stated that she was aware of 'unpopular patient' tensions but as the investigation progressed it would this may produce a host of other questions, therefore it is too soon to produce any sort of questionnaire to progress the theory beyond analysis of patients notes. Det Ch Supt Watts concluded that any for the time being the team could flag up any issues where the patient has been written up as disruptive, any further investigations into this area could be dealt with if evidence of an emerging pattern is established, with possibly an independent panel reviewing any retrospective questionnaires of patients behaviour in comparison with the experts findings. Dr Forrest suggested that Dr Furners scale would most likely identify any trends in patients.

Dr Forrest supplied a list of patients with missing drug charts :

BCJ 12
8A
02
01A
06 (no information on patients prior health)
M17
BCJ 09

Also supplied was a list of patients whose treatment caused most concern:

17
16
15
04

The meeting was concluded to allow the experts to discuss more individual cases.

A date will be set for a meeting between the Clinical Team in approximately six weeks time.