Minutes of meeting with Hampshire Constabulary re: Gosport War Memorial Hospital Investigation.

Wednesday 6th November 2002 1.30pm

Present:
Steve Watts (SW)
Nigel Niven (NN)
Owen Kenny (OK)
N285 Ann Alexander (AA) NOM
N286 Code A NOM

SW introducing himself and his colleagues.

SW: Our objective today is to talk through where our investigation is going. We feel as though we've lost our engagement with the relatives. It is of paramount importance that the relatives have confidence in us, and it disappoints me that we are in a situation where some relatives do not have confidence in us.

AA: Some, yes, but many have been singing your praises – particularly those who have contacted you for the first time recently, with their concerns.

SW: It would be helpful if we could have the names and details that you have – to ensure that we have the full figure. I will also talk you through where I see this investigation going.

I am Head of Hampshire CID. Prior to this position, I was the Senior Investigating Officer of East Hampshire – my number there was DCI Ray Burt. N24 I am aware of the difficulties encountered since the start of this investigation. I was content at the time that he was carrying out his investigation competently, and consulting the right experts. Then, the investigation was taken over by N411 DCI Paul Clark and John James- N23 As head of CID, I was happy that the investigation was going well. I was aware of the material provided by Professor Livesey, and the fact that it was found wanting by Treasury Counsel. Then, John James chose two further cases, and instructed two further experts. Their conclusions were that they could not provide a causal link between the administration of morphine and the deaths. On that basis, I was happy that John James had conducted his investigation.

Complaints have been made by relatives, but I will not go into those here. John James has now been promoted to CSI, and the investigation has been handed back to me. Nigel Niven is my deputy, and Owen Kenny is managing the investigating team – which comprises 11 officers.

We have already spoken to N140 Professor Baker and N341 Professor Bob Forrest [Deputy Coroner for Sheffield], and we must liase further with the CPS. We must also look to obtaining further evidence from relatives. The 1991 document was discovered at around the time I took over. A nurse had come

forward, and meetings were held about the issue of the administration of diamorphine.

Then, the CMO appointed Baker. We want to get to the point where all of the material has been analysed, and all the relevant people have been spoken to, in addition to Dr Barton. We will also be speaking to the two administrators in the NHS who have now been relocated.

So, where are we going to go from here? We are going to go back to the relatives, to see if they have any evidence to give, and we will be taking statements. Then, we have to decide whether to go back over each case, or whether to take a random sample. We shall be asking Professor Forrest (forensic toxicologist) and Professor Baker about the most valid way of approaching this – it may well turn out that the best way is to take a random sample, which will in fact include just those cases that we have already looked at.

We will be consulting further experts. We are very conscious of the questions that can be raised over individual experts, and the importance which hangs on their word.

AA: Have you thought about approaching Professor Grenville – he is an expert on the use and effect of diamorphine – he was brought in by the prosecution in the Shipman trial, and has assisted the Inquiry to investigate each and every death. Grenville looked at the information in every case, which ran into hundreds.

SW: That's very interesting – where's he based?

AA: I'm not sure, but we will get his details for you.

SW: Professor Baker has already come to see us.

AA: I have every confidence in him. In Shipman, he only ever looked at the medical records, but got his conclusions pretty much spot on. He came to a public meeting right at the beginning of the Shipman Inquiry, and he would happily have sat, all night, answering questions from the relatives.

SW: Professor Baker has explained the concepts to us –

AA: Some families will have very little to add, but some will have a lot. Some sat and watched what was going on, and some made a complete fuss at the time. If you can go and take notes from every family, that will undoubtedly repair their confidence in you.

SW: We will go and speak to every family – we will not necessarily take a full statement from every person, but I think that if we can spend some time with them, at least they will fell as though they have been listened to.

AA: Have you any idea as to how many of the deceased were in Gosport War Memorial for palliative care.

OK: Probably about half and half. Prior to 1998, it was pretty much all palliative care, but since then, it has become 50/50.

NN: The ratios have changed – sometimes those that were not there to die, died.

AA: We haven't yet seen all of the documents, so we are not yet in a position to talk about ratios. The discharge summaries from the previous hospitals are, in our opinion, the most important piece of evidence. Many say "sprightly, OK, need rehab for a few days/weeks". Then, if you look at the admission notes to GWMH, you would not recognise that they were speaking about the same person.

SW: It does raise a question – we're struggling with the fact that the relative was going into hospital for a small operation, and dying within days from bronchopneumonia as a result of diamorphine.

NN: Simply, are you saying that you accept that causation is legitimately challengeable.

AA: Possibly, although I have not seen the experts reports. I do not know the experts.

SW: Ford and Munday.

AA: I don't know them, but I know that there are some really good experts. It comes down to a degree of confidence on the experts.

NN: We've had a very sensible view, in Richards and the 5 others. But, it may be the causation issues which are not there, and I feel that the causation issue is challengeable. Professor Bob Forrest is very impressive.

SW: Where you find your experts from is a big issue. I've looked at creating guidelines relating to hospital deaths, to put into a murder investigation manual. I have been to several expert witness database holders.

AA: We have a database of about 1200 experts, of which I would recommend probably 200 - I'm sure some of them would be happy to help you.

SW: Perhaps, separately, we'll talk about that.

NN: In terms of the expert, Forrest, there seems to be a challenge to causation. We're exploring other opportunities to pin down issues of causation. It will have to be based on more than the 5 cases we have already looked at. So, if you have any clear-cut cases, we would be grateful if you could let us know. Because, if we're not going to anywhere with this, we need

to get out of the way quickly, to let you get on with the GMC route, and any other route you are considering.
Steve Watts has had a meeting with the GMC lawyers to discuss this case – with Judith Christie from Field Fisher Waterhouse. We need to show the GMC that either there is a case to answer or not. We need to throw up the most alarming issues. Therefore, if there are any on your list that you think are particularly alarming, perhaps you could let us know.

CLA: No problem – I shall have to obtain the authority from all the relatives who have contacted us, and I shall let you have the list, along with details of the deaths, by tomorrow afternoon.

AA: There needs to be an exercise of caution on relying on records from Gosport. Baker will be quite used to this, as Shipman altered many of the records. It would be useful to take the records from the discharging hospital and the GWMH, and send them both together to an expert.

CLA: The records, in general, from GWMH are particularly poor.

NN: But, is that not the case across the NHS?

CLA: May be, but some relatives have good recollections of syringe drivers, where there is nothing noted in the records. In one case, the wrong death has been written up in the wrong records – that, if nothing else, indicates that undue emphasis should not be put on the notes.

SW: With the summary you provide, we can start to drop-feed the experts with information – particularly regarding what happened between the discharging hospital and the GWMH.

NN: So, your concerns are that in the notes, things are missing, and notes have been altered. There's a difficulty in making that quantum leap from inadequate note taking to systematic failings, to prove some sort of protocol on the ward.

AA: We're going to involve Richard Lissack QC, perhaps on the issues of causation.

SW: I know Richard well. I haven't worked with him for some time, but we've come across him on a few occasions.

AA: We will send you a list of the relatives who have contacted us, including a summary of what they had to say to us. If we've got the medical records, we'll try to send you what we've got.

NN: Yes, we certainly need to look at the relevant medical records. There appears to be a horrifyingly consistent rate of bronchopneumonia as certified cause of death on these death certificates.

A 234 LIAISE RICHARD LISSACK QC WITH VIEW TO FRAMING QUESTIONS FOR EXPERTS

AA: We could help you, with Richard Lissack QC, to frame questions to experts, as that is so vital, in obtaining the right answers.

AA: With regards the families, we propose to write to them all, stating that we have had this meeting, and it has been extremely helpful and informative.

SW: As far as the families are concerned, Code A was appointed as the Family Liaison Officer, to handle the complaints made against those undertaking previous investigations. He then fell into the position of FLO with regards the general cases, because he was involved with the families already, and we jumped on the back of that. It would be inappropriate to continue with that now.

We would be happy to attend any public meeting from now on.

AA: Would you like the families with whom we are in contact, to direct any information or queries through us?

SW: To a certain extent, although we do not want to seem completely out of touch, so if they have any pressing issues, they are more than welcome to contact us directly. It would certainly help matters if request for updates were dealt with by yourselves, to just keep down the numbers.

CLA: There is certainly a core group of families who would like constant contact, and perhaps if you could keep us updated, we could pass that information on. That core group of clients would very much appreciate a visit by the police, some of whom have not been seen for years, or never seen at all.

NN: If you could highlight those families on your list, that would be helpful.

SW: Would it be appropriate for a more senior officer to visit some of the families.

AA: That would go down extremely well – yes

NN: Can I just say a word about the press? It is a concern that there should be no inaccurate information of anyone who worked at GWMH, or other patients. We do not want to look as though we're on a crusade for the families- we must be fair to all parties. Although we must have a degree of joint media management, we are very independent. If a prosecution does go ahead against Dr Barton, there would be a problem if we looked as though we'd taken the families' side. I ask that you let us know of all plans for the media, in advance.

[Discussion re: funding of Alexander Harris].

AA: Regarding the expert reports which the police commissioned, what are the chances of us seeing those?

SW: That's a difficult question, as the reports name names. I, personally, would love to let you see them, but I shall look into that. You could always just ask, and see how far you get.

[AA thanked the officers for coming, and assuring that our list shall be with them by tomorrow.]

Meeting ends 3.00 pm