REPORT INTO THE INVESTIGATION CARRIED OUT BY HAMPSHIRE CONSTABULARY INTO DEATHS OF PATIENTS AT GOSPORT WAR MEMORIAL HOSPITAL IDENTIFIED AS

OPERATION ROCHESTER

Conducted by

Detective Chief Superintendent Dave JOHNSTON

Avon and Somerset Constabulary

2 February 2004

INTRODUCTION

1 On 6 October 2003 the Police Complaints Authority (PCA) ~~Angela~~ MacDOUGALL, wrote to ACC Steve MORTIMORE of Avon and Somerset Constabulary, requesting that the Force undertake a 'review of the adequacy of the investigation and to comment on any professional standards issues which may arise'. This review relates to a supervised complaint against Detective Superintendent JAMES of Hampshire Constabulary regarding the manner in which an investigation was carried out relating to the death of Mrs RICHARDS at the Gosport War Memorial Hospital in Gosport on 21 August 1998 and, latterly, the further investigation into 10 similar incidents reported after the 3 April 2001 following press coverage of the Richards case.

2 Following further discussion, Detective Chief Superintendent Dave JOHNSTON, the Head of CID for Avon and Somerset Constabulary, was appointed to commence this task. The following Terms of Reference were agreed between the Reviewing Officer and the Police Complaints Authority member:

> To review the investigation conducted by Detective Chief Inspector BURT and latterly, by Detective Superintendent JAMES, into the death of Mrs RICHARDS at the Gosport War Memorial Hospital and other cases subsequently reported to Hampshire Police.
>
> To advise the PCA member whether, given the facts as known at the time that the investigation was of sufficient depth and quality and was properly conducted.

BACKGROUND

3 The background to this investigation is well known to the PCA and is therefore outlined only so far as is necessary for the purpose of this report.

4 There have been two enquiries conducted under Operation ROCHESTER by the Hampshire Constabulary that are relevant to this report. Both relate in the main to the complaint made by Mrs MacKENZIE over the death of her mother Mrs Richards on 21 August 1998 whilst a patient at The Gosport War Memorial Hospital in Hampshire.

5 Detective Inspector MORGAN undertook the first investigation in 1999 following an original crime complaint by Mrs FITZGERALD. After some investigation, this matter was referred to the CPS. This investigation was concluded as insufficient to proceed.

6 Mrs FITZGERALD made a public complaint regarding the standard of this investigation, which was investigated by Hampshire's Complaints Department.

7 Hampshire Constabulary have accepted that this original investigation was not of sufficient depth or standard and Inspector Morgan was later given operational advice regarding her approach to the investigation. This matter is therefore concluded, its relevance to this report is that the recommendations arising from the complaint, lead to the appointment on 18 August 1999, of

Detective Chief Inspector BURT as the SIO to review and continue the investigation into Mrs RICHARDS' death.

8 DCI BURT continued with this investigation until his imminent retirement at which time, he was replaced by Detective Superintendent JAMES (since promoted to Chief Superintendent).

9 It is the conduct of this second investigation by DCI BURT and latterly, Detective Superintendent JAMES, which this report seeks to focus on.

10 It is relevant to state that the Reviewing Officer is aware that Hampshire Constabulary are currently conducting a new and much wider criminal investigation under the name of ROCHESTER which, incorporates Mrs FITZGERALD's original complaint and others which, later came to light.

11 The Reviewing Officer is also aware that an extensive complaint file supervised by the PCA has been submitted following numerous public complaints made by families at the conclusion of the second investigation on 28 January 2002.

METHODOLOGY

12 The Reviewing Officer attended Hampshire Headquarters on 22 and 23 December 2003, where the current ROCHESTER Senior Investigating Officer, Detective Chief Superintendent WATTS and other key staff, provided a briefing.

13 Following this briefing, the Reviewing Officer accompanied by a Detective Inspector from Avon and Somerset Constabulary's Major Crime Investigation Unit (the Review Team) were provided with free access to the original papers from the investigation undertaken by Detective Chief Inspector BURT and Detective Superintendent JAMES.

14 Additionally, the Deputy Chief Constable Mr READHEAD provided an overview of the complaint investigation undertaken by Assistant Chief Constable JACOBS. Copies of the Investigating Officers report and statements were made available for review.

15 Clearly, such an investigation and the subsequent complaint investigation, comprises many thousands of pages. Short of completing a further full re-investigation, it would not be possible to read and assimilate all the detail within these volumes.

16 The Review Team therefore selected key documents to read as a means of fulfilling the terms of reference set.

17 These documents comprised:

- The policy books of Detective Chief Inspector BURT and Detective Superintendent JAMES
- Copies of management review minutes and update reports
- Correspondence between CPS, the SIOs and other relevant parties
- Copies of Dr LIVESLEY's report
- Full Investigating Officers report into complaints against Detective superintendent JAMES
- Miscellaneous documents files
- Witness statements
- Report completed by Chief Superintendent CLACHER
- Copy of the written response to complaints by Chief Superintendent JAMES

18 These documents were read by the Review Team and are the basis of the findings below. From many of the findings, questions arise which may have to be answered by further interview of Chief Superintendent JAMES or other senior officers within Hampshire Constabulary. These questions are included in the body of the report to ensure that they are considered in context.

FINDINGS

19 The policy book should provide a clear indication of the terms of reference and parameters of an investigation. No such written terms of reference appear within the policy book on commencement of the investigation. The only oblique reference to any such terms of reference, are set out in a typewritten document attached to policy decision No 19, entitled 'Initial briefing'. This document provides a chronology of events to date and suggests lines of investigation. No actual terms of reference are set. Paradoxically, if this is to be viewed as the terms of reference, at page 11 para 5, there is a line of investigation set to '***research and investigate other cases which may involve a similar pattern of medical conduct at the Gosport War Memorial Hospital'***

20 The absence of clear terms of reference means that there was no clear direction or parameters set for the investigation.

Q. Was there any formal agreement to accept the 'initial Briefing' document as the terms of reference?

21 The Review Team believe that the policy book of DCI BURT has been written after the event. Several of the policy entries, which should relate to 1999 as contemporaneous entries, have been entered initially as 2000 and later crossed out and amended as 1999. This strongly suggests writing during 2000. There is also a strong reliance on typewritten and printed documents within the policy book. This is unusual and further suggests that these documents have been used to refresh memory when constructing the policy book.

22 If this is the case, the policy book cannot be relied upon as an accurate record of the decision making process in this investigation.

Q. Did Supt JAMES receive a complete policy book from DCI BURT on taking control of the investigation?

23 At policy decision 36, (DCI BURT's policy book) there are two letters attached which were sent to the CPS. At page 3 0f the letter headed Dear Mr Conner, the following sentence appears

'it has however been decided that further work will not be carried out regarding other possible cases until CPS advice is received in connection with this case'.

This decision is not reflected in any policy and is in fact contrary to the proposed line of investigation suggested by DCI Burt on 12 April as outlined in paragraph 18 above.

Q. In respect of the above statement, who had decided this and where was it recorded?

Q What other possible cases were being referred to here? i.e. were there specific referrals or was this a hypothesis for investigation?

24 The decision on whether or not to pursue other cases is further confused in policy No 43 with an attached email dated 12 May 2001 where again, reference is made to 'an agreed policy to await the outcome [of the Richards case]'. There is no such policy apparent.

25 It is around this time, that there are definite additional complaints received. This follows a media article on 3 April 2001 and is acknowledged by DCI BURT in his email of 12 May as accounting for a further 9 complaints from families of patients who have died in similar circumstances at the hospital.

26 It is clear from DCI BURT's email on this date, that he is uncomfortable with the current 'decision'. He is requesting a widening of the investigation to his original outline of 12 April 1999 and to the change of SIO to Superintendent level to reflect the serious nature of the investigation.

27 It is following this email that a decision is made to replace DCI BURT and C/Supt JAMES assumes the role of SIO on 21 May 2001.

Q What was Supt. James' view on the replacement of DCI BURT, was it due to his imminent retirement? Or, was it due to his protestations over the apparent refusal of others to widen the investigation?

28 The final policy No 50 of DCI BURT again suggests a decision-making forum separate to the policy book – ***'It was originally agreed that this investigation would be placed on hold...'.*** No record of this decision-making forum has been found.

Q Was there a separate decision-making forum operating at corporate level in the force? If so, where were such decisions and the rationale for those decisions recorded?

29 It appears to the reviewing officer that DCI BURT had become frustrated by what he saw as a lack of expediency by his force and a failure to allow him to extend the parameters of the investigation to include other reported incidents. In his final email , he reiterates the need to ***'act positively and quickly'.***

Q. Was the SIO being forced into recording decisions that were being made corporately elsewhere and if so were these recorded?

30 Summary of DCI BURT's policy

- Appears to have been written in haste and retrospectively - relying heavily on 'other documents' stapled to pages to provide support to policy.
- Dates altered (giving rise to 1 above)
- Policy lacks detail in both descriptions of acts of commission and omission, also lacks clear rationale in many instances and fails to explain reasons for policy
- Several of the 'other documents' make oblique or direct reference to policy and decisions on this case with some significant changes to the investigative direction - none of which are actually shown in policy
- It is difficult, from the policy file, to be clear what exactly the policy or strategy was for progressing this investigation
- It is clear that the policy is written based on the outcomes of 'other' meetings at a corporate or departmental level. No minutes appear to have been kept of these meetings

31 In respect of DCI BURT's investigation, the reviewing officer feels that it was driven by organisational influences outside the actual investigation. This created uncertainty as to the terms of reference being pursued and consequently, the documentation, which should underpin the investigative strategy, is not auditable for accountability of decision-making.

32 There is a failure throughout this investigation to appoint any formal Family Liaison Officers (FLO) to the FITZGERALD's in the first instance, and to the other families who reported to the police following the media article of 3 April 2001. This undoubtedly added to the communication difficulties expressed by families and was contrary to best practice guidance available at the time on FLO strategy.

33 Supt JAMES took control of Op ROCHESTER on 21 May 2001. There had been a significant development in the investigation just before this change of SIO with a media article appearing on the 3 April. A further 9 (ultimately 10) families contacted the police to make complaints relating to the death of their relatives. Despite an acknowledgement of this development, a further opportunity to appoint FLOs was again missed and in fact, Supt JAMES never addressed this issue during his stewardship of the investigation.

34 Policy No 2 of Supt JAMES' policy book outlines the need to 'extend' the original parameters of the investigation agreed on 12 April 2000. As outlined at paragraph 19 above, it is unclear as to what, if any policy was actually agreed. It appears that the parameters referred too by Supt JAMES relates to the typewritten document entitled 'initial briefing'.

If this is the document being relied upon, the decision to extend the parameters had already been made 13 months earlier and not acted upon. This is specifically referred to at bullet point 2 of the suggested lines of investigation within the 'initial briefing' document.

> ***'Research and investigate other cases which may involve a similar pattern of medical conduct at the Gosport WMH'***

35 The significant shift to now incorporate an 'extension' of the scope of the investigation seems to be based on the media article of 3 April and the subsequent statement of Pauline SPILKA. This is an appropriate response to events but does not alter the fact that the document that is referred to as 'policy' specifically outlined this course 13 months earlier and it had not been acted upon. Indeed, this course of action is commented upon as 'progressing', in the management review of 26 July 2000 and appears to remain adopted until a reference is made in a letter from DCI BURT, to Mr CLOSE of the CPS dated 14 April 2001 at which time he refers to

> ***'Our current policy is to await the outcome of the decision concerning Mrs. Richards deceased before considering our position regarding the scrutiny of other cases'***

36 Supt JAMES' policy continues to indicate an intention to 'scope' and 'widen' his investigation to incorporate other allegations. This included a decision to seek advice from officers involved in the 'SHIPMAN' investigation. Despite this, there appears to be little progress on this front. It is ironic that Detective Superintendent James, in his written response to the complaints against him, alludes to the lack of responsibility shown by the local paper in making drawing parallels between this investigation and the SHIPMAN investigation. His own policy book makes similar links as outlined above.

37 It is clear to the reviewing officer, that part of the reason for delaying further enquiries into the additional allegations, is based on an increasing concern of the SIO over the evidence provided by Professor LIVESLEY. This concern appears to be well founded, as a meeting with Treasury counsel on 19 June 2001 appears to be a fatal blow in the investigation into Mrs RICHARDS' death.

38 The reviewing officer has contacted the CPS and asked for access to their written advice from Counsel. This has not been forthcoming and in the absence of this advice, can only draw inference from the various documents seen.

39 Professor LIVESLEY appears to have capitulated under close questioning from Counsel and his position as an expert witness was called into question.

40 Despite this blow to the investigation, Supt JAMES attempted to seek alternative medical opinion from Dr MUNDY and Dr FORD. This was a good investigative line to pursue but again, despite a reiteration in policy No 18, to 'assess' the other allegations reported to the police post 3 April 2001, no statements appear to have been taken from relatives to be considered by Dr MUNDY or Dr FORD. Each of these relatives would have had a story to tell which would have provided the Doctors considering the medical records with a better contextual understanding of the impact of the medical treatment provided to these unfortunate patients.

41 It is difficult to comprehend from the recorded policy, why these matters were not progressed beyond an assessment by a Detective Sergeant Code A There appears to be some organisational reason behind this reluctance, which in the view of the reviewing officer was a reluctance to expand the investigation into an area with significant resource and financial implications.

42 The final outcome of the CPS review of the RICHARDS' case is well documented in C/Supt CLACHER's report of 21 July 2002 (P6-7) and I concur with his belief (para. 5.6) that it is at this point that the investigation begins to lean towards a civil remedy through the various medical bodies represented.

43 This is a significant period in the investigation, as there now seems to be a possible exit for the police from what has the appearance of becoming a massive investigation with significant resource and political implications. Supt JAMES' policy No 30 indicates that he is now preparing to wind down the investigation by countermanding his decision to have DS Code A contact some of the additional families.

44 The policy from this point leans heavily towards justification for closing down the criminal investigation and passing the matter to the medical agencies. There is no clear rationale for this. The reasons given are, in the view of the reviewing officer, spurious and untenable given the facts. They include:

- Policy 30 - suggests raising significant expectation [families] of police outcome

  These families had no expectation as no one had kept them informed or advised.

- Policy 31 - expounds the need to ensure that Dr BARTON is not 'scapegoated'

  Up to this point, it is her care of patients that is being examined criminally (along with Mr BEED). The effort to realign this to one of management failures is a significant indication of the path the investigation is now following.

- Policy 32 - suggests an obligation on the SIO not to undermine the public confidence in the hospital.

  An effective investigation into all the allegations raised would have more impact on this. Again, this is indicative of preparation by the police of withdrawal from the matter.

45 This shift in emphasis continues through to policy No 42 when a specific decision is made to conclude the investigation. There are 7 reasons outlined as justification for closure of the criminal investigation. It is the view of the reviewing officer that these reasons are in fact a self - fulfilling prophecy based on the fact that a decision had been made as early as June of 2001 to close down this investigation as quickly as possible.

CONCLUSIONS

46 In considering the adequacy of this investigation, the reviewing officer has been careful to acknowledge the passage of time and to apply the standards of investigative strategy for Senior Investigating Officers applicable at the relevant time.

Reviews

47 It is clear that this investigation was never independently reviewed and the absence of such a review was contrary to the guidance included in the Major Incident Room Standardised administrative procedures (MIRSAP) manual of guidance to SIO's chapter 14.

48 In addition, an independent review in line withMIRSAP, would have presented an opportunity to place this investigation on a more structured footing and would by its framework, have questioned the absence of clear terms of reference and investigative strategy at an early stage.

Family Liaison Strategy

49 A further major area of concern is the absence of any FLO input. This provision is key to any major investigation involving allegations of homicide and was contained in guidance to SIOs at the relevant time. This failure to communicate effectively with the wider group of families is the major area of complaint and would have been avoided by the deployment of FLOs. No strategy was found regarding this aspect of the investigation.

General Policy

50 Neither policy book reviewed, complied with the guidance to SIOs at that time contained within the murder manual or (MIRSAP).

51 There was a noted absence of structure relating to the construction of strategy and policy on issues such as forensic matters, Suspect category, witnesses, finance and set up. Each of the policy books contains a printed guide to investigating officers in its foreword. This alone, if followed, would have provided a checklist to the SIO, which would have benefited the structure of the investigation. For instance, there is no reference made as to why, or at what point, this investigation moved onto HOLMES.

52 It is the view of the reviewing officer that this investigation was not carried out with sufficient depth or quality given the facts that were known at the time.

53 There is no clear rationale made out for failing to engage the ten families who reported their concerns to the police following the news interest of 3rd April 2001.

54 The failure to investigate these complaints and to forward a file of evidence to the CPS and Counsel for consideration was based on the failure of the Richards case. This was a flawed decision and does not withstand even superficial scrutiny.

55 It is Clear to the reviewing officer, that D/Supt JAMES was following some unwritten policy from the corporate entity of the force. Not withstanding this, he had a duty as the SIO and failed to effectively perform that duty to investigate allegations of serious crime.

Dave JOHNSTON
Detective Chief superintendent
Avon and Somerset Constabulary