
# COMPLAINT AGAINST POLICE

## Gillian M MacKENZIE

## REPORT OF

## INVESTIGATING OFFICER

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# INVESTIGATING OFFICER'S REPORT

**Deputy Chief Constable**

V2, pp 1-11

1. This investigation follows a complaint against police made by Mrs Gillian M MacKENZIE of Code A She alleges that Detective Inspector Code A Stephanie MORGAN failed to properly supervise the police investigation in relation to the death of Mrs MacKENZIE's mother, a Mrs Gladys Mabel RICHARDS. Mrs MacKENZIE further complains that DI MORGAN spoke to her by telephone in an inappropriate manner, and did not respond to her allegations in relation to believed irregularities in the completion of her mothers' will appropriately. Mrs MacKENZIE makes an allegation against Detective Constable Code A Richard MADDISON that, having been charged with the investigation into the matters concerning the death of Mrs RICHARDS, he failed to secure all of the evidence available before submitting the file to the Crown Prosecution Service for a prosecution decision and that his investigation into the death of the circumstances of the death of Mrs RICHARDS was flawed.

2. It is important to note that a further police investigation, supervised by DCI BURT, into the circumstances surrounding Mrs RICHARDS' death is ongoing at this time, and that the mention of a situation referring to a film crew has been withdrawn.

3. Superintendent Adrian WHITING of the Professional Standards Department at Police Headquarters was appointed the Investigating Officer in this case on the 23rd June 2000.

THE BACKGROUND

4. Gladys Mabel RICHARDS, aged 91 years, died at the Gosport War Memorial Hospital on the 21st August 1998. The cause of her death was recorded as bronchopneumonia and a death certificate was issued. The death certificate was dated the 24th August 1998. No post-mortem was carried out and Mrs RICHARDS was cremated.

5. For four years preceding her death, Mrs RICHARDS had been a resident at a nursing home in Lee-on-Solent. It was recorded that she suffered with Senile Dementia. Mrs RICHARDS has two daughters, Mrs MacKENZIE who is the complainant, and Mrs LACK who was a registered nurse (a fact that is relevant later on when considering the decisions made by the Investigating Officer).

6. At 1.30 p.m. on the 29th July 1998 at that nursing home, Mrs RICHARDS fell over and was injured. At 8.30 p.m. the same day, she was admitted to Haslar Hospital and diagnosed as having a fractured femur. The fractured femur was operated on the following day.

7. On the 11th August, she was moved to the Gosport War Memorial Hospital. On the 13th August, at that hospital, she fell over and appeared to be suffering in great pain. On the 14th August, she was re-admitted to Haslar Hospital and under an epidural anaesthetic her leg was manipulated and she was admitted to an orthopaedic ward.

8. On the 17th August 1998 Mrs RICHARDS was again returned to the Gosport War Memorial Hospital. She appeared to be in great pain and what appeared to be a displaced hip was straightened by a nurse, who was assisted by Mrs LACK.

9. On the morning of the 18th August 1998, the daughters were informed that Mrs RICHARDS had a large haematoma at the site of her operation and, apparently after discussion with them, pain relief was administered. The injection of the pain relieving drug ( Diamorphine ) was controlled by use of a device called a syringe-driver.

10. Both Mrs MacKENZIE and Mrs LACK remained with their mother at the hospital from the 19th August until her death on the 21st August.

11. On the 27th September 1998, Mrs MacKENZIE contacted Gosport Police Station by telephone and alleged that her mother had been unlawfully killed. The essence of her allegation was that whilst receiving pain killing treatment by way of an injection, assisted by the syringe-driving device, between the 19th and 21st August, she was not

drip-fed by intravenous drip which thereby deprived her of any nourishment and caused her death, and that the injection of Diamorphine in that way, in itself, contributed to her death.

THE PROCESS OF COMPLAINT

12. For clarity the Investigating officer will now set out the process of the complaint. It is immediately apparent that the complaint was made some considerable time ago and it is appropriate that an explanation be given here as to the progress of the complaint in relation to the investigation into the circumstances surrounding the death of Mrs RICHARDS.

V2, pp 10-11 13. On the 20th November 1998 Mrs MacKENZIE wrote to the Chief Constable at Police Headquarters, setting out her complaint against DI MORGAN and DC MADDISON. In that letter she is specific in relation to DI MORGAN. Mrs MacKENZIE alleges discreditable conduct in that DI MORGAN's behaviour was, in Mrs MacKENZIE's view, reasonably likely to bring discredit upon the Force, that it was an abuse of authority in that DI MORGAN had treated her in an uncivil manner and that there had been a neglect of duty through her failure to properly supervise the investigation. Mrs MacKENZIE specifically set out a similar complaint against DC MADDISON for not properly investigating the matter that Mrs MacKENZIE put before him in respect of her mother's death.

V2, p 12

14. This letter of complaint was acknowledged on the 10th December 1998 from the then Complaints and Discipline Department at Headquarters.

15. It should be borne in mind that this complaint had been made whilst the initial investigation was still under way. At this point, the second opinion from the CPS had not been obtained. Inspector Peter FUGE of the Complaints and Discipline Department, on behalf of Superintendent LOCKWOOD, contacted Mrs MacKENZIE and explained that since the CPS had advised that the further independent medical opinion be sought, then it would be appropriate to await the outcome of that inquiry and resubmission to the CPS, before progressing the elements of complaint that Mrs MacKENZIE had set out. Mrs MacKENZIE agreed to this. However, to

V2, pp 14-17

safeguard the interests of both the complainant and the officers, Inspector FUGE arranged the service of Regulation Notices on both DI MORGAN and DC MADDISON.

16. On the 25th March 1999, Inspector FUGE wrote to Mrs MacKENZIE, explaining that he was now aware of the advice from the CPS and had been advised by DI MORGAN that she had informed Mrs MacKENZIE of that advice. Inspector FUGE set out, that in prosecution terms, the potential criminal prosecution of medical staff from the Gosport War Memorial Hospital depended upon the advice now given by the CPS, but

that it was now a matter for Mrs MacKENZIE if she wished to progress further the elements of complaint that she had outlined in her original letter.

17. Further to the points of complaints set out above, in a hand-written letter of the 9th February 1999 to Inspector FUGE, Mrs MacKENZIE had added, in respect of DC MADDISON, that she had made some points to him on the 2nd October 1998, that she felt needed to be included in the file submitted to the CPS and lacking reassurance on that point she added to her complaint that these points had not been included in the prosecution advice file.

V2, pp 1-9 18. On the 27th April 1999, Mrs MacKENZIE provided a witness statement, setting out her complaint to Inspector FUGE. This statement clarified the issues that had originally been raised by Mrs MacKENZIE and accordingly revised Regulation Notices clarifying these issues of complaint were served upon DI MORGAN and DC MADDISON, dated the 12th May 1999.

19. In the light of these allegations, which essentially concerned the professionalism of the investigation into the circumstances of Mrs RICHARDS' death, Superintendent LOCKWOOD of the Complaints and Discipline Department asked Detective Superintendent LONGMAN to review the investigative professional aspects of the inquiry up to the point at which the CPS' advice was received for the second

time.

V2, pp 18-21 20. Detective Superintendent LONGMAN completed a review of the investigation. Detective Superintendent LONGMAN commented that since Mr LORD, the consultant geriatrician, had a management responsibility for the Gosport War Memorial Hospital his medical opinion on the treatment, or lack of treatment, administered by staff of that hospital, may not have been as entirely independent as it would have been wished or perhaps more importantly, it may not appear to have been as independent as would have been wished. Detective Superintendent LONGMAN drew a number of conclusions from his review of the progress of the investigation and referred the matter to the Head of Force CID, Detective Chief Superintendent AKERMAN, with a recommendation that further work be done on the case, in respect of seeking a truly independent medical opinion. This was allocated to Detective Chief Inspector BURT. Detective Superintendent LONGMAN informed Superintendent LOCKWOOD of this on the 20th August 1999.

21. The practical effect of seeking a further independent medical opinion on the treatment was to re-open the investigation. Superintendent LOCKWOOD (now retired) formed the view that the Complaints and Discipline investigation should be stayed, pending the completion of DCI BURT's inquiries. DCI BURT was, of course, by that time in contact with Mrs MacKENZIE and had set out what it was he intended to do.

22. A further medical opinion has now been sought and this indicates that there may well be some questions over the lack of medical treatment, in the form of intravenous feeding, of Mrs RICHARDS during her care at the Gosport War Memorial Hospital.

23. On the 12th April 2000, the matter was subject to a case conference, when Detective Chief Superintendent AKERMAN decided that the investigation should continue and that DCI BURT should continue to lead the further investigation. DI MORGAN was informed of this as was Mrs MacKENZIE.

24. On the retirement of Superintendent LOCKWOOD, Superintendent STOGDON took over responsibility for investigating the complaint. On the 20th April 2000, Superintendent STOGDON spoke to Mrs MacKENZIE on the telephone and advised her that he considered the appropriate course of action was for the continued criminal investigation to be pursued and that at the end of that investigation, a view could be taken on DI MORGAN's capability and the complainant's views sought further. Superintendent STOGDON states that Mrs MacKENZIE accepted this though she emphasised that she was not withdrawing the complaint at that stage.

25. On the 23rd June 2000, responsibility for the investigation of this complaint was taken by Superintendent WHITING, Professional Standards Department, and on the 10th July 2000, following liaison with DCI BURT, Superintendent WHITING discussed the investigation with Mrs MacKENZIE and updated her. He then updated

DI MORGAN and DC MADDISON.

26. The Investigating Officer formed the opinion that the matters of complaint could be investigated independently of the continued investigation into the circumstances surrounding the treatment of Mrs RICHARDS. The reason for this change of policy was that the allegations were quite clear, and the actions taken by DIMORGAN and DC MADDISON, and the process of supervision of the inquiry, was recorded. In the opinion of the Investigating Officer it would not be fair to judge the initial investigation in the light of any subsequent investigation that utilised separate independent medical opinion. Essentially, what had or had not been done in the initial police investigation was recorded and could, therefore, be investigated. In addition, the complaints did not relate solely to the conduct of the investigation. This was discussed with the Head of Professional Standards Department and agreement reached that the investigation of the complaints should proceed alongside the continuing investigation by DCI BURT.

27. Accordingly, DC MADDISON and then DI MORGAN were interviewed by the Investigating Officer as part of this investigation.

THE OFFICERS' ACCOUNT

Detective Constable MADDISON

V2, p 27-28 28. DC MADDISON was the office manager of the Gosport CID office, assisting the detective sergeant in that office with a number of extensive inquiries and he received a message by telephone from Mrs MacKENZIE, seeking a meeting to discuss the issues she had to raise.

V2, p 28 29. He made an appointment to see her, together with her sister, Mrs LACK, at Gosport Police Station and on that occasion Mrs MacKENZIE explained in some length the circumstances surrounding her mother's death. DC MADDISON made notes of what she had said. In particular he states that he took notes from her, which included the contemporaneous notes made by Mrs LACK, of what had happened to her mother over the days before she died and at that point he also ascertained that Mrs RICHARDS had been cremated. After discussing the issues with Mrs MacKENZIE and Mrs LACK for an hour to an hour-and-a-half, DC MADDISON asked them to leave the papers with him so that he could further consider what would be an appropriate course of action to progress the inquiry. DC MADDISON states that he formed the opinion at that meeting that there were a number of contributory factors leading to the death of Mrs RICHARDS, and that he formed an opinion that the matter might more properly be progressed through the General Medical Council, which he conveyed to Mrs MacKENZIE.

V2, p 41 30. It was made clear to DC MADDISON that Mrs LACK was a qualified nurse with some 40 years experience in nursing and he treated her contemporaneous notes of her

mother's treatment as a semi-professional document.

V2, p 43

31. DC MADDISON then states that as he considered the allegation that Mrs RICHARDS' death had been caused or hastened by the omission to feed her through an intravenous drip, he would be unable to establish the relationship between that omission to feed and the actual cause of death ( which was recorded on the death certificate as bronchopneumonia ) because Mrs RICHARDS' body had been cremated. He formed the opinion that it would be extremely difficult to challenge the content of the death certificate in the absence of the body.

V2, pp 34-36 & 46

32. DC MADDISON formed the opinion that it would be necessary to obtain a separate independent medical opinion on the use of a syringe-driver administering Diamorphine as part of a regime of palliative care, and he challenged the assertion by Mrs MacKENZIE that Mrs MacKENZIE and Mrs LACK were unaware of the potential effects or long-term effects of the use of a syringe-driver, administering diamorphine as a means of palliative care, by reference to the last page of Mrs LACK's notes where she had indicated that the use of the syringe-driver had been fully explained to them and that they had agreed with it. DC MADDISON, therefore, arranged for a statement from a State Registered Nurse who is mentioned above, Barbara DAVIS, who works for McMillan Nursing, whom he considered to be possessing some expertise in the operation of a palliative care regime.

V2 pp 48-50 33. DC MADDISON accepts that he did not secure any of the hospital records from the Gosport War Memorial Hospital, or any other medical records relating to Mrs RICHARDS, that may have existed at Haslar Hospital or indeed at the nursing home at which Mrs RICHARDS had previously been a resident. DC MADDISON believed that he had no right to secure those documents on the basis that he was not certain that a crime had taken place.

V2 pp 50-53 34. DC MADDISON considered that the contemporaneous notes made during the period of Mrs RICHARDS' care at the Gosport War Memorial Hospital were more significant and of more evidential value than would have been taking a statement from either Mrs MacKENZIE or Mrs LACK. Accordingly, for the purposes of seeking the advice of the CPS, he decided not to take statements from either of them. It was his intention that if it became necessary he would arrange the production of the contemporaneous notes as an exhibit for any subsequent Hearing.

V2 p 59 et seq. 35. DC MADDISON states that having compiled a file to seek the CPS' advice, he submitted that to his sergeant and it went through the line-management to his Inspector, DI MORGAN, to the acting detective superintendent and then to the CPS. He states that the file was returned from the CPS, seeking further medical opinion, basedupon the notes from the hospital.

V2 p 61 36. The CPS' prosecution team leader, Mr Robert WHEELER, had reviewed the statement

of Mrs DAVIS and he considered that further independent medical opinion as to the treatment received by Mrs RICHARDS was necessary before a decision in relation to potential prosecution could be made. In his letter of the 24th November 1998 to DI MORGAN at Gosport, he draws the distinction between the administration of an anaesthetic through a syringe-driving device as a means of administering pain control and the decision not to administer intravenous nourishment. He says that he feels they are not the same thing at all and that a medical opinion is required on the second specifically.

V2 p 61 et seq.

37. DC MADDISON then states that he sought the opinion of a geriatrician, Dr LORD, who examined the notes and made comment on the care provided by the staff at the Gosport War Memorial Hospital. The file was then resubmitted through the same line management to the CPS as has been detailed in the background of events above. DC MADDISON was specifically asked if he had left a message on

V2, p 63

Mrs MacKENZIE's answer machine, a BT Call Minder Service on Friday, 30th October 1998 at 2.55 pm. The text of a message and a taperecording of it was available and disclosed to him prior to interview and he agreed that it was him speaking and that was the message he left. He agreed that in that message it was his belief that there was no reason for a criminal prosecution and in saying that, leaving it on that message, he had made it quite clear to Mrs MacKENZIE that he had formed an early opinion that there would not be a criminal case to answer in relation to the matters that she had asked him to investigate.

V2, p 65

38. DC MADDISON states that he did this because he did not want to inappropriately raise her expectations that any criminal prosecution action would arise from the circumstances of her mother's death.

39. On the 17th December 1998, DC MADDISON wrote to Mrs MacKENZIE, notifying her of the advice from the CPS and that he had made an application to the Portsmouth Health Care Trust to obtain release of the relevant hospital notes. His letter also stated that he was unable to interview any of the hospital staff as "they would need to be interviewed under caution and on tape".

V2, pp 22-23

40. A report from Mr LORD was obtained, dated the 22nd December 1998 and it was established that Mr LORD was the consultant geriatrician with responsibility for the relevant ward in the Gosport War Memorial Hospital. He compiled his report from examination of the medical, psychiatric and nursing notes and other documentation, together with discussions with relevant staff in the hospital. Mr LORD had not attended at any time to Mrs RICHARDS and had had no contact with her daughters.

41. Mr LORD's report was attached to the papers and the papers were re-submitted to the CPS on the 1st February 1999. The file was received back from Mr WHEELER, of the CPS on the 17th March 1999 and his advice was that he did not consider that there was evidence to justify a prosecution of the medical staff involved in the case of

Mrs RICHARDS for manslaughter or any other criminal offence.

42. Mrs MacKENZIE was informed of this result by letter by DI MORGAN the same day.

43. Mrs MacKENZIE was quite specific that she was concerned that DC MADDISON had not included a number of issues on the CPS' advice file sent in October of 1998, specifically those points relating to information from a letter she had had from the Portsmouth Health Care Trust. Inspector FUGE established with DIMORGAN that the points referred to in that letter had indeed been included in the submission to the CPS and would have been considered again when the file was resubmitted in 1999.

Detective Inspector MORGAN

V2, pp 73-76 44. DI MORGAN states that she became aware of the allegation when the file was submitted to her by DC MADDISON through Code A and she then sought advice simultaneously from the CPS and from Detective Superintendent LANE as to how the investigation should progress. The file was forwarded to DI MORGAN by Code A on the 8th October 1998. DI MORGAN states that the Gosport CID office had a considerable workload at that time and that she effectively sought the direction of Detective Superintendent LANE in terms of any decisions about the extent of the investigative response to these allegations and refers to the minutes on the prosecution advice file. DI MORGAN states that having referred the file to Detective

Superintendent LANE prior to it going to the CPS, Mr LANE minuted the file to the effect that he agreed that there were very real issues for investigation and that the decision in terms of any criminal offence, specifically manslaughter could only be made given an expert medical opinion on the procedures in relation to administrating diamorphine through a syringe-driver without there being feeding through an intravenous drip. She states that Detective Superintendent LANE asked for an appropriate medical opinion to be sought and for the file to then be submitted to the CPS for advice. At the point DI MORGAN states she considered this to be an agreement with the management of the case locally at the CID office at Gosport. With the advice file now returned from the CPS, DI MORGAN states that she returned the file through Code A to DC MADDISON, asking him to obtain an independent medical opinion and that DC MADDISON sought such an opinion from Dr LORD.

V2, p 77

45. DI MORGAN states that in terms of ensuring the independence of the medical opinion she had made it clear to DC MADDISON that any doctor whose opinion was sought could not have been involved in the treatment of Mrs RICHARDS. She accepts that this condition was conveyed by conversation and that there is no specific written note to this effect on the file.

V2, pp 77-79

46. DI MORGAN states that she did not review the decision of DC MADDISON in the selection of Dr LORD. She accepted his judgement in that selection. DI MORGAN now accepts that, given Dr LORD's responsibility for management of part of the

Gosport War Memorial Hospital, it is conceivable that his opinion may not now be perceived as wholly independent.

V2, pp 80-85 47. DI MORGAN states that she reviewed the progress of the investigation, firstly, when the file was initially submitted to her prior to it going to the CPS on the first occasion and then subsequently after the medical report of Dr LORD had been obtained and again prior to the file being resubmitted to the CPS. DI MORGAN states that in reviewing the case she shared with DC MADDISON the opinion that the detailed notes that Mrs LACK had prepared and supplied would suffice for the purposes of an advice file and she recognised that those notes would have to be converted into a statement form and be presented as an exhibit if proceedings were commenced. In relation to not interviewing any of the medical staff of the Gosport War Memorial Hospital in preparing of the advice file, DI MORGAN states that it was her opinion that no individual stood out as being wholly responsible for the treatment of MrsRICHARDS and that it would, therefore, have been necessary to formally interview all members of the medical staff under caution.

V2, p 86 48. DI MORGAN also states that she did not direct that the medical records of Mrs RICHARDS were to be seized. It was her view that an early decision needed to be made about whether or not there was likely to be a case to answer and if there was then the investigation would need to have been dramatically stepped up and these then would have formed part of that investigation process but in order to put a file before the

CPS for advice, this was not a necessary step.

V2, p 87

49. DI MORGAN states that when Mr WHEELER of the CPS returned the file for the second time, stating that he did not consider there was any evidence to justify a prosecution of any medical staff for manslaughter or any other criminal offence. She inferred that Mr WHEELER was satisfied with what had been submitted and that there was sufficient information made available to him for him to make that decision on. She states that had she felt this were not the case, she would immediately have queried it with him.

50. Mrs MacKENZIE was informed of this result by a letter from DI MORGAN the same day.

V2, pp 89-90

51. DI MORGAN states that she received a message to telephone Mrs MacKENZIE during this process and she did so. It became clear, she states, that Mrs MacKENZIE was referring to a situation in relation to the execution of her late mother's will. Initially DI MORGAN was confused as to her purpose and believed that what was actually being discussed were the circumstances of Mrs RICHARDS' death. When it became clear that this was not so DI MORGAN states that she did ask Mrs MacKENZIE if Mrs MacKENZIE truly wanted DI MORGAN to arrest Mrs LACK, her sister, on an allegation of theft and when Mrs MacKENZIE responded, "Yes, I do, that is your duty", DI MORGAN recollects saying that she found that very sad.

V2, p 90

52. DI MORGAN's view is that whilst this was not what Mrs MacKENZIE wanted to hear, DI MORGAN was at no point impolite, aggressive and certainly did not intend to be judgmental about the circumstances.

V2, p 94

53. Mrs MacKENZIE alleges that DI MORGAN further accused her of delaying things insofar as her mother's death was concerned. DI MORGAN states that this was not true and she would not have said something that insensitive.

V2, p 95

54. Mrs MacKENZIE states that DI MORGAN had told her that she had more important things to deal with and that she had cases of rape to deal with as an example. DI MORGAN states that such a comment was only partially true. DI MORGAN did explain to Mrs MacKENZIE that work need to be prioritised within the office but that she was referring only to the allegations in relation to the execution of the will and not in any way to the situation surrounding the death of Mrs RICHARDS. DI MORGAN states she did not speak in the blunt fashion as has been suggested, but that she tried to paint a realistic picture of the conflicts in prioritising work. Mrs MacKENZIE also alleges that DI MORGAN accused her of not being interested about what had happened to her mother whilst she was at the nursing home and DI MORGAN states that this is not true, at no time had she made any such comment.

MRS RICHARDS' WILL

55. In her statement of complaint, Mrs MacKENZIE sets out that she wishes to be assured that the Force Solicitor had all the evidence she had supplied available to him when he made his decision. Whilst it is not part of the complaint against police per se, the Authority may wish to know that this was indeed the case.

CONCLUSIONS

56. The Investigating Officer is very aware in this case that the matter to be investigated here is whether or not the conduct of the investigation meets the professional standards reasonably required of the officers involved in it, whether the conduct of the investigation was appropriately supervised and whether any incivility was shown towards the complainant on the part of DI MORGAN during that process. It is difficult to prevent the issues surrounding the medical treatment of Mrs RICHARDS from influencing the view taken about the professionalism of the investigation. Nonetheless, the Investigating Officer feels it is very important that these two issues are separated and that the questions surrounding the medical treatment, as may now be revealed by the further investigation conducted by DCI BURT, are not allowed to influence the decision-making process in relation to the conduct of the initial investigation.

57. The Investigating Officer concludes that it would have been reasonable to have obtained formal statements at an early stage from Mrs MacKENZIE and Mrs LACK,

outlining their allegation and concerns, in addition to the securing of the notes made by Mrs LACK.

58. In relation to the notes made by Mrs LACK, the Investigating Officer considers that it would have reasonable at that point to have secured a statement, exhibiting these notes, pending any further decision from the CPS. Such a statement exhibiting them would have clarified how, when and where the notes were compiled.

59. The Investigating Officer concludes that it would have been reasonable to have secured and produced the relevant hospital notes and medical records, even though at this stage no decision had been made about further prosecution action, such items would doubtless have been essential to the proceedings had any commenced at that point.

60. In terms of influencing the CPS decision not to proceed, the Investigating Officer concludes that the only issue that may have materially affected the outcome would have been obtaining an opinion from a more independent medical expert. Though the Investigating Officer is very much aware that experts may have widely differing opinions.

61. The Investigating Officer concludes that the opinion obtained from Dr LORD was not as independent as ought to have been the case , and that this ought to have been clear from his report, where he sets out his responsibility for the ward.

been included in the CPS advice file.

66. In relation to the complaints of incivility, in relation to subsequent phone conversations on the matter of the will, the Investigating Officer forms the opinion that these matters remain in contention. Only the accounts of the complainant and DI MORGAN are available upon which to make a judgement and in the circumstances the Investigating Officer concludes that there is an insufficient basis to proceed further.

RECOMMENDATIONS

67. The Investigating Officer believes that DC MADDISON and DI MOGAN both acted with an honesty in their purpose and none of their actions were motivated by anything other than a genuine desire to properly review the case and obtain the professional opinion of the CPS as to any further action.

68. In relation to his early indication to Mrs MacKENZIE and Mrs LACK that he felt this matter was best dealt with by the General Medical Council, the Investigating Officer recommends that DC MADDISON should receive operational advice, to the effect that such an opinion, as expressed, did not assist the initial stages of the investigation and in building up a rapport between the complainants and the Investigating officer.

69. In relation to the independence of Dr LORD as a medical expert, the Investigating

Officer recommends that operational advice be given to DI MORGAN, that there was a need to have reviewed the independence of this particular person as that may well have had an influence upon the advice given by the CPS.

70. The Investigating Officer recommends, in respect of the comment made by DI MORGAN in the phone call to Mrs MacKENZIE that she found the possibility that Mrs MacKENZIE would want her sister arrested upon an allegation of theft as being sad, that this comment be the subject of operational advice to the effect that this did not assist the investigation and was likely to be misinterpreted by Mrs MACKENZIE as indicating a lack of understanding and sympathy from DI MORGAN.

71. In respect of the fact that statements were not taken from Mrs MacKENZIE or Mrs LACK, that Mrs LACK's notes were not produced as an exhibit and that the hospital notes and medical records were not secured, the Investigating Officer recommends that operational advice be drawn to the attention of DI MORGAN that this would have been an appropriate and relatively easy step to safeguard a potential prosecution.

72. The Investigating Officer also recommends that in respect of the fact that no policy book was utilised at that point to record the decision-making process that this be brought to the attention of Detective Superintendent LANE, to consider the need to ensure that investigating staff are aware of the benefits of such a policy book being used in such circumstances.

73. The Investigating Officer recommends that it would be appropriate that the Constabulary offer Mrs MacKENZIE a suitable apology, in relation to the matters mentioned at paragraphs 68 and 70 above.

**A WHITING**
**Superintendent**