Code A **(PA-ACC TO)**

From: Stevens, Derek
Sent: 26 June 2002 08:37
To: Jacobs, Phillip [ACC TO]
Subject: GWMH

Sir,

Please find attached the notes for both meetings we have had in relation to Gosport War Memorial Hospital.

Gosport War Memorial Hospital....

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Derek Stevens
Chief Superintendent

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Gosport War Memorial Hospital

Meeting in DCC's Office, 1730 hours Thursday, 20th June 2002.

Present:
Deputy Chief Constable READHEAD
Assistant Chief Constable JACOBS (PJ)
Chief Superintendent CLACHER (DC)
Chief Superintendent STEVENS (DS)

DCC said that the purpose of the meeting was to:

1. Review where we are;
2. Consider the feedback from the families so far;
3. Test what we do in response;
4. Consider what else we can do as a response to the meeting with ACC SO and Detective Chief Superintendent Watts.

DC reported that he had now seen all of the families. Their main complaint that they had no contact or visit from the investigating team, and they feel that they had been deliberately kept in the dark. The way some information was conveyed was in their opinion inappropriate. They feel that the conduct of the case was fundamentally flawed. They did not feel that their evidence had been considered.

DC said that informal resolution was possible in three or four cases, but with two there was no chance of resolving it.

DC he felt that the group was not as cohesive as was first thought. Code A

Code A

DC said that all the families had common issues and questions.

DC said he had been through the policy files and some of the significant events. His view was that the logic applied did not satisfy the human needs of the families. He felt Hampshire Constabulary had done a good job, but there were some questions over judgement.

DC feels that if statements were now taken and an enquiry team was appointed, 70% of the families' concerns would be addressed. After they had told their stories they became less agitated and some faith in Hampshire Constabulary was restored. The next step that the force took would be the significant one.

DC said he had cautioned all of them against any approaches from the press. He explained that if a trial were conducted in the public domain it would considerably weaken the possibility of a criminal trial. They are now waiting for an update.

DC said that he had served Regulation 9 notices on Detective Superintendent James (JJ).

He said that the Commission for Health Improvement (CHI) report was due in mid July. It will be critical of the Health Trust, management especially. However the report will be general in nature making no reference to individuals.

He said he had sought out the documents to see if any of the families' views are valid. So far he had seen two policy logs and some significant issues had come to light.

He said that Time was a critical factor. The longer this went on the more difficult it becomes.

He said that the initial enquiry in Gosport was not good. It resulted in some staff getting 'Operational Advice'. It was the review of that case that prompted the Detective Superintendent to resurrect the investigation.

August 1999 - Detective Chief Inspector Ray Burt (RB) was appointed as the Senior Investigating Officer (SIO).

October 1999 – The SIO went to the National Crime Faculty (NCF) and sought a medical expert. He was given Professor Livesey's name. Drs BARTON and BEDE were interviewed under caution. Enquiries were commenced. They were steered by the professor's report, which strongly intimated that this was a case of manslaughter.

November 2000 – Final report prepared.

December 2000 – File went to the Crown Prosecution Service.

January 2001 – RB hands over the role of SIO to JJ. He highlighted critical factors to JJ. One was the appointment of Family Liaison Officers (FLO). This was not taken up. At this stage other people were coming forward.

At this stage a 'whistle blower' comes forward. A nurse describes the situation as a culture of euthanasia on the ward controlled by BARTON and BEDE. This had a significant effect on the investigation.

JJ said in his log that it was critical to look at other deaths in order to get a clear picture. The investigation now became more complex.

Two years after the death Treasury Council question the credentials of the expert. Treasury Council meet with JJ and the professor to test his evidence. He is, according to Treasury Council, found wanting and they conclude that some of his findings are flawed. They felt his evidence undermined the case.

DC pointed out that both the CPS and TC had only considered one case.

JJ sought a meeting with the SIO from the Shipman case in June 2001. He also sought geriatric practitioners outside of the Portsmouth area.

The SIO went to the NCF for more names of experts. These came up with differing views. This presented conflict in the evidence and the case was no longer clear-cut.

19 June 2001 – JJ calls for a review of the professor's evidence.
25 June 2001 – an urgent opinion is ought from a new expert. At this stage other cases were assessed. No families had been contacted since April. The investigating team relied on medical records only. JJ wanted something other than the Richards case to give to the experts.

3 July 2001 – four other cases are selected. This was done with advice from Code A Code A who identified some cases with similarities, e.g. the use of syringe drivers for diamorphine. The team was now under pressure to get things moving.

4 July 2001 – JJ writes to Code A and suggests visits to all of the families, to review the cases. This was to ensure that any expert was provided with all of the relevant information to inform their decisions.

9 August 2001 – JJ withdraws the request to visit all of the families and gives his justification. He said that he did not want to raise expectations. His view was now that the case was unlikely to go anywhere due to the differing opinions of the experts.

DC said that this was JJ's decision and there is no record of contact with ACC SO and SW. However, he then briefed those two individuals.

DC feels that the mistake that has been made is that we did not present best evidence to the CPS, TC or the experts. BARTON was only interviewed on one case. The policy book only includes a strategy for the one death. However DC feels that RB was not under the same pressure as JJ.

The basis of the evidence presented was just the medical files and no evidence from relatives who may have been present when drugs were discussed or administered.

Other lines of enquiry that he is trying to find include:

(a) Drawing and method of administration of drugs in other hospitals
(b) Doctor's history
(c) Level of drugs prescribed in other hospitals

He repeated the concern of the families that elderly patients left the Queen Alexander Hospital walking with zimmer frames, who are immediately prescribed diamorphine on arrival at the GWMH, apparently without a clinical assessment of pain. It would appear that this was a standard practice.

DCC said that he could not understand the rationale for not informing the families of the cases, which were subject to dip sample.

PJ felt that the decision not to go forward was based upon the difference of opinion of the experts. However he wondered why there had been no analysis of death levels.

DC said that RB had asked for that, and a comparative study. The families were alleging that there was a significant rise on the death rate when this particular doctor arrived, which then fell when she left. RB wanted to confirm this.

What most upset the families was that when JJ saw them he said that it was his decision, and he was paid to make decisions. If they were unhappy with any decisions he made he said they could complain.

DC said that one family only found out that the death of their relative was on of those dip sampled at the meeting held to tell relatives nothing further was going to be done.

DCC said that the first issue was whether what JJ did could have been done in a better way with more understanding and sympathy for the families. He needed to know if there was any substance in this complaint.

DC said that even at this stage he felt that JJ could benefit from 'Operational Advice'. He believed that he had made flawed judgements, for example a letter summoning them to attend a police station, to be told of results of things they had no idea had been happening. They were promised in April 2001 that someone would update them, and yet this meeting did not take place until February 2002, when they were told the case was closed.

DCC said that having seen the letters they did not contain any 'niceties', they were very formal and to the point. He had been led to believe that it is national policy not to contact bereaved families.

DC said that this policy did exist but only for cases which were brought to the attention of the police by 'whistle blowers'. However in this case it was the families who had come forward as well as the 'whistle blower'.

PJ felt that the families should have been updated and supported.

DCC asked where the policy for contact with bereaved families came from, was it the SIO training?

DC said that he was trying to locate that policy and that was one line of his current enquiry.

DCC asked whether the investigations into the four dip sampled deaths had been put to TC. Were the doctors re-arrested and interviewed about these other deaths? On what basis was the decision to take no further action taken?

PJ asked whether there actually was any work done to carry out comparisons.

DCC said that when the professor was first spoken to he described the ward as a 'Factory of Death'. TC had decided that his evidence was not good enough. What was not clear from the meeting with ACC SO and SW was whether the evidence from the four dip sampled cases was similar or not. If there was a sequence, similar fact, it may be disproportionate. The care given by this doctor would appear to be inconsistent with the previous care given to the old people. He said that we need to do some work on the crime enquiry.

DC said that he was rapidly coming to the limit of his enquiry.

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DCC said that his decision now was whether we could conduct an enquiry internally or whether we need to go to another force.

PJ asked whether the analysis had been done. He believed that the statistics could inform decision-making, and were not necessarily for evidential use.

DS said that the inference from SW and ACC SO was that in the Shipman enquiry, they were not allowed to use the statistics. Having spoken to the Deputy SIO he said that when looking at statistics you need to be quite sophisticated and look at different age groups.

DCC said that medical evidence was diverse. Some felt the administration of diamorphine was appropriate, other felt it was a bit excessive. ACC SO and SW had gone through the same mental struggle to understand why, with the number of cases, the evidence was not sufficient to proceed.

DCC asked whether all of the cases had been put to the CPS. Only four were dip sampled, just on the basis of administration of drugs, and not on the circumstances, and not including any evidence from the families.

DS said that he was surprised there was not in existence a detailed report showing what had been done, the decisions that had been made, the advice that had been sought, and clear reasons why the enquiry could go no further. Had this been in existence it may have helped the families.

DC said that the families had been promised the medical records and reports, which we had commissioned. Now they have been told they cannot see them.

PJ said that there were two issues:

1. The confidence of the public in the investigation. Will they ever accept the view of Hampshire Constabulary officers?
2. There are concerns over the Major Crime enquiry and none of us present are competent to judge that.

DCC said the needs to know what went to CPS before he can make a decision.

DC said that by next Friday 28th June 2002, he would have an interim report ready.

DCC said that if there were any doubt as to the integrity of the investigation we would have to go to an outside force.

DC felt that Hampshire Constabulary would not come out too badly from any scrutiny and at the end we would be able to give detailed feedback to the family. He said that the imminent CHI report will possibly include criticism of Hampshire Constabulary as well and this would fan the flames.

DCC said that he was concerned that there is a possibility that the investigation was flawed. We did not present the best evidence available. If it was flawed we need to put it right. Particular doctors may have brought about the deaths and could still be

doing so somewhere else. We need to track the doctor to see if it is happening again. Why did it happen at the GWMH? Who was there before and what was the death rate then? Were doctors put under pressure from nursing staff?

DS said that GWMH was one of four convalescent hospitals run by this Trust and we need to look at the other three to make comparisons.

DCC said that we would:

1. Wait for the interim report.
2. DC is conducting an enquiry that will cause some concern for senior officers. He wanted to state that DC has his full support. If any person tries to influence the investigation, he would act robustly, because the force comes first. We must be impartial.
3. If the report shows JJ may have made some errors of judgement, he wants to draw that part to a swift conclusion.
4. DS should copy the notes of the previous meeting to DC and PJ.

The next meeting was scheduled for 1700 hours on Tuesday 25th June at Netley.

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Gosport War Memorial Hospital

Meeting in DCC's Office, 1730 hours Thursday, 30th May 2002.

Present:
Deputy Chief Constable READHEAD
Assistant Chief Constable SMITH (CS)
Chief Superintendent WATTS (SW)
Chief Superintendent STEVENS (DS)

The DCC said there were two issues:

(1) Did Detective Superintendent Jon James (JJ) communicate effectively with the families about the progress of the investigation?
He was not originally convinced there were grounds to record this as a complaint. However, having spoken to Chief Superintendent Clacher (DC), who conducted a preliminary investigation, he had arranged for JJ to be served with Regulation 9 notices.

(2) The Investigation into the deaths.
He said that he wanted to establish whether decisions were made by individuals or whether they were as a result of a corporate view.

DCC said DC had been appointed as he was recently arrived from another force and so would be able to take a fresh look at matters with no previous knowledge of the case. DC has spoken to eight families. Having discussed the issues with DC, the DCC wanted to pose a series of questions:

a) Why weren't witness statements taken from the complainants and their families?
b) Why weren't the medical notes of the deceased discussed and commented on in detail with the families?
c) Why, when there appeared to be a pattern of conduct by one doctor (Dr Barton) regarding numerous patients, was the decision made to 'dip sample' only a few cases?
d) Why and by whom was this decision made?
e) Why was there such a disparity in the numbers of people dying at the hospital during the years in question? It is alleged that the yearly average had gone from circa 50 to circa 263, and what was the *current* figure?
f) Was Dr Barton or any members of staff ever arrested or interviewed under caution?
g) Why, and on whose authority, have the independent medical reports been withheld from the families?
h) Has JJ ever had any connection with care homes for the elderly, or any private interest in caring for elderly people and/or kindred matters?
i) Why was there a change in Senior Investigating Officer, midway through the enquiry?
j) Did JJ know about the McKenzie case and the fact that officers had been given *'operational advice'* because of the poor handling of the matter?

SW said that he would give an account of how the investigation commenced and progressed. However, the decision to withhold the independent medical reports was made by the Medical Defence Union. In relation to (h), JJ had taken a career break to go into business with his now father in law in connection with 'care homes'. That did not work and he had returned to the force.

SW said that the issue came to the fore shortly after he was appointed as Detective Superintendent, Major Crime, in the South East. It was originally a complaint against Detective Inspector Stephanie Morgan. That complaint was substantiated and she received *'operational advice'*. On the basis of that he asked (then) Detective Chief Inspector Ray Burt (RB), to review the case and determine whether any further investigative action was required. RB' response was that there was a need to re-investigate, and he was appointed as SIO.

Initially he spoke with Mrs Mckenzie and the hospital, looked at medical records. He also appointed a Professor Livesey as an expert medical witness. He was a professor in Geriatric Care and was seen as a national authority on the subject.

SW said that in recent months he had been involved in writing a chapter for the Murder Investigation Manual, on behalf of ACPO, in relation to Health Care related deaths. This has proved to be a very difficult job. There is no guidance, and no structure, to the selection of expert medical advisors. In essence the NCF recommend certain people, but only on the basis of feedback from SIO's who have used them. There is no independent validation of the experts.

At this stage, RB was posted to PHQ, and SW became Head of CID.

DCC asked if RB had obtained a statement from Mrs Mckenzie, before he moved on.

SW was sure he had, but could not confirm this. In his view a statement from a relative may not have added to the enquiry. All the relevant evidence was held at the hospital.

CS said that JJ took over a SIO, with Detective Chief Inspector Paul Clark (PC) as deputy. The report from the professor was provided. JJ, PC and CS met to discuss the report. They agreed to take the matter forward. JJ and PC wanted to open the enquiry further. CS said that he wanted to test the expert's report. He did not feel that it would be appropriate to open up the enquiry to cover the other 80 deaths, until that had been done.

A meeting was held with the Crown Prosecution Service, who then took the report to Treasury Council. They wanted to see how good a witness Professor Livesey would be. They subjected him to examination and were not happy with his credibility and he eventually crumbled under the pressure of questioning.

In view of this CS took the decision not to expand the enquiry.

SW said that as a result of publicity further people came forward and JJ tried to find further experts. All the complaints were of a similar nature and related to the same

doctor. It did not surprise SW that no statements had been taken, and he would not criticise JJ, but he would expect the families to be kept informed.

CS agreed and said that to take statements may unnecessarily raise the expectations of the relatives. He said the enquiry was about the level of Diamorphine, and the statements from relatives would not have helped in that regard. If the enquiry were to show that the level of Diamorphine was inappropriate, then it would be relevant to contact the families to see if the dose was with their agreement.

DCC said that, in relation to a Mr Page, the first they knew about the 'dip sampling', was when they went to a meeting with JJ in February this year. He said that Mr Page, a Laboratory Technician, and his sister, a senior nurse, decided to obtain the medical reports in relation to their mother. They came to the conclusion that something was very wrong. Their mother, who was 91, came from a hospital in Portsmouth to the GWMH for convalescence. On the very first day she was put on Diamorphine. That was in their view clearly not consistent with her needs.

SW said that all of this sort of evidence was given to Treasury Council, and they had not been interested in pursuing any criminal charges.

CS said that it was not an issue of whether giving the Diamorphine was wrong; it was about whether the level was appropriate. Was there any evidence of a criminal offence or a serious breach of medical procedures? There was no evidence of either.

CS asked JJ to get the case notes and see if he could find an expert who could say that what had happened had been an offence.

DCC asked if there was a direction from either CS or SW to JJ not to take statements. They both said this was not the case.

SW said he had met and consulted with over 70 bodies and was in the process of developing a model for Health Care related deaths. He said that there was a trend for families to complain. There are 40K *Untoward Clinical Deaths'* (UCD) each year. These range from people being given the wrong medicine, the wrong dosage, or the wrong organs removed. The police nationally investigate 1500 to 2000 deaths a year. We could not cope if we had to investigate all UCD's.

The model he was developing directed SIO's to collect Forensic, Pathological, and documentary evidence, whilst maintaining contact with the family. The evidence obtained is then to be sent to an expert. That person will help to determine whether:

(1) Gross Negligence
(2) Deliberate act
(3) Not gross negligence, but sufficient negligence to refer to the GMC
(4) An expected outcome.

Only if the expert opinion indicates (1) or (2) applies, will a full Major Crime enquiry commence.

DCC asked whether it was true that once a person is put on Diamorphine, they will inevitably die? SW said that it was often used for terminal patients and they will often die under that regime, although, people do have the drug and survive. It was the medical version of Heroin and removed pain.

DCC then asked how that sat with a person taken from a hospital in Portsmouth, sent to GWMH for rehabilitation with an expectation of recovery, who is then put on Diamorphine and dies.

SW said that these were the same concerns that JJ and PC had and they in no way tried to sweep this under the carpet. In fact they wished to escalate the enquiry and put a lot of pressure on CS. CS had asked that they focus on a small number of cases and then send the results to Treasury Council for an opinion. This was done and their response was there was no evidence to support a charge. When it was suggested that we could provide them with another 76 similar cases, they still said it would not be sufficient.

CS said that the suggestion is being made that Hampshire Constabulary, and in particular JJ and PC tried to cover this up. That could not be further from the truth.

CS said that when a patient says they are in pain, they are prescribed Diamorphine. The question is whether the dose given is appropriate. We have never been able to find an expert willing to say that what was done was wrong. If they had we would have proceeded. It is a judgement for the individual doctor. In this case the doctor had recorded what was been prescribed, and in what quantities, so there was no dishonesty or attempt to hide what was being done.

DCC was still uncomfortable where we had evidence of a regime that as soon as a person was admitted they put them on Diamorphine, which inevitably means the person will die.

SW said that they had presented that argument to experts and none was prepared to comment.

DCC said that we had a situation where there were 80 cases, which all revealed the same diagnosis, treatment and application of Diamorphine, and this was only the case since a particular doctor had arrived. He wondered whether historically, the patients came in, got better and went home, now under this doctor, they came in, were treated and then died.

SW said that the same argument was used on the Shipman case and it showed a marked difference in the levels of death for Dr Shipman's patients. The CPS had not allowed the SIO to use this information.

SW said that despite the fact that we had been advised there was no prospect of a conviction, the matter had been referred to the General Medical Council and Commission for Health Improvement (CHI). The result of that may be that the doctor is struck off.

DCC asked what Professor Livesey had said about this.

SW said that Professor Livesey had felt that the treatment was inappropriate, and had even used the phrase *'factory of death'*. People who were hale and hearty had died as a result of treatment. That is why RB took the matter so seriously. When JJ and PC took over they took it equally seriously and took the matter via CPS to Treasury Council. As already stated the experts was tested and not proved to be reliable or credible.

DCC asked whether in view of that, if we had been to other experts.

CS confirmed we had done so and that no one supported Livesey.

SW said that the CHI were going into the hospital to look at systems and ensure that they are not so flawed that patients are at risk.

SW was happy that we have investigated this appropriately and the steps taken by JJ were exactly as SW's proposed model. JJ had advised him of the contact with the families and the meetings he had held. Some families were understandably not happy. However, it was our job to try and manage expectations.

DCC said that with the benefit of hindsight, the issue that really concerned the families was that no statements were ever taken from them. He accepted the comments from both CS and SW, but felt that the taking of statements would have perhaps been a better option.

SW said that there was a policy decision not to inform the families that a dip sample had taken place, again to prevent expectations from being raised.

DCC said that the families do feel that their evidence makes a difference. We could have advised them that Treasury Council considered their views.

CS said that the danger was that if the other 76 had known of the dip sample, they would have all wanted to make statements.

The DCC said that he had a feeling that the family were being briefed from within the organisation.

SW agreed and his view was that RB was in close contact with Mrs McKenzie and probably briefing her. He said that RB had a tendency to get too involved with families in major enquiries and gave an example of another instance. He said that originally the contact with Mrs McKenzie was appropriate. However, over time, he had continued to keep in touch, even after he was replaced as SIO. When the evidence of the expert collapsed, RB was convinced that there was a conspiracy. He was told that this was not the case and asked to leave it. SW said that he knows RB is still talking to Mrs Mckenzie and has been told that this contact is inappropriate.

SW said that RB had not seen the expert '*crumble*' and was also not aware of JJ's desire to push for a full investigation.

DCC asked to just check the original questions and ensure they had been covered.

(a) Covered.
(b) Medical notes: would not add value. Even if the families had said no to the Diamorphine, the doctor's loyalty is to the patient.
(c) Covered.
(d) CS decision, based on advice from Treasury Council.
(e) Covered.
(f) Neither SW nor CS were sure.
(g) Advice from the MDU.
(h) Covered.
(i) RB was posted to a new role. The new SIO was a rank higher and supported by a DCI, showing the importance we placed upon the enquiry.
(j) Yes.

DCC said he wanted to find a way forward. He was aware of the support from the Portsmouth News and the television coverage. A meeting with the family to explain decisions may be useful. CS said that there was no prospect of Treasury Council meeting the families. However he warned that we should not go too far at this time as the matter was still with the GMC. It was passed to them on the basis that we have no evidence of criminal activity, so what is there in from an internal medical perspective.

DCC outlined his options:

(1) Review the investigation.
(2) Refer to another force.
(3) Refer to the Police Complaints Authority.
(4) Close it now.

SW was concerned that DC was not qualified to conduct a review of the investigation. He was assured that DC was confining his investigation into the complaint, but nevertheless felt it would inevitably stray into other matters.

He said he had deliberately not involved DC in this meeting. However he asked, What if the Treasury Council got it wrong? Can we give it to a Judge to review?

CS said we had produced the best evidence possible and been told by the CPS that it was a non-runner.

SW said that JJ had received some threats from one family, with words such as *'my sole intention in bringing this complaint is to destroy your career.'* Some families had also become aware of JJ's career break and were asking questions about that.

DS said that we needed to make an early decision as the families were under the impression we are investigating all of their concerns, when in effect we are simply dealing with the issues of *'communication'* in relation to JJ. If we as a force decide not to pursue the other aspect of their complaint, we are duty bound to let them know as soon as possible.