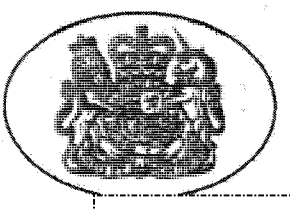
David C. Horsley LLB
Her Majesty's Coroner
for Portsmouth and
South East Hampshire

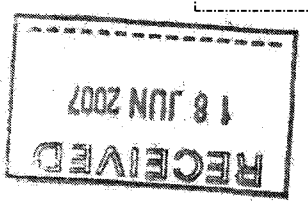


Code A

Coroner's Office
Room T20
The Guildhall
Guildhall Square
Portsmouth
PO1 2AJ

Code A

Code A
Coroners Unit
5th Floor, Steel House
11 Tothill Street
London SW1H 9LH



15 June 2007

Dear Code A

Hampshire Police Operation Rochester – Deaths at Gosport War Memorial Hospital, Gosport, Hampshire:

I have recently been passed a report by Hampshire Police on Operation Rochester which was an investigation they conducted between 1998 and 2006 into the deaths of some 92 elderly patients at Gosport War Memorial Hospital between 1989 and 2000. The investigation was commenced following allegations made to the Police that the patients had been inappropriately administered Diamorphine or other opiate drugs and that had caused or contributed to their deaths.

The final phase of this lengthy investigation was a review of the 92 cases by a team of medical experts with specialisms in toxicology, general medicine, palliative care, geriatrics and nursing. Of the 92 deaths, the team found that 78 of them failed to meet the threshold of negligence required to conduct a full criminal investigation. Of the remainder, the team reached the conclusion that four of the deaths could be described as being entirely natural. The ten others were then the subject of a full criminal investigation as the team had reached the conclusion on them that they were cases of "negligent care that is today outside the bounds of acceptable clinical practice and the cause of death is unclear".

A common denominator in these ten cases was the involvement of a Dr Jane Barton who at relevant times had been the attending clinical assistant at the hospital and responsible for the ten patients' initial and continuing care, including prescribing and administering opiates via syringe drivers. It should also be noted that none of the ten deaths (nor any of the remaining 82) had been reported to the then Portsmouth and South East Hampshire Coroner.

Full files on the ten cases were forwarded to the Crown Prosecution Service for consideration of criminal proceedings in relation to the deaths. Subsequently, the Crown Prosecution Service concluded in December 2006 that having regard to overall expert evidence it could not be proved that negligence had occurred to a criminal standard and whilst the expert medical evidence was detailed and complex, it did not prove that the drugs which had been administered to the patients had contributed substantially to their deaths. Even if causation could be proved, there was not sufficient evidence to prove that the conduct of doctors was so bad as to be a crime and there was no realistic prospect of convictions.

The decision of the Crown Prosecution Service was then communicated to the families of ten deceased persons and the criminal investigation was then closed. Following this, Hampshire Police forwarded their files on Operation Rochester to me to consider whether I should investigate and conduct Inquests into any of the deaths involved.

Given the fact that the Police investigated 92 deaths, hundreds of witnesses were interviewed and their statements run into many thousands of pages. For obvious reasons, I have not read in detail the totality of the evidence gathered but from my understanding of it and my discussions with police officers involved in the investigations, I take the view that in respect of the ten deaths which were ultimately the subject of full criminal investigation I have reasonable cause to suspect that the ten persons concerned have died in the circumstances described in Section 8(1)(a) and (b) of the Coroners Act 1988 and that I am under a duty to hold Inquests into their deaths.

The ten persons are: -

1. Elsie Devine: died 21.11.99. Recorded cause of death "bronchopneumonia and glomerulonephritis".

2. Elsie Lavender: died 22.2.96. Recorded cause of death "cerebrovascular accident".

3. Sheila Gregory: died 22.11.99. Recorded cause of death "bronchopneumonia".

4. Robert Wilson: died 14.10.98. Recorded cause of death "congestive cardiac failure and renal/liver failure".

5. Enid Spurgin: died 26.3.99. Recorded cause of death "cerebrovascular accident".

6. Ruby Lake: died 21.8.98. Recorded cause of death "bronchopneumonia".

7. Leslie Pittock: died 24.1.96. Recorded cause of death "bronchopneumonia".

8. Helena Service: died 5.6.97. Recorded cause of death "congestive cardiac failure".

9. Geoffrey Packman: died 3.9.99. Recorded cause of death "myocardial infarction".

10. Arthur Cunningham: died 26.9.98. Recorded cause of death "bronchopneumonia".

Needless to say, there has been intense interest and speculation regarding the police investigation not only amongst the families concerned but also in the local media and the general public. Once criminal prosecution was ruled out, this has turned to how the Coroner will react to being presented with the results of Operation Rochester.

As I have stated above, the evidence in relation to the foregoing ten deaths (which runs to 39 experts' reports totalling several thousand pages and 368 witness statements) indicates to me that I should open Inquests into these deaths. However, I have a problem in this regard. Of the ten people, only the bodies of three of them – Sheila Gregory, Elsie Devine and Elsie Lavender – are buried within my district. The rest have been cremated.

Given that all ten families will not now have the circumstances of the deaths explored in criminal proceedings, the only way a public examination of the circumstances of the deaths can be conducted is by Inquest hearings. It seems to me to be most unfair to the families of the seven cremated people that they will miss out on this opportunity simply because there are no remains within my district. Accordingly, I should be grateful if this letter could

be treated as my report to the Secretary of State under Section 15(1) of the Coroners Act 1988 to enable the Secretary of State to consider whether it is desirable for me to hold Inquests into all ten deaths rather than simply the three where bodies remain.

To assist the Secretary of State's deliberations, I enclose a copy of an overview of Operation Rochester prepared for me by the senior investigating officer, Detective Superintendent David Williams of Hampshire Police.

Due to the intense local interest in this matter, and the need to address questions of resources and logistics necessary to conduct what will inevitably be ten long and complex Inquests, early directions from the Secretary of State would be greatly appreciated.

Please contact me if you require any further information to assist the Secretary of State.

Yours sincerely

Code A

David C Horsley
Tel: Code A
Email: Code A

Enc

cc Asst. Ch. Constable S Watts) Hampshire Police
Det. Supt. D Williams)
Andrew Smith, Hampshire County Council
Karen Murray, Hampshire County Council

Code A

From: Code A
Sent: 22 June 2007 15:38
To: Code A @dh.gsi.gov.uk'
Subject: RE: Deaths of elderly patients at Gosport War Memorial Hospital, Gosport Hampshire

I'm sure even a doctored version will be fine, Code A

My secretary, Code A, will be in touch with you shortly about dates for the meeting.

Code A
Head of Current Coroner Policy
Coroners Unit
Ministry of Justice

Tel: Code A
Fax:
Code A @justice.gsi.gov.uk

-----Original Message-----
From: Code A @dh.gsi.gov.uk [mailto: Code A @dh.gsi.gov.uk]
Sent: 21 June 2007 11:26
To: Code A
Subject: RE: Deaths of elderly patients at Gosport War Memorial Hospital, Gosport Hampshire

Code A

Indeed; but the offer would be for you to see the brief to the CMO to fill in the background-it would not be appropriate for further distribution as it relates to a number of issues covered by both patient confidentiality and personal information on NHS professionals. I will, in any event, even then, have to send you a slightly "doctored" version

Code A

IIU/DOH/GB@DOH

Code A
gsi.gov.uk>

21/06/2007 08:31

To: Code A /CQEG-
cc:
bcc:
Subject: RE: Deaths of elderly patients at Gosport War Memorial Hospital, Gosport Hampshire

Many thanks Code A. You mentioned that you had advice to the CMO or a report on this which you could share with us in advance of the meeting.

Code A
Head of Current Coroner Policy
Coroners Unit
Ministry of Justice

Tel: Code A
Fax:
Code A @justice.gsi.gov.uk

-----Original Message-----
From: Code A @dh.gsi.gov.uk [mailto: Code A @dh.gsi.gov.uk]

Sent: 20 June 2007 18:02
To: Code A
Subject: Re: Deaths of elderly patients at Gosport War Memorial Hospital, Gosport Hampshire

Code A

OK; happy to attend

Code A

Code A

Code A @justice. To:
Code A

gsi.gov.uk> cc:
Code A

Code A QEG-IIU/DOH/GB@DOH, Code A
Code A justice.gsi.gov.uk>,
20/06/2007 17:56 Code A
Code A justice.gsi.gov.uk>

bcc:

Subject: Deaths of elderly patients at Gosport War Memorial Hospital, Gosport Hampshire

Code A

We spoke yesterday about this case. You had written to Code A on 15 June indicating that you would be making an application to the Lord Chancellor under section 15 of the Coroners Act 1988 but now thought that there might be another course of action, perhaps a public inquiry.

I mentioned to you that I had spoken to Code A leads on inquiries and inquiries at the Department of Health (phone number Code A
Code A .
Code A is familiar indeed with the case and advised that DH had ruled out holding a public inquiry.

We agreed that it would be helpful to meet to discuss the case in the round and consider the most appropriate course of action. You would like to bring DS David Williams to the meeting.

I will have Code A arrange a meeting here in the next few weeks.
I would have thought it sensible to book a 2 hour slot but we may finish before then.,

Kind regards

Code A

OPERATION ROCHESTER

Investigation Overview 1998-2006.

Background.

Gosport War Memorial Hospital (GWMH) is a 113 bed community hospital managed during much of the period under investigation by the Fareham and Gosport Primary Care Trust. The hospital fell under the Portsmouth Health Care (NHS) Trust from April 1994 until April 2002 when services were transferred to the local Primary Care Trust.

The hospital operates on a day-to-day basis by nursing and support staff employed by the PCT. Clinical expertise was provided by way of visiting general practitioners and clinical assistants, consultant cover being provided in the same way.

Elderly patients were generally admitted to GWMH through referrals from local hospitals or general practitioners for palliative, rehabilitative or respite care.

Doctor Jane BARTON is a registered Medical Practitioner who in 1988 took up a part-time position at GWMH as Clinical Assistant in Elderly Medicine. She retired from that position in 2000.

Police Investigations.

Operation ROCHESTER was an investigation by Hampshire Police into the deaths of elderly patients at GWMH following allegations that patients admitted since 1989 for rehabilitative or respite care were inappropriately administered Diamorphine and other opiate drugs at levels or under circumstances that hastened or caused death. There were

further concerns raised by families of the deceased that the general standard of care afforded to patients was often sub-optimal and potentially negligent.

Most of the allegations involved a particular General Practitioner directly responsible for patient care Doctor Jane BARTON.

Two allegations (SPURGIN and PACKMAN) were pursued in respect of a consultant Dr Richard REID.

Of 945 death certificates issued in respect of patient deaths at GWMH between 1995 and 2000, 456 were certified by Doctor BARTON.

The allegations were subject of three extensive investigations by Hampshire Police between 1998 and 2006 during which the circumstances surrounding the deaths of 92 patients were examined. At every stage experts were commissioned to provide evidence of the standard of care applied to the cases under review.

The Crown Prosecution Service reviewed the evidence at the conclusion of each of the three investigation phases and on every occasion concluded that the prosecution test was not satisfied and that there was insufficient evidence to sanction a criminal prosecution of healthcare staff, in particular Dr BARTON.

The General Medical Council also heard evidence during Interim Order Committee Hearings to determine whether the registration of Dr BARTON to continue to practice should be withdrawn. On each of the three occasions that the matter was heard the GMC was satisfied that there was no requirement for such an order and Dr BARTON continued to practice under voluntary restrictions in respect of the administration of Opiate drugs.

The First Police Investigation.

Hampshire Police investigations commenced in 1998 following the death of Gladys RICHARDS aged 91 years.

Mrs. Richards died at the GWMH on Friday 21st August 1998 whilst recovering from a surgical operation carried out at the nearby Royal Haslar Hospital to address a broken neck of femur on her right side (hip replacement).

Following the death of Mrs. Richards two of her daughters, Mrs. MACKENZIE and Mrs. LACK complained to the Hampshire Police about the treatment that had been given to their mother at the GWMH. Mrs. MACKENZIE contacted Gosport police on 27th September, 1998 and alleged that her mother had been unlawfully killed.

Local officers (Gosport CID) carried out an investigation submitting papers to the Crown Prosecution Service in March 1999.

The Reviewing CPS Lawyer determined that on the evidence available he did not consider a criminal prosecution to be justified.

Mrs. MACKENZIE then expressed her dissatisfaction with the quality of the police investigation and made a formal complaint against the officers involved.

The complaint made by Mrs. MACKENZIE was upheld and a review of the police investigation was carried out.

Second Police Investigation

Hampshire Police commenced a re-investigation into the death of Gladys RICHARDS on Monday 17th April 2000.

Professor Brian LIVESLEY an elected member of the academy of experts provided medical opinion through a report dated 9th November 2000 making the following conclusions:

- "Doctor Jane BARTON prescribed the drugs Diamorphine, Haloperidol, Midazolam and Hyoscine for Mrs. Gladys RICHARDS in a manner as to cause her death."

- "Mr. Philip James BEED, Ms. Margaret COUCHMAN and Ms. Christine JOICE were also knowingly responsible for the administration of these drugs."

- "As a result of being given these drugs, Mrs. RICHARDS was unlawfully killed."

A meeting took place on 19th June 2001 between senior police officers, the CPS caseworker Paul CLOSE, Treasury Counsel and Professor LIVESLEY.

Treasury Counsel took the view that Professor LIVESLEY's report on the medical aspects of the case, and his assertions that Mrs. RICHARDS had been unlawfully killed were flawed in respect of his analysis of the law. He was not entirely clear of the legal ingredients of gross negligence/manslaughter.

Professor LIVESLEY provided a second report dated 10th July, 2001 where he essentially underpinned his earlier findings commenting:-

- "It is my opinion that as a result of being given these drugs Mrs RICHARDS death occurred earlier than it would have done from natural causes."

In August 2001 the Crown Prosecution Service advised that there was insufficient evidence to provide a realistic prospect of a conviction against any person.

Local media coverage of the case of Gladys RICHARDS resulted in other families raising concerns about the circumstances of their relatives' deaths at the GWMH as a result four more cases were randomly selected for review.

Expert opinions were sought of a further two medical professors FORD and MUNDY who were each provided with copies of the medical records of the four cases in addition to the medical records of Gladys RICHARDS.

The reports from Professor FORD and Professor MUNDY were reviewed by the Police and a decision was taken not to forward them to the CPS as they were all of a similar nature to

the RICHARDS case and would therefore attract a similar response as the earlier advice from counsel. A decision was then made by the Police that there would be no further police investigations at that time.

Copies of the expert witness reports of Professor FORD and Professor MUNDY were forwarded to the General Medical Council, the Nursing and Midwifery Council and the Commission for Health Improvement for appropriate action.

Intervening Developments between Second and Third Investigations

On 22nd October 2001 the Commission for Health Improvement (CHI) launched an investigation into the management provision and quality of health care for which Portsmouth Health Care (NHS) Trust was responsible at GWMH interviewing 59 staff in the process.

A report of the CHI investigation findings was published in May 2002 concluding that a number of factors contributed to a failure of the Trust systems to ensure good quality patient care.

The CHI further reported that the Trust post investigation had adequate policies and guidelines in place that were being adhered to governing the prescription and administration of pain relieving medicines to older patients.

Following the CHI Report, the Chief Medical Officer Sir Liam DONALDSON commissioned Professor Richard BAKER to conduct a statistical analysis of the mortality rates at GWMH, including an audit/review of the use of opiate drugs.

On Monday 16th September 2002 staff at GWMH were assembled to be informed of the intended audit at the hospital by Professor BAKER. Immediately following the meeting nurse Anita TUBBRITT (who had been employed at GWMH since the late 1980s) handed to hospital management a bundle of documents.

The documents were copies of memos letters and minutes relating to the concerns of nursing staff raised at a series of meetings held in 1991 and early 1992 including :-

- The increased mortality rate of elderly patients at the hospital.
- The sudden introduction of syringe drivers and their use by untrained staff.
- The use of Diamorphine unnecessarily or without consideration of the sliding scale of analgesia (Wessex Protocol).
- Particular concerns regarding the conduct of Dr BARTON in respect of prescription and administration of Diamorphine.

Nurse TUBRITT'S disclosure was reported to the police by local health authorities and a meeting of senior police and NHS staff was held on 19th September 2002 the following decisions being made:-

- Examine the new documentation and investigate the events of 1991.
- Review existing evidence and new material in order to identify any additional viable lines of enquiry.
- Submit the new material to experts and subsequently to CPS.
- Examine individual and corporate liability.

A telephone number for concerned relatives to contact police was issued via a local media release.

Third Police Investigation

On 23rd September 2002 Hampshire Police commenced enquiries. Initially relatives of 62 elderly patients that had died at Gosport War Memorial Hospital contacted police voicing standard of care concerns (including the five original cases)

In addition Professor Richard BAKER during his statistical review of mortality rates at GWMH identified 16 cases which were of concern to him in respect of pain management.

14 further cases were raised for investigation through ongoing complaints by family members between 2002 and 2006.

A total of 92 cases were investigated by police during the third phase of the investigation.

A team of medical experts (key clinical team) were appointed to review the 92 cases completing this work between September 2003 and August 2006.

The multi-disciplinary team reported upon Toxicology, General Medicine, Palliative Care, Geriatrics and Nursing.

The terms of reference for the team were to examine patient notes initially independently and to assess the quality of care provided to each patient according to the expert's professional discipline.

The Clinical Team were not confined to looking at the specific issue of syringe drivers or Diamorphine but to include issues relating to the wider standard and duty of care with a view to screening each case through a scoring matrix into predetermined categories:-

Category 1- Optimal care.
Category 2- Sub optimal care.
Category 3- Negligent care.

The cases were screened in batches of twenty then following this process the experts met to discuss findings and reach a consensus score.

Each expert was briefed regarding the requirement to retain and preserve their notations and findings for possible disclosure to interested parties.

All cases in categories 1 and 2 were quality assured by a medical/legal expert, Matthew LOHN to further inform the police decision that there was no basis for further criminal investigation.

Of the 92 cases reviewed 78 failed to meet the threshold of negligence required to conduct a full criminal investigation and accordingly were referred to the General Medical Council and Nursing and Midwifery Council for their information and attention.

Fourteen Category 3 cases were therefore referred for further investigation by police. Of the fourteen cases, four presented as matters that although potentially negligent in terms of standard of care were cases where the cause of death was assessed as entirely natural. Under these circumstances the essential element of causation could never be proven to sustain a criminal prosecution for homicide.

Notwithstanding that the four cases could not be prosecuted through the criminal court they were reviewed from an evidential perspective by an expert consultant Geriatrician Dr David BLACK who confirmed that the patients were in terminal end stage of life and that in his opinion death was through natural causes.

Accordingly the four cases ...Were released from police investigation in June 2006:-

- Clifford HOUGHTON.
- Thomas JARMAN.
- Edwin CARTER.
- Norma WINDSOR

The final ten cases were subjected to full criminal investigation upon the basis that they had been assessed by the key clinical team as cases of 'negligent care that is to day outside the bounds of acceptable clinical practice, and cause of death unclear.'

The investigation parameters included taking statements from all relevant healthcare staff involved in care of the patient, of family members and the commissioning of medical experts to provide opinion in terms of causation and standard of care.

The expert witnesses, principally Dr Andrew WILCOCK (Palliative care) and Dr David BLACK (Geriatrics) were provided guidance from the Crown Prosecution Service to ensure that their statements addressed the relevant legal issues in terms of potential homicide.

The experts completed their statements following review of medical records, all witness statements and transcripts of interviews of Dr Reid and Dr Barton the

healthcare professionals in jeopardy. They were also provided with the relevant documents required to put the circumstances of care into 'time context' The reviews were conducted by the experts independently.

Supplementary expert medical evidence was obtained to clarify particular medical conditions beyond the immediate sphere of knowledge of Dr's BLACK and WILCOCK.

A common denominator in respect of the ten cases was that the attending clinical assistant was Dr Jane BARTON who was responsible for the initial and continuing care of the patients including the prescription and administration of opiate and other drugs via syringe driver.

Dr BARTON was interviewed under caution in respect of the allegations.

The interviews were conducted in two phases. The initial phase was designed to obtain an account from Dr BARTON in respect of care delivered to individual patients. Dr BARTON responded during these interviews through provision of prepared statements and exercising her right of silence in respect of questions asked.

During the second interview challenge phase (following provision of expert witness reports to the investigation team) Dr BARTON exercised her right of silence refusing to answer any questions.

Consultant Dr Richard REID was interviewed in respect of 2 cases (PACKMAN and SPURGIN) following concerns raised by expert witnesses. Dr REID answered all questions put.

Full files of evidence were incrementally submitted to the Crown Prosecution Service between December 2004 and September 2006 in the following format:-

- Senior Investigating Officer summary and general case summary.

- Expert reports.
- Suspect interview records.
- Witness list.
- Family member statements.
- Healthcare staff statements.
- Police officer statements.
- Copy medical records.
- Documentary exhibits file.

Additional evidence was forwarded to the CPS through the compilation of generic healthcare concerns raised by staff in terms of working practices and the conduct of particular staff.

The ten category three cases were:-

1. Elsie DEVINE 88yrs. Admitted to GWMH hospital 21st October 1999, diagnosed multi-infarct dementia, moderate/chronic renal failure. Died 21st November 1999, 32 days after admission cause of death recorded as bronchopnuemonia and glomerulonephritis.

2. Elsie LAVENDER 83yrs. Admitted to GWMH 22nd February 1996 with head injury /brain stem stroke. She had continued pain around the shoulders and arms for which the cause was never found. Died 6th March 1996, 14 days after admission cause of death recorded as cerebrovascular accident.

3. Sheila GREGORY 91yrs. Admitted to GWMH 3rd September 1999 with fractured neck of the femur, hypothyroidism, asthma and cardiac failure. Died 22nd November 1999, 81 days after admission cause of death bronchopnuemonia.

4. Robert WILSON. 74 yrs. Admitted to GWMH 14th October 1998 with fractured left humerus and alcoholic hepatitis. Died 18th October 1998 4 days after admission cause of death recorded as congestive cardiac failure and renal/liver failure.

5. Enid SPURGIN 92 yrs. Admitted to GWMH 26th March 1999 with a fractured neck of the femur. Died 13th April 1999 18 days after admission cause of death recorded as cerebrovascular accident.

6. Ruby LAKE 84 yrs. Admitted to GWMH 18th August 1998 with a fractured neck of the femur, diarrhea atrial fibrillation, ischemic heart disease dehydrated and leg/buttock ulcers. Died 21st August 1998 3 days after admission cause of death recorded as bronchopneumonia.

7. Leslie PITTOCK 82 yrs. Admitted to GWMH 5th January 1996 with parkinsons disease he was physically and mentally frail immobile suffering depression. Died 24th January 1996 15 days after admission cause of death recorded as bronchopneumonia.

8. Helena SERVICE 99 yrs. Admitted to GWMH 3rd June 1997 with many medical problems, diabetes, congestive cardiac failure, confusion and sore skin. Died 5th June 1997 2 days after admission cause of death recorded as congestive cardiac failure.

9. Geoffrey PACKMAN 66yrs. Admitted to GWMH 23rd August 1999 with morbid obesity cellulitis arthritis immobility and pressure sores. Died 3rd September 1999 13 days after admission cause of death recorded as myocardial infarction.

10. Arthur CUNNINGHAM 79 yrs. Admitted to GWMH 21st September 1998 with Parkinson's disease and dementia. Died 26th September 1998 5 days after admission cause of death recorded as bronchopneumonia.

Dr David WILCOCK provided extensive evidence in respect of patient care concluding with particular themes 'of concern' in respect of the final 10 category ten cases including:-

- *'Failure to keep clear, accurate, and contemporaneous patients records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed'*

- *'Lack of adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination'*

- *'Failure to prescribe only the treatment, drugs, or appliances that serve patients' needs'*

- *'Failure to consult colleagues Including:-*

  Enid Spurgin – orthopaedic surgeon, microbiologist
  Geoffrey Packman – general physician, gastroenterologist
  Helena Service – general physician, cardiologist
  Elsie Lavender – haematologist
  Sheila Gregory – psychogeriatrician
  Leslie Pittock – general physician/palliative care physician
  Arthur Cunningham – palliative care physician.

Many of the concerns raised by Dr WILCOCK were reflected by expert Geriatrician Dr David BLACK and other experts commissioned, the full details being contained within their reports.

There was however little consensus between the two principal experts Drs BLACK and WILCOCK as to whether the category 3 patients were in irreversible end stage terminal decline, and little consensus as to whether negligence more than minimally contributed towards the patient death.

As a consequence Treasury Counsel and the Crown Prosecution Service concluded in December 2006 that having regard to overall expert evidence it could not be proved that Doctors were negligent to criminal standard.

Whilst the medical evidence obtained by police was detailed and complex it did not prove that drugs contributed substantially towards death.

Even if causation could be proved there was not sufficient evidence to prove that the conduct of doctors was so bad as to be a crime and there was no realistic prospect of conviction.

Family group members of the deceased and stakeholders were informed of the decision in December 2006 and the police investigation other than referral of case papers to interested parties and general administration was closed.

David WILLIAMS.
Detective Superintendent 7227
Senior Investigating Officer.
16th January 2007.