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05 June 2001

Mr. B. LIVESLEY,
Code A

Dear Professor Livesley,

I am writing as promised following our meeting of the 31st May, in regard to the current planning issues we are seeking to address in Operation Rochester.

You will recall that we discussed two critical planning issues that you agreed to comment upon.

The first issue concerns identifying the deaths we would want to examine in greater detail from the total deaths over an agreed period. The "population" of deaths we would examine would be dictated by the following criteria:

"All those deaths in a period from twelve months before the commencement of the employment of Dr. Barton or Mr. Beed, dependent upon who was first appointed, through to the date of the notification to the Health Authority of the second investigation into the death of Gladys Richards".

I think we were all in agreement that these parameters for the deaths we should examine were appropriate. In particular, the period twelve months before allowed some scrutiny to identify:

- Whether the clinical practices you identify preceded the arrival of Dr. Barton and Mr. Beed.
- Whether there is a need to widen the scale of the investigation, depending upon the outcome above.

- A control sample for comparative purposes if the examination of the pre-Beed/Barton regime reveals no irregularities in patient care practice.

I believe we are also demonstrating some clear objectivity in seeking to identify whether or not the clinical practices preceded Beed and Barton. This is crucial in relation to the integrity of the investigation, particularly in demonstrating that we are not scapegoating Dr. Barton and Mr. Beed.

The identification of a control sample of the nature indicated should be statistically significant for comparative purposes. If necessary, we will seek professional statistical advice in this regard.

I believe the cut-off date is appropriate at this stage, given that the commencement of Ray Burt's investigation precipitated a series of actions within the Health Trust and the hospital. We can always re-visit this date if appropriate.

My recollection of our meeting was that there was broad agreement on the parameters of the wider investigation. I would welcome any further suggestions you may have, having had the opportunity for further reflection.

The second issue for your comments concerns the process for examining the deaths on a case-by-case basis to identify:

- Those that may be categorised as unlawful.
- The criminal liability of any individual.

We discussed a phased process for examining each case which followed the process described below:

1. From the broad population previously identified all those cases where Dr. Barton or Mr. Beed were involved in managing the patient's care.
2. From this "secondary" population all those cases where the cause of death registered with the Coroner was Bronchopneumonia.

This process will reveal a number of deaths that will need to be examined in some greater detail. You suggested the first discriminating factor would be the patient's organic condition on admission. This would identify patients at risk of being inappropriately treated depending upon the nature of the condition i.e. a high risk patient would be one with say broken bones (clearly not life-threatening), a low risk patient would be one with a potentially terminal condition.

It was suggested at out meeting we should categorise as either low risk or high risk. On reflection, I would prefer to use high, medium and low risk. This would enable us to be more discriminating in what may be a large number of cases and would help to phase the examination of records. I believe we should seek to identify what organic conditions would dictate a high, medium or low risk. I would be grateful if you could confirm you would be able to develop some discriminating criteria in this respect.

Following the process of categorising in relation to risk, a more-detailed scrutiny of each case can be applied.

The first indicator we should then examine is any pre-prescription at the point of admission for Diamorphine or any drug in that family.

We should also identify what dosages were administered and over what timescale.

We should identify whether or not the Diamorphine was delivered via a syringe-driver and whether or not any conditions were prescribed in relation to the use of a syringe-driver.

We should identify whether or not the delivery of drugs via the syringe-driver was subject to any review.

Finally, we should identify whether or not the delivery of Diamorphine via a syringe-driver continued through to death or a period immediately preceding death.

The outcome of the case by case-examination should identify those persons:

- Who were at high risk by virtue of their organic condition on admission.
- Who were pre-prescibed Diamorphine on admission.
- Who were delivered inappropriately high dosages of Diamorphine given their organic condition.
- Received these doses via a syringe-driver, which may be an indicator of a pre-determination of likely death.
- Were not subject to regular reviews of the delivery of Diamorphine.
- Were subject to the delivery of Diamorphine continuously until death.

This process of scrutiny is entirely consistent with your judgement concerning the classification of death as unlawful where:

- The organic condition on admission cannot be in any way considered terminal at that point in time.
- The administration of high levels of Diamorphine continuously via a syringe-driver will lead to death.
- There is no evidence of a review of the course of drugs prescribed which will have as an inevitable outcome the death of the patient.
- There is no evidence of any clinical intervention to change the course of treatment.

I trust that I have summarized our discussions accurately. I am happy to acknowledge this may be rather lengthy but I am sure you will appreciate the significance of this process.

I would welcome any comments you may have on the process outlined.

I would also appreciate some help on two other issues we briefly discussed. You undertook to consider where we might seek some guidance on the relevance of comparative mortality

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rates in hospitals demographically similar to Gosport. You may have some update on that matter.

Secondly, I would appreciate some guideline on your future fees for examining the cases we identify as a consequence of applying the screening process I have outlined. I am sure you will recognize the importance of my guidance to the Force on all resource issues.

Finally, I would like to express my thanks to you for your professional support and guidance. Paul Clark and I are new to the investigation as you are aware, and we are both conscious that others have had more time to digest the detail, principles and potential outcomes. It would be helpful if you would view our thought processes at this time in that context.

I look forward to hearing from you at your earliest convenience.

Yours sincerely

Code A

John JAMES
Detective Superintendent