Professor Brian Livesley MD FRCP
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18 June, 2001

Your ref: MIC/D.Supt/JJ/MK

Detective Superintendent John James
Major Incident Complex
Fratton Police Station
Kingston Crescent, North End
Portsmouth
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Dear Detective Superintendent James

RE: OPERATION ROCHESTER

Thank you for your letter dated 5 June describing the current planning issues you are seeking to address in Operation Rochester and the principles we agreed to use.

In response to your request in paragraph five on page two of your letter, you will recall that during our recent telephone conversation I suggested that the Statisticians concerned with the Shipman Enquiry might be the most appropriate to approach for professional advice in relation to control sampling and cluster analysis.

In response to the second issue you raise in the following paragraph it may be helpful if some comments I made during our discussion on 31st May are detailed here. I cite now from MA Branthwaite's (2000) *Law for Doctors.*[1]

> **"Manslaughter by gross negligence**
>
> "It is arguable that deaths arising as a result of medical treatment can be distinguished from the usual case of homicide because it is the defendant's professional obligations which require him to deal with a pre-existing danger which is not of his own making. This philosophy lay behind the original definition of gross (ie criminal) negligence [R v Bateman (1925) LJKB 791] which required
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> 1. the existence of a duty of care
> 2. breach of the duty
> 3. death occurring as a consequence of the breach of duty
> 4. negligence which went beyond a mere matter of compensation between the parties.

[1] Branthewaite MA. *Law for Doctors: principles and practicalities.* The Royal Society of Medicine Press Ltd. 2000. pp. 75-76.

"After some years when 'gross negligence' was regarded by the courts as synonymous with recklessness, the importance of specific criteria for a finding of gross negligence in the discharge of professional responsibilities was re-emphasised by the Court of Appeal in the course of three appeals, heard simultaneously, against convictions for manslaughter electrician, two junior doctors, and a locum anaesthetist. Two of the appeals succeeded but the third did not. The third appellant appealed, unsuccessfully, to the House of Lords [R v Adomako [1994] 5 Med LR 277] when the criteria for a finding of involuntary manslaughter by breach of duty suggested by the Court of Appeal were confirmed as

7. the existence of a duty
8. breach of the duty causing death
9. gross negligence which the jury considered justified a criminal conviction.

"The third of these is the only one which differs in terminology, if not in meaning, from the original definition of 'gross negligence'. A jury is entitled to make a finding of gross negligence if evidence is adduced to show that the defendant

10. was indifferent to an obvious risk of injury to health
11. had actual foresight of the risk but determined nevertheless to run it
12. appreciated the risk and intended to avoid it but displayed such a high degree of negligence in the attempted avoidance as the jury considered justified conviction
13. displayed inattention or failure to advert to a serious risk which went beyond 'mere inadvertence' in respect of an obvious and important matter which the defendant's duty demanded he should address.

"Given these directions, it is the *jury* which decides whether the evidence suffices to fulfil one or more of the criteria and, if so, whether the charge of gross negligence has been made out."

For convenience I have numbered the bullets points made above by Branthwaite. Against this background I am of the firm opinion that in the case of Gladys RICHARDS (deceased) sufficient evidence has been adduced to make paragraphs 7, 8, 9 10,11, & 13 operative and a formal case should be made to allow a jury to decide.

I will be using similar principles in my assessment of the further cases we discussed.

To avoid confusion can I also suggest that if we "identify patients at risk of being inappropriately treated [and categorise them, as 'high-risk']" it may be thought we are prejudging the issue. It may be helpful if the terms 'high-risk patient' and 'low-risk patient' are replaced with those that are more clearly associated with their condition on admission to the hospital. In this connection perhaps you will consider whether patients could be described as 'Type **OS**: (for **O**bviously **S**table) admitted and dying having had a previously stable condition'; 'Type **OT** (for **O**bviously **T**erminal): admitted and then dying from a natural condition present on admission'; and, 'Type **OU** (for **O**bviously Unexpected): admitted and then death occurring naturally but unexpectedly.

Type OS would include patients admitted for rehabilitation or continuing care with for example fractured femur with a future for ongoing survival.

Type OT would include patients admitted for terminal care having suffered some catastrophic life-threatening condition for example cancer, a severe stroke (as opposed to a stroke for which some continuing survival may be expected), or chronic chest disease.

Type OU would include those patients dying suddenly and unexpectedly from for example a heart attack.

It may be that patients in each of the three groups may have been managed in the terminal stage in a manner similar to Gladys RICHARDS. In these circumstance the OS group would still be the core group but comments may be required later for some of those placed initially in the other two groups as to whether their terminal management had been appropriate.

The more detailed scrutiny of the relevant cases for the criteria you have detailed follows on from our discussions in page three of your letter of 5th June 2001.

The key elements in any scrutinised case include whether the delivery of drugs by syringe driver were or were not subject to recorded regular review of the patient's response to such treatment.

I am grateful for all your comments and am giving careful reflection to this whole matter.

In answer to your final question concerning my future fees. It may also be helpful for you to know that I have already been dealing with the Force in this matter as a Preferred Client. My previous hourly rate had already been discounted. Code A

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I look forward to hearing from you and to our further discussions when we meet as arranged with Counsel tomorrow.

This letter is being faxed to allow time for your consideration prior to our meeting tomorrow and I will bring a hard copy with me for your file.

Yours sincerely

Brian Livesley