**Professor Brian Livesley MD FRCP**
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19 June, 2001

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

Detective Superintendent John James
Major Incident Complex
Fratton Police Station
Kingston Crescent, North End
Portsmouth
Hampshire PQ2 8BU

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.

To avoid confusion can I 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 in page three of your letter of 5th June 2001 follows on from our discussions.

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

Yours sincerely

Brian Livesley