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CONFIDENTIAL
Ian Piper
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24th May 2002

Dear Ian

Gosport War Memorial Hospital

Thank you for meeting with me earlier today to discuss the situation around Gosport War Memorial Hospital. I found the meeting helpful and am grateful for the open exchange of views on the way forward.

We discussed the issues that arise following the incident in 1998, and the implications for the PCT of the imminent publication of the report form the Commission for Health Improvement. It is clear that you and your colleagues have worked very hard to deal with the fallout from 1998, and to ensure that processes and standards of care for patients are now able to stand up to external scrutiny.

I outlined to you my own perceptions of the areas of concern, based upon my reading of the documentation made available to me. You added your own perceptions and we were able to bring together a list of issues where we felt that comment by CHI would result in a need for answers and explanation.

We reviewed the possible outcomes from the CHI review and analysed them against a simple risk matrix. As expected, this demonstrated that very few outcomes will result in a completely favourable situation for the Trust and that these are the least likely. We agreed that the Trust needs to prepare thoroughly in view of the potential adverse effect of most outcome scenarios.

For the record, my own observations were these:

- Following the original complaint (regarding a transfer) in 1998, why was there no formal consideration of disciplinary action against nursing or ambulance staff?
- What was the view of the Director of Nursing Services and the Medical Director about standards of nursing and medical care in 1998?
- Once the Chief Executive became aware of police involvement, why was the Trust Board not notified?

- Why did the allegation of "unlawful killing" not prompt action by the Trust, e.g. suspension of staff whilst an investigation was undertaken?
- Why was no formal internal management review (other than the limited complaint investigation) commenced at any time between 1998 and now?
- What ~~action was~~ taken by the Medical and Nursing Directors to investigate professional standards, in the light of the allegation?
- Once the issue of unusual prescribing was raised, was there any immediate internal review of prescribing records to determine irregularities or trends?
- Why did it take until mid 2001 before a formal audit of prescribing took place?
- As an employee of the Trust, was the GP clinical assistant subject to any management review or action?
- What action was taking place through 1999,2000 and 2001? Was there an agreed action plan developed and monitored to reassure the Board that changes were being made to practice?
- Are the passage of time, the existence of changed policies and the current records of individuals sufficient reasons for deciding not to pursue disciplinary action, in the face of serious concerns about past conduct, backed up by objective evidence?
- What information would have triggered a referral by the Trust, of professionals to their regulatory bodies?

We also discussed the actions that the Trust has taken since 1998. I would be grateful if you could set out what these actions have been, how their effects have been monitored, whether there is documentary evidence of such monitoring and the outcome of this. We agreed that this would be an important baseline of shared understanding, which would be helpful in preparing for media questions. Along with this there would need to be explanation of the reasons for of any trends in prescribing of opiates and sedatives, whether variations over time, or differences between wards.

We discussed the issue of out clarity about out of hours cover and clinical responsibility. We agreed that it was appropriate that the Medical Director and Clinical Governance Forum should address this issue urgently, so that there is no lack of clarity in presentation about the lines of responsibility and supervision.

Finally, you told me that there has been discussion about the most appropriate person or persons to front any media events. I agreed with you that it seemed appropriate for the current PCT team to do this, since it is they who are in a position to account for the future quality of the service. Clearly, we both appreciated that questions may be asked about individual responsibilities and accountabilities in 1998, but I agree that it is better to place emphasis on the future rather than the past. I will ensure that Gareth Cruddace is made aware of the implications of this for individuals.

I recognise that this letter will involve you and your team in further work. I do feel, however, that this would not be wasted effort if it ensures that we are all well prepared. Once the CHI report has been issued, the Health Authority will work with you in the development of an action plan, should there be recommendations that need to be addressed through management action.

Please let me know if you have any queries about the contents of this letter. I can be contacted on my mobile phone on Code A or at the Health Authority.

Yours sincerely

Code A

Dr. Simon Tanner
Director of Public Health/Medical Director

Cc Gareth Cruddace, Eileen Spiller, Mike Gill