CONFIDENTIAL

GOSPORT WAR MEMORIAL HOSPITAL

INDEPENDENT MANAGEMENT INQUIRY:

PHASE 1 REPORT

Michael Taylor
February, 2003

CONTENTS

FOREWORD

This report is the preliminary analysis of issues associated with the management of Gosport War Memorial Hospital from 1988 to 1998. It is clear that the truth first about prescribing practice at the hospital and, secondly, the effectiveness of the response to concerns by those responsible for the hospital will only emerge from further investigation.

Additional lines of inquiry based on a series of key questions are suggested in this report. A number of conclusions are provided that flow from analysis of archives, reports, informal scene-setting interviews and knowledge of acceptable NHS practice.

The main conclusion at this stage is that a case to answer does exist in respect of prescribing practice and the inadequate response by the former Unit Management Team and NHS Trust Board to the expression of concerns that were first raised in the late 1980s. No other conclusion is realistic given the many pointers towards poor practice and poor communication before 1998 that are contained within the Commission for Health Improvement (CHI) report published in 2002.

I would like to acknowledge the support received during this work from Ed Marsden and Sarah Seabrook of The Inquiry Consultancy.

Michael Taylor
February 2003

CONCLUSIONS

a) The failure to follow-up the expression of concerns made by nursing staff about prescribing practice in Redclyffe Annexe from 1988 was a negligent act by the Unit Management Team.

b) It is unrealistic to accept that senior managers of the Unit Management Team were unaware of the concerns about prescribing practice. The main managerial responsibility for inaction following formal correspondence in 1991 appears to lie with Mr Horne, Mr Hooper, Mrs Evans and Mr Millett. Managers seem to have placed too much reliance on the unwillingness of junior nurses to speak out in front of GPs at a meeting held on 17 December 1991 to justify any further action. If correct, this was both a naïve and wholly wrong conclusion by the managers named above.

c) It is highly regrettable that the Royal College of Nursing failed to follow-up the referral of its concerns to the Community Unit and the Heath Authority in 1991. This may well have contributed to the issue "remaining silent" until the police investigation of 1998 and the CHI investigation of 2001.

d) Clear evidence exists to demonstrate continuing concern and confusion about prescribing practice at the hospital during the years following the establishment of the Portsmouth Healthcare NHS Trust e.g. external clinical opinion in 1999. The Trust Board failed to respond to external clinical concerns about usage of opiates and initiate appropriate investigations.

e) The board of the Portsmouth Healthcare NHS Trust was assiduous in preparing formal policies and procedures. What remains unclear is:

- the degree of staff and consumer involvement in the construction of policies.
- the awareness and application of the policies by the majority of clinical staff.
- whether or not the policies were regularly evaluated.

f) The finding within the CHI report that the Portsmouth Healthcare NHS Trust failed to review prescribing practice following various trigger events in 1998 is strongly supported. The inevitable conclusion from this inaction is that inappropriate practice continued up to 1998. What, however, must be established is the degree to which practice at Gosport War Memorial Hospital was atypical of practice in other community hospitals. If practice was significantly different, then executive and non-executive members of the former Portsmouth Healthcare NHS Trust board should be held accountable for this failing. If it can be established that opiates were routinely prescribed in excess of conventional practice, the clinicians responsible would be culpable of professional malpractice.

CONTEXT

1. This Inquiry was established by Hampshire and Isle of Wight Strategic Health Authority, Fareham and Gosport, and East Hampshire Primary Care Trusts. This followed the production in 2002 of information by nursing staff at Gosport War Memorial Hospital about long-standing concerns about prescribing practice. This work has proceeded at the same time as other investigations initiatated by the Chief Medical Officer and Hampshire Constabulary. It is now temporarily in abeyance following a recent decision associated with the progression of investigations by the Police.

2. This is a Phase 1 report providing information and conclusions generated from initial action associated with progressing the final draft of the terms of reference (see Appendix A.) The conclusions, together with suggested further questions for consideration, have been derived from work on two fronts. First analysis of archives relating to the Portsmouth Healthcare NHS Trust and the Portsmouth and South East Hampshire Health Authority (no archival material relating to the former district health authority and the Portsmouth Community Unit has been available). Secondly, various informal scene-setting interviews with current and past holders of executive and non-executive positions within local health organisations.

3. The Community Hospitals Association has been commissioned to provide information about practice in community hospitals during the 1980s and 1990s. The outcome of this work is awaited; details of the requested work are given in Appendix B.

4. The report is structured in a way that facilitates the progression of any further specific inquiries that are deemed necessary to establish the truth about events and the associated responsibility of individuals at Gosport War Memorial Hospital ("the hospital".) To this end, key questions are presented.

5. It is imperative to recognise that opinions expressed in this preliminary report are based on work to date. Views and conclusions may well have been different if the main body of interviews had been undertaken (see Appendix C.) In carrying out this work it has been vital to assess what happened at the Gosport War Memorial Hospital against acceptable managerial and clinical practice in the 1980s and 1990s. Any further investigations should bear this point in mind.

WHO HELD RESPONSIBILITY?

6. Between 1988 and 2000 the hospital was managed as an integral part of an NHS community unit and from April 1994 was part of the Portsmouth Healthcare NHS Trust. The hospital became a constituent part of the Fareham and Gosport Primary Care Trust in 2002. Appendix D provides details of those with senior managerial responsibility during the period. Before NHS Trust status being attained in 1994, the Unit Management Team, supported by more junior managers, held operational responsibility for the hospital. After becoming part of the Portsmouth Healthcare NHS Trust, the Executive Directors of the Trust, supported by more junior staff at hospital level, assumed that responsibility.

7. From 1988 until NHS Trust status was obtained in 1994, the Unit General Manager was directly accountable to the District General Manager of the Health Authority, the late Mr Chris West, for the effective day to day running of the organisation and more strategic managerial issues. In 1988 the UGM was Mr J Henly, he was followed in late 1989 by Mr A Horne, who was succeeded by Mr M Millett in 1991. Following the establishment of the Portsmouth Healthcare NHS Trust in 1994 direct responsibility for day to day performance was vested in the Trust board headed by a chair appointed by ministers. Mr Millett was the substantive Chief Executive from the formation of the Portsmouth Healthcare NHS Trust until dissolution in 2002.

8. The areas of executive responsibility that are relevant to this investigation are as follows:

   8.1. Who was responsible at hospital level to the Unit General Manager and subsequently the NHS Trust Chief Executive for the day to day managerial responsibility of the hospital?

   8.2. Who was responsible to the Unit General Manager and subsequently the NHS Trust Chief Executive for the hospital at Unit Management Team level and subsequently Trust Executive Director level? In particular, who was responsible for the oversight of clinical practice at ward level?

   8.3. Who was responsible for the monitoring of prescribing practice within the hospital from 1988?

   8.4. Who was responsible for the development of policies relating to communications with staff and staff associations from 1988?

9. The answers to these questions should be available from the job descriptions within the personal files of existing and former members of staff. Many senior staff with direct and vicarious responsibility for the hospital provided long and loyal service to local health services. These files should help in identifying levels of individual responsibility if they have been maintained in the conventional way, i.e. a continuous record of all posts held in the local NHS over a number of years.

10. During the late 1980s NHS organisations were required to introduce the formal appraisal of individual managers against a set of annual objectives based on corporate priorities. Personal files are the most likely repository of these records and will assist in determining what was expected of key personnel holding a level of direct or indirect responsibility for the hospital.

11. To establish the level of responsibility of key individuals it is suggested a number of personal files should be examined. The personal files of the following existing and former NHS staff were requested for examination in December 2002. At the time of preparing this report they are being assembled together by the Hampshire and Isle of Wight Strategic Health Authority:

Isobel Evans	Max Millett	Bill Hooper	Eileen Thomas
Martin Severs	Ian Reid	Pam Grosvenor	Peter King
Trevor Abbotts	Liz Ross	Tony Horne	Nicky Pendleton
Barbara Robinson	Fiona Cameron	Ian Piper	Lesley Humphries
John Henly	John Kirtley	Sheila Clarke	

EVENTS 1988 - 1991 AND MANAGERIAL RELATIONSHIPS

12. A number of sources have advised that the relationship between the most senior health authority and unit staff was strained in the period leading up to the establishment of NHS Trusts in the Portsmouth and south east Hampshire area. Of equal importance is information to the effect that relationships between certain accredited staff associations and the local NHS were poor during the late 1980s and early 1990s. To assess the veracity of this criticism it would be necessary to interview available local staff representatives and full-time officials who held office at the time. A useful source would be the minutes from meetings of the staff consultative committees at hospital, unit and health authority level, if they can be located via the human resources network or from the archives of local staff associations.

13. Should further research corroborate this information it does go some way towards understanding the apparent tardy response by management to the expressions of concern about the usage of diamorphine in the Redclyffe Annexe part of the Gosport War Memorial Hospital. These concerns were apparently first aired between 1988 and 89. According to the RCN little progress was made in resolving the issue with local hospital managers in the period up to 1991. Specific requests for an investigation and the introduction of a policy were made to the Hospital Manager, Mrs I Evans.

14. During 1991 two recorded events relating to this issue are of significance. First, managerial inaction following a formal complaint by a nurse working on Redclyffe Annexe about prescribing practice. Secondly, the inaction following a meeting held on 31 October 1991 involving hospital nurses that was led by a nurse tutor, Ms G Whitney. The local management attitude following this meeting appears to have changed from inertia to one of expecting those staff raising a professional concern to prove that a problem existed. A meeting was held on 17 December 1991 involving hospital staff and GPs for the purpose of discussing concerns about the prescribing of diamorphine. In a memo confirming the meeting dated 5 December 1991, Mrs. Evans *stated "...It is not our intention to make this meeting in any way threatening to staff, our aim is purely to allay any concerns staff may have....."* This does imply that managers felt the concerns to be unfounded.

15. Before the meeting held on 17 December the RCN sent a letter dated 2 December 1991 to Mr West, District General Manager, expressing concern about a failure to follow-up at local hospital level the concerns raised by some nurses. In doing so, the RCN by-passed the Unit Management Team and its General Manager Mr Millett. The RCN has confirmed this was undertaken due to inaction at local level. On 11 January 1992 the RCN Branch Convenor, Mr Murray wrote to Staff Nurse Tubbritt stating that Mr West had passed the matter to Mr Millett. It was further stated that Mr Horne and Mr Hooper were aware of the issue and that Mr Horne would be reporting back to the RCN. No evidence has emerged to date that confirms Mr Horne, or other senior unit managers reported back to the

RCN. Of equal concern is the absence of any evidence that the RCN pursued management in obtaining redress to the concerns raised by the nurses working in Redclyffe Annexe.

16. Given the seriousness of the concerns it is difficult to accept that no action ensued. However, that must be the inevitable conclusion given the subsequent events culminating in the initial police inquiries of 1998 and the CHI investigation of 2001. Reliance could have been placed by hospital level and unit level managers on the discussion of the meeting held on 17 December 1991 led by Mrs. Evans at which it is stated that no staff member felt a need to review existing nursing practice on prescribing. If this indeed was the basis for inaction hospital and unit managers should be considered to have exercised very serious misjudgment on three counts.

    16.1. No senior manager from the unit was present at the meeting held on 17 December 1991 despite the longevity of the issue and despite the matter presumably having been referred to Mr Millett by Mr West, before 17 December after he received the letter from the RCN dated 2 December 1991.

    16.2. The poor approach to addressing the issue by Mrs Evans. In a memo to staff dated 7 November 1991 Mrs. Evans stated that together with Drs Logan and Barton she was "... *concerned about these allegations...*" over the appropriateness of prescribing diamorphine and nurses with concerns about the use of diamorphine should identify "*...the names of <u>any</u> patients that they feel Diamorphine (or any other drug) has been prescribed inappropriately...*" It is hardly surprising given the tone of this note from their manager that relatively junior nurses did not offer any specific cases for discussion at the meeting on 17 December 1991.

    16.3. On page three of the notes of the meeting held on 17 December 1991 three significant concerns are raised by nursing staff that should have acted as a trigger for the matter to be followed up by managers. For example "*The night staff present did not feel that their opinions of patients condition were considered before prescribing of Diamorphine... There appeared to be a lack of communication causing some of the problem.... Some staff feared it was becoming routine to prescribe diamorphine to patients that were dying regardless of their symptoms....*"

17. The most worrying issue is the fact that the original concerns appeared to go quietly underground from the end of 1991 until the initial police investigation in 1998. A belief that these issues were widely known about within the local and wider health economy does appear to exist, but in the absence of written proof and interviews with key individuals this must remain conjecture. No one at local level emerges with credit. This perhaps speaks volumes in confirmation of poor professional relationships and ineffective communications on three levels.

- between local hospital managers and certain nursing staff working in the Redclyffe Annexe.
- senior unit managers and health authority staff
- between management and staff associations.

18. The lack of any visible and assiduous follow-up action by individuals and organisations is of concern. In particular, the fact that certain, relatively junior nursing staff working in Redclyffe Annexe appear to have decided, or felt obliged, to live with deeply felt concerns about professional practice for a number of years. This is possibly explained by reported dysfunctional relationships between nursing staff in Redclyffe Annexe.

19. Overall, a climate of this being viewed as a problem of little managerial importance pervades the limited analysis of this issue. The conclusion to be drawn is that managers at hospital, unit and district level failed to give the concerns raised due weight. They were aided by the RCN failing to follow-up the referral to the Health Authority and crucially, but understandably, by the nurses themselves accepting inaction.

Key Questions

20. A memo dated 7 November 1991 from Mrs Evans suggests that the usage of diamorphine might be reviewed. What was the official practice existing within the hospital at that time? If yes, was it followed and reviewed on a regular basis? If no, were any policies relating to the usage of diamorphine produced before the preparation of the trust wide draft policy in 1999 relating to the subcutaneous administration of diamorphine? Did any health authority-wide policies exist in relation to the usage of powerful analgesics from the mid 1980s? If yes, what arrangements existed for monitoring the application of the policies?

21. Did any action ensue from the notes of the meeting led by Ms G Whitney (nurse Tutor) and were the concerns made known to the Director of Nurse Education?

22. What executive action did Mr Millett take in 1991 following the apparent referral to him by Mr West of the expression of concerns received from the RCN in November1991? What action did Mr Horne take after referring the matter to Mr. Hooper as reported in the RCN letter of 11 January 1992? Given the very serious and longstanding nature of the concerns did Mr. Millett or Mr. Horne raise the issue at Unit Management Team level? Did they brief the GP and consultant advisors to the Management Team? Was any report given back to Mr West about action taken?

23. Why did the RCN fail to follow-up the concerns from certain of its members as expressed from 1988 to 1991 about the high usage of diamorphine for pain relief and to aid catheterisation, and its provision to rehabilitation patients?

24. Did the nurses raising the initial concern give-up, in the light of apparent inaction by local managers and the RCN failing to secure action between 1988 and 1991?

POINTERS FROM THE CHI REPORT - JULY 2002

25. A reading of the July 2002 CHI report ("Investigation into Portsmouth Healthcare NHS Trust - Gosport War Memorial Hospital") provides a number of important pointers and areas for further investigation about practices, procedures and policies within the hospital during the 1990s. The terms of reference for the CHI report called for an investigation into systems and procedures since 1998. It is assumed that the indicators of possible problems before 1998, that are inferred throughout the CHI report were not subject to further investigation by CHI because they fell outside the terms of reference. It is surprising that CHI did not provide a supplementary report, or at least indicate those pointers that required deeper analysis.

26. The individual references from the CHI report are given below followed by the key questions each point appears to generate.

Paragraph 3.16 considerable confusion of clinical terminology in describing the level of care for the older people.

Key questions

- What were the implications for patient care resulted from this confusion in 2001?
- During the 1980s and early 1990s less differentiation existed between categories of older patients.
- Is it fair to assume the confusion in modern ward facilities in 2001 would have been worse in the facilities that existed before the redevelopment of the main hospital and Redclyffe Annexe being converted for alternative use?

Paragraph 4.3 and 4.4: excessive usage of painkillers in 1998.

Key questions

- What was the prescribing practice for diamorphine before 1998? What was the prescribing practice for diamorphine combined with haloperidol and midazolam?
- Did any member of staff raise this issue with CHI during the interviews?
- Was any hospital policy in use during the 1980s and 1990s? If yes, was it part of a HA/unit/trust wide policy?
- If no, did health authority/unit/trust wide policies exist and were these being ignored in some wards of the hospital? It is reported that sicker patients were being admitted in recent years. Would the use of opiates and tranquilisers have been expected to rise rather than fall as a consequence of this trend?

Paragraph 4.5: dramatic decline in usage of diamorphine, haloperidol and midazolam followed by increase diamorphine usage in 2000/01.

Key questions

- What was the actual quantifiable peak in the usage of these drugs recorded in 1998/99? Was the level atypical when compared with the usage of these drugs within other local community hospitals?
- Were the patients of some admitting GPs more likely to receive these drugs than other patients?
- In addition to patients in severe and terminal pain, is it true these drugs were prescribed in the 1980s and 1990s to some patients undergoing catheterisation or rehabilitation patients to ease mobilization.
- If yes, was this common practice within other local community hospitals at this time?

Paragraph 4.6: no trust wide policy for pain management was in place in 1998.

Key questions

- When were pain management policies introduced at other hospitals in the local health economy?
- What was the evolutionary timetable for national and regional guidance in this area of clinical practice?
- Why did it take the senior unit and Trust managers so many years to move this matter forward when it had been the subject of a formal staff complaint and an expression of concern by the RCN in 1991?

Paragraph 4.11: CHI was told that the previous practice of anticipatory prescribing of palliative opiates had ceased after the introduction of the pain assessment and management policy in 2001.

Key questions

- How many staff raised this issue with CHI and did they indicate how long this practice had been going before the introduction of the pain assessment and management policy in 2001?
- Was anticipatory prescribing of opiates, with wide dose ranges, conventional practice in other local hospitals?

Paragraph 4.16: limited number of nurses trained in use of syringe drivers.

Key questions

- Was it usual for so few nurses working in wards for older people to have received training in the use syringe drivers?
- Is it of concern that training and information about usage was received from a local hospice where the majority of patients would be terminally ill?

Paragraph 4.20: Pharmacists spoke of remote relationship between community hospitals and the main pharmacy resource.

Key questions

- Was this applicable to all local community hospitals?
- Was any routine analysis undertaken in the 1990s by the health authority pharmaceutical and GP advisors into prescribing levels by individual GP's or whole Practices?
- Has the Prescription Pricing Authority any record of atypical practice in the Gosport area over the last 12 years?

Page.19 Key Finding 2: CHI critical of prescribing checking mechanisms.

Key question

- Although unable to establish whether high levels of opiate prescribing contributed to the death of any patients in 1998, did the CHI believe this issue warranted further investigation in respect of previous years?

Page.19 Key finding 3: nursing staff confirmed decreased usage of diamorphine and syringe drivers since 1998.

Key question

- CHI was told about anticipatory prescribing of opiates before 1998, were opinions formed by any member of the CHI investigation team about the level and centre of this practice?

Paragraph 6.4: risk of professional isolation identified by Trust in 2001.

Key question

- Was any view formed by the CHI that professional isolation of medical staff working at the hospital was worse before 2001?

Paragraph 7.8: concerns over absence of clear pain management policies.

Key questions

- What action did the Trust Management Team undertake after receiving external clinical advice in 1999 about the prescribing of diamorphine in connection with a formal patient complaint?
- Why were dose ranges of 20mg to 200mg of diamorphine being allowed when concerns about usage were first raised in 1991?
- What responsibilities did the Trust Medical Director and Trust Director of Quality have for monitoring prescribing practice within Trust hospitals and the community?

Page. 38 Key finding 1: Trust failed to initiate review of prescribing practices following various triggers.

Key questions

- How serious did the CHI judge the absence of any review of prescribing practice to be in the light of accepted practice elsewhere and available published national guidance?
- Why were the Trust Board and Trust Management Team so slow in responding to regular internal and external prompts that all was not well in respect of the prescribing practice associated with opiates?

Paragraph 8.9: Trust established a risk management group in 1995.

Key questions

- Which executive director held responsibility for the analysis of complaints as opposed to the process of meeting target response times?
- Which Executive director held responsibility for the analysis of prescribing practice?
- Did the Chair of the Risk Management Group (for a period this position was held by Mr Piper) initiate deep-inquiries into serious individual adverse events and repeated trends or was the group a receiver of information?
- Did the Risk Management Group receive any referrals of concern about prescribing practice at the hospital?
- Did the group analyse prescribing patterns across its range of services and facilities?

Appendix A insert 69:- Draft protocol for prescription and administration of diamorphine by subcutaneous infusion. December 1999.

Key questions

- Did policies exist before 1999 in relation to the usage of diamorphine by other routes?
- If no, why not, when concerns were first raised by nursing staff at least 10 years previously?
- If yes, were the policies in use at the hospital in line with those applied at other local community hospitals?

27. These pointers and securing answers to the associated questions from key personnel, offers the optimum way of establishing the truth about practice at the hospital in the decade from 1988. Without the benefit of formal focused interviews and the limited nature of the archives made available, caution must be exercised in forming opinions and conclusions. On the basis of the evidence to date however, it does seem clear that local managers at hospital, unit and trust level failed in their duty to follow up expressions of concern about prescribing practice from a number of sources. One of the most worrying features is that these concerns emanated from both internal and external sources. Attached at

Appendix D is a list of people who would have been interviewed in order to assist in establishing the truth.

28. It would be stretching credibility too far for senior managers at unit and subsequently, trust level not to have known about these issues. The salient facts are:

- correspondence took place between hospital managers and Nursing staff working on Redclyffe Annexe in 1991
- correspondence took place between the RCN and the HA in 1991
- correspondence took place between the RCN and hospital managers in 1991
- perhaps most disturbingly, the same issues were commented on in a critical manner by an external clinical expert in 1999 to certain senior managers who held responsibility in 1991

29. The first fundamental question is what action did Mr Millett, Mr Horne, and Mr Hooper take in response to the concerns raised in 1991? If none, or they relied on the local hospital manager to resolve the issue without follow-up, they appear to have been professionally negligent.

30. If action were undertaken it would have centred on the construction of a policy for the usage of powerful painkillers in the hospital from 1992. Evidence about the availability, and diligence in the application of such a policy could be sought from clinical staff working in the hospital during the 1990s. Such evidence must then be reconciled against the following statement in paragraph 7.9 of the CHI report "*...correspondence in October 1999 indicated that a doctor working on the wards requested a trust policy on the prescribing of opiates in community hospitals.*"

31. The second fundamental question relates to the dosage range of opiates used in the hospital and in local GP practices during the 1980s and 1990s. Was a range of 20mg to 200mg conventional practice across the UK at that time? If not, then very serious further questions need to be faced by those holding clinical and managerial responsibility for patients at the hospital during the 1980s and 1990s.

32. The third fundamental question relates to the use of policies during the mid 1990s that were geared to monitoring standards of care within the NHS Trust and the effectiveness of the Risk Management Group under the initial leadership of Mr Piper. Were these policies available, but applied inconsistently? If yes, members of the former Trust Board are accountable for a failure to detect and then rectify chronic problems in prescribing practice within a hospital for which it had responsibility. This question is impossible to answer without a deeper investigation and formal interviews with executive and non-executive Directors of the former Portsmouth Healthcare NHS Trust Board. Some pointers are provided in the next section.

POLICIES AND PROCEDURES

33. It is clear from the archives made available relating to events following the establishment of the Portsmouth Healthcare Trust that the organisation was assiduous in devising a comprehensive range of NHS formal policies and procedures covering patient care. It is also apparent from these records that the Trust Board received regular reports at its public meetings about complaints and untoward incidents. What cannot be established is the rigour of follow-up analysis. For example, at its meeting in September 1994 the board received information concerning an increasing number of complaints about services for older people. Available records for subsequent meetings do not indicate this matter being addressed. To be fair, if the designated director tackled the issue then the matter would not have been subject to further scrutiny by the board. A reference however, at a future meeting to the effect that corrective action was successful would be usual practice. A further example relates to the adoption of the Risk Management Strategy, also in 1994. The board wished to receive a six monthly follow-up. It has not been possible to find in subsequent minutes this being reported.

34. The new Trust Board produced a wide range of formal policies during its inaugural year. It would be useful to establish the degree of input from accredited staff representatives and consumer representatives to the preparation of relevant policies. More importantly, it would be valuable to establish the regularity of evaluation and the degree of staff and consumer input to this process from the mid 1990s.

35. Taking as one example the staff whistleblowing this was subject to some criticism at paragraph 8.12 of the CHI report " *...Fewer staff were aware of the trust's whistleblowing policy...*"

36. At its meeting in February 1994 the Shadow Trust Board decided that a revision to the existing staff handbook would enable compliance with proposed national codes of conduct for NHS Trusts. Four years later at its meeting in September 1998 a new Whistleblowing Corporate Policy was adopted. If input from staff and consumer representatives was systematic and regular, for respectively, policies addressing human resources and quality of care this would ameliorate the criticism at paragraph 8.12 of the CHI report. A failure to regularly seek non-managerial input would suggest a culture that was centred on process. This view has recently been expressed by the RCN, but it would however require much wider corroboration.

Appendix A

Fareham and Gosport NHS Primary Care Trust | East Hampshire NHS Primary Care Trust | Hampshire and Isle of Wight NHS Strategic Health Authority

Terms of Reference – Final Draft

To **seek to** establish:

- whether or not any concerns were raised about any of the following:
  - the use of diamorphine [or any other opiate substance] ; or
  - prescribing regimes; or
  - the use of syringe drivers to administer medication;

  in relation to the treatment of patients at Gosport War Memorial Hospital ("the Hospital") at any time between 1988 and 1998;

- If so, the way in which any such concerns were raised, by whom, to whom and when;

- What action (if any) was taken (and by whom) as a result of any such concerns and when;

- The effect (if any) that any action taken had, on any of:
  - the use of diamorphine [or any other opiate substance]; or
  - prescribing regimes; or
  - the use of syringe drivers to administer medication;

  within the Hospital in that period.

- Whether any action taken **at the time** was justified, in all the relevant circumstances;

- Whether any failure or omission to act **at the time** was justified in all the relevant circumstances;

- Whether any events at the Hospital (such as but not limited to patient deaths, untoward incident reports or complaints) during the period in question should have prompted those with management and/or clinical management responsibility for the Hospital at the time to take any steps, and if so, what steps and whether such steps were in fact taken;

- Whether any individual working at the Hospital or working in a post which involved responsibility for either clinical or administrative matters at the Hospital during the period in question either :
  - acted; or
  - failed to act; or
  - omitted to act; or
  - neglected to act

  in an appropriate manner in response to any such concerns or events, given their level of knowledge, seniority, experience and responsibilities at the relevant time.

Appendix B

GOSPORT WAR MEMORIAL HOSPITAL INDEPENDENT MANAGEMENT INQUIRY

Room 037 Lower Ground Floor
40 Eastbourne Terrace
London
W2 3QB

Direct Line Code A
Email : theinquiryteam@hotmail.com

8 January 2003

Dear Barbara,

Gosport War Memorial Hospital

Further to our very useful meeting in December I have agreed with the StHA that value would be obtained from requesting a piece of work from the CHA.

Essentially, what I believe is required fits around the key discussion areas at our meeting.

OVERALL:
What characterised conventional Clinical and Managerial practice in larger Community Hospitals during the period 1988 - 2000?

SPECIFICALLY:
What was expected of the Unit / Trust Management Team in the areas of service quality and management of risk.

What was expected of those holding day to day Clinical and Managerial responsibility for individual Community Hospitals in the areas of service quality and management of risk?

What would have been expected from key advisory professional staff in these areas of responsibility i.e. GP Advisor, Consultant Advisor?

A description of the evolving importance of service quality initiatives with key dates of associated national policies and implementation requirements at local level.

A description of the requisite records for individual Nursing staff relating to post-graduate competence in Clinical practice and new procedures.

What was recognised as conventional practice at Ward level in respect of the administration of drugs with particular reference to pain relief?

What degree of discretion would one expect Medical staff to have given ward Nursing staff in relation to the range and dosage of the more powerful painkillers?

A description of the evolving guidance about standards of Clinical record keeping at ward level.

A statement of conventional working arrangements between ward based staff and GP's in relation to the management of beds, admission and discharge arrangements.

I hope this is reasonably clear. If you feel that I have omitted a key point then please go ahead and cover it. I am enclosing a copy of our Terms of Reference in case you did not take one when we met in Southampton.

I believe it is important in being fair to Gosport that your work uses acceptable and conventional practice as the benchmark rather than exemplary practice.

With Kind Regards,

Michael Taylor

Ms B Moore,
Community Hospitals Association,
Meadow Brow,
Broadway Road,
Broadway,
Ilminster,
Somerset,
TA19 9RG

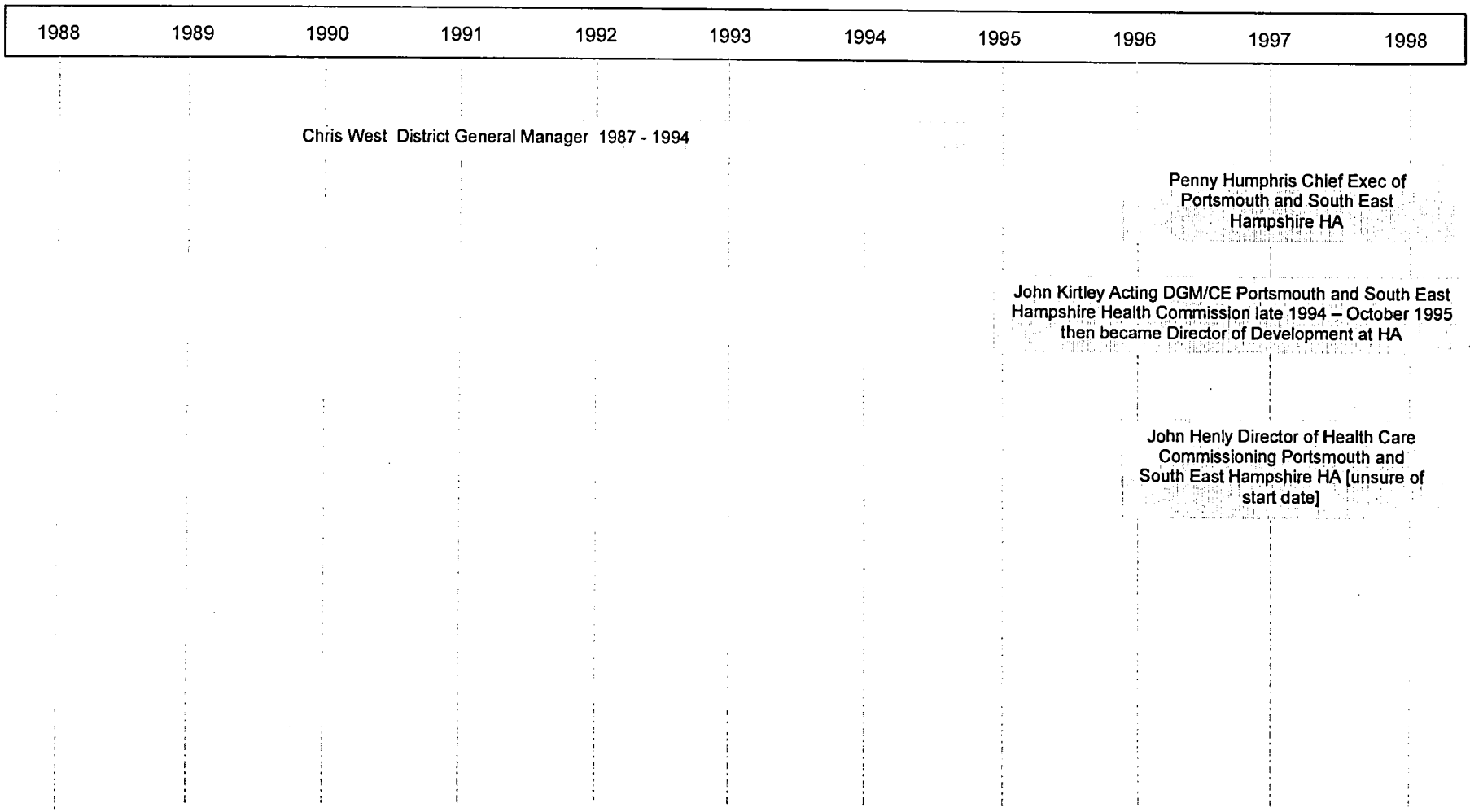
Appendix C

LIST OF POTENTIAL WITNESSES

Mr T Abbotts	Dr A Lord
Mr S Barnes	Mr M Millett
Staff Nurse Barrett	Ms Y Mills
Staff Nurse Barrington	Mr K Murray
Dr J Barton	Ms R Paxton
Ms F Cameron	Ms N Pendleton
Ms S Donne	Mr I Piper
Ms S Clarke	Dr I Reid
Ms I Evans	Ms B Robinson
Ms D Farmer	Ms E Ross
Staff Nurse Giffin	Staff Nurse Ryder
Sister Goldsmith	Prof M Severs
Ms P Grosvenor	Ms D Tarrant
Sister Hamblin	Ms E Thomas
Mr J Henly	Staff Nurse Tubbritt
Mr W Hooper	Enrolled Nurse Turnball
Mr A Horne	Ms P Turvey
Ms L Humphries	Ms G Whitney
Ms S Hutching	Enrolled Nurse Wigfall
Dr D Jarrett	Staff Nurse Williams
Mr P King	Ms E Woodland
Dr R Logan	

Appendix D

Staff Timeline
Portsmouth & SE Hampshire DHA / Portsmouth & SE Hampshire HA

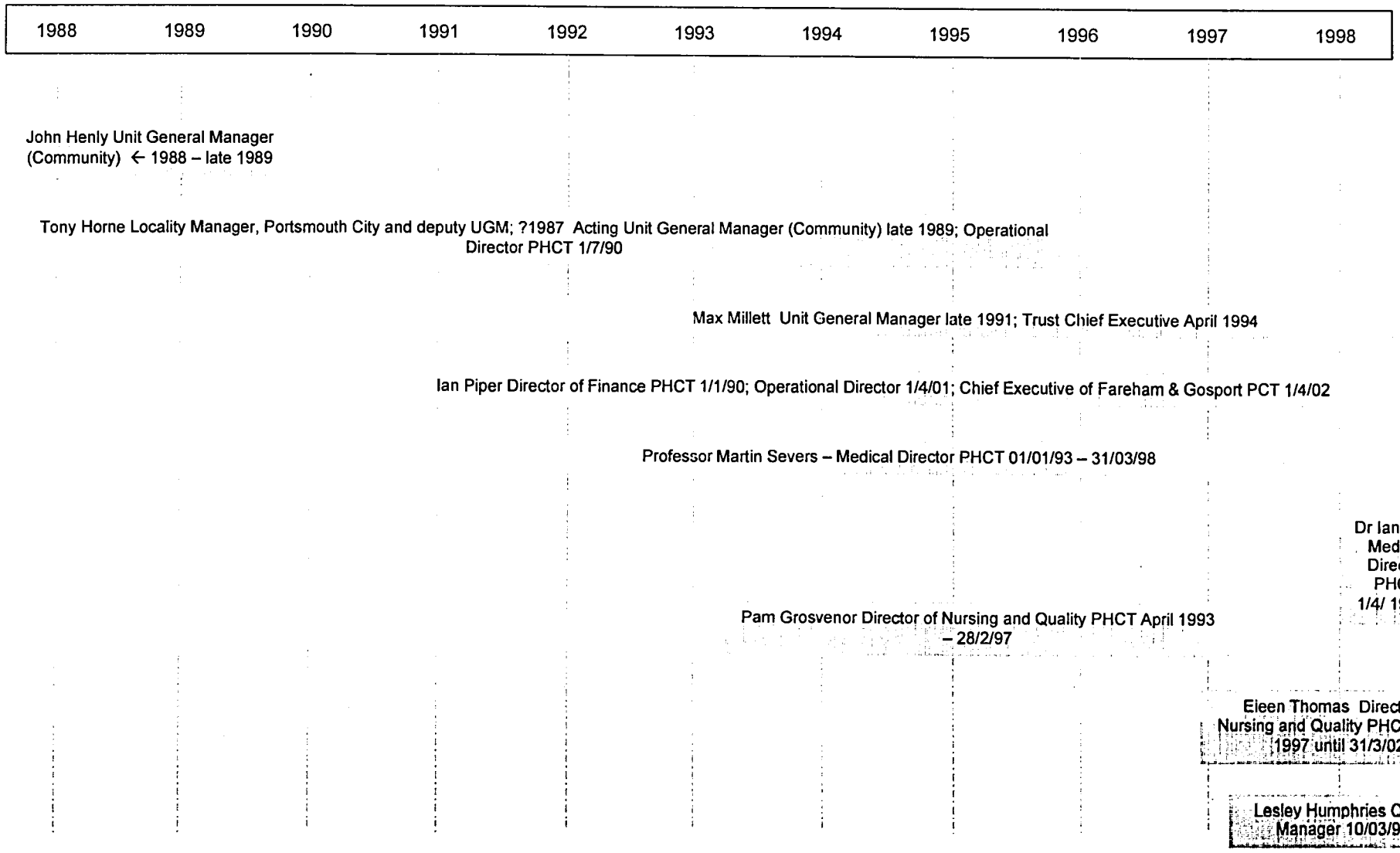


Footnote : The information used to construct these timelines was provided by local organisations. Where possible the review team have cross referenced the information to other sources. The timeline covers the period referred to in the management investigation terms of reference other than in the case of the GWMH chart which extends to 2000.

Appendix D

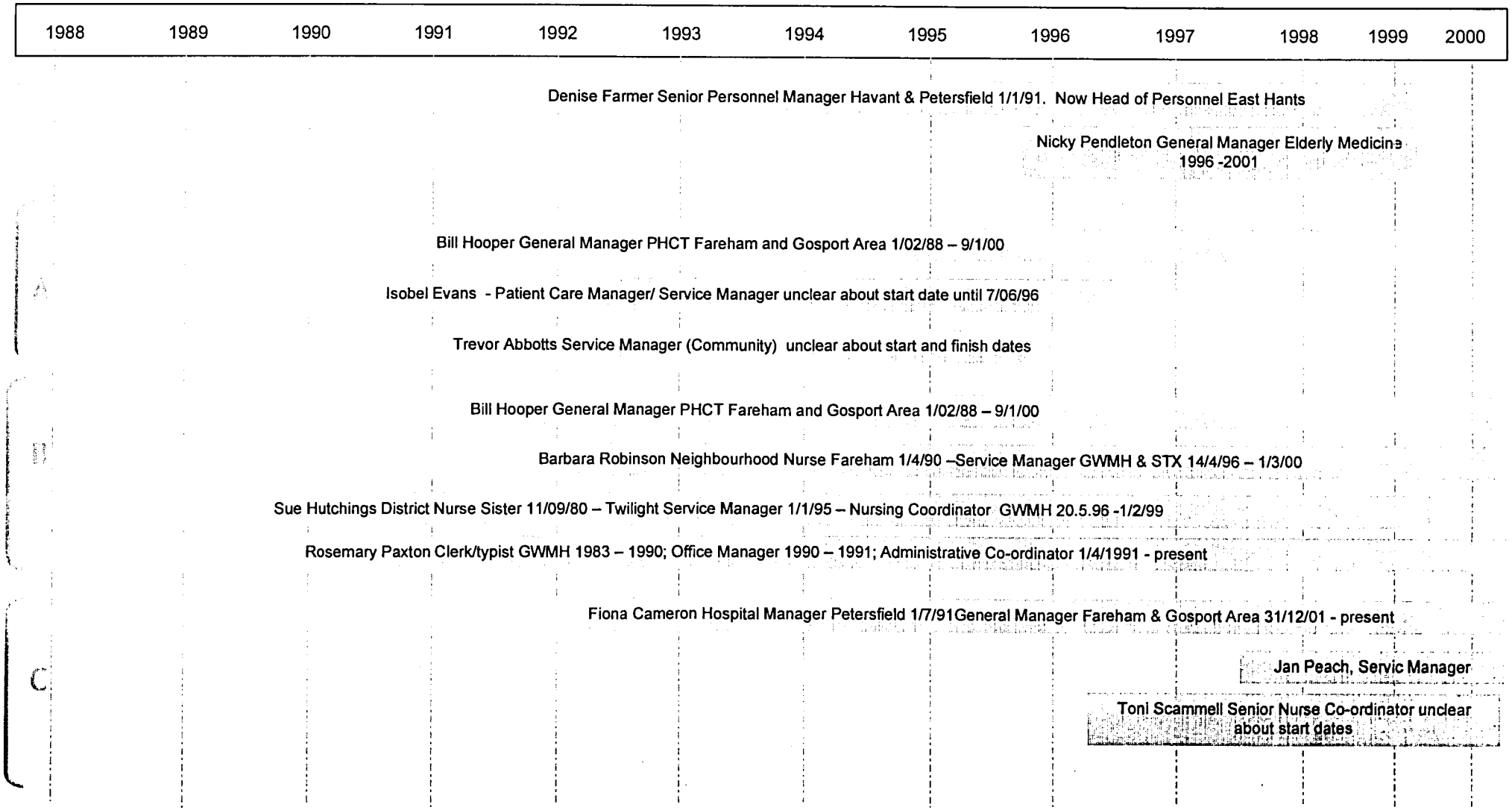
Staff Timeline

Portsmouth & SE Hampshire Community Health Care Unit / Portsmouth Healthcare NHS Trust



Appendix D

Staff Timeline
GWM Hospital



Footnote : This timeline shows the three management teams responsible for the hospital during the period referred to in the management investigation terms of reference. It also shows mangers in the trust with more general responsibilities for GWMH.