## Private & Confidential

## Gosport War Memorial Hospital Independent Management Investigation

## Meeting with Liz Fradd & Julie Miller on 13 January 2003 at 5.30pm at CHI, Bunhill Row

Matters for discussion :

- 1. Update on respective inquiries, CHI's terms of reference & timetable.
- 2. Differences between the two terms of reference i.e. management inquiry making judgements about responsibilities of individuals and whether or not they fulfilled them adequately.
- 3. Scope for complementary working.
- 4. Issues associated with the published CHI report:
  - Para 3.16 (page 10) What implications for patient care resulted from this confusion in terminology?
  - Para 4.4 (page 13) CHI confirmed use of excessive painkillers in 1998. Did they have any concerns about prescribing practice prior to 1998? Did staff raise these concerns with CHI?
  - Para 4.5 (page13) What has accounted for this decline in drug usage?
  - Para 4.6 (page 17) Should the trust have had a pain management policy in 1998? Would the expectation have been that the trust should have had such a policy i.e. was it nationally accepted good practice at the time?
  - Para 4.11 (page 17) CHI indicated that staff raised the matter of anticipatory prescribing. How long had this been going on? How many staff raised this matter with CHI?
  - Para 4.16 (page 18) Did CHI have concerns about nurses overseeing the administration of diamorphine via syringe driver without due training?
  - Para 4.20 (page 19) What is CHI's view of the nature of the relationship between PHCT and the acute trust's pharmaceutical services?
  - Page 19 (key finding 2) Did CHI feel this matter warranted further investigation?
  - Page 19 (key finding 3) Did CHI form any views about the level of diamorphine administered prior to 1998?
  - Para 6.4 (page 27) Did CHI form the view that the professional isolation of medical staff at Gosport was significantly worse prior to 2001?
  - Para 7.8 and 7.9 (page 36) and (key finding 1) How serious did CHI think this delay in devising a policy to be? (We now know that the unit had received expressions of concern about opiate prescribing in 1992 and action had been promised.)

• Para 8.9 (page 40) – Did CHI have any views about the effectiveness of the trust's risk management group? Did they find evidence of under-reporting of adverse events and incidents at GWMH? (An initial trawl of the trust's forms shows few forms about GWMH.) Did CHI feel the trust exhibited a culture of listening to staff?

Michael Taylor 7 January 2003 Ed Marsden