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DRUG ERROR – GOSPORT WAR MEMORIAL HOSPITAL
22ND OCTOBER 2003

FILE NOTE 1

1. Rosemary Salmond alerted me to the drug error at Gosport War Memorial Hospital in Dryad Ward at approximately 12.30 on the 22nd October having being alerted herself by the fact of a incident form acknowledging the critical nature of this particular incident. At that time Rosemary was able to confirm that the patient was stable that the relatives had been fully informed by Doctor Davis and that there had been an agreement not to administer a drug to reverse the effect of the diamorphine.

   The details of the incident are that the two nurses involved were asked by the relatives to provide Mr Hickman with top-up diamorphine; he was already on a syringe driver. The two nurses then went to the prescription chart, drew up a bolus dose of diamorphine and subsequently administered this to the patient. On returning to sign the patient's drug card, they recognised that in fact, they had given the patient the syringe driver dose rather than the bolus dose, which was prescribed for top-up. They immediately reported this to the doctor and the local manager and the steps taken thereafter were around supporting the family and supporting the nurses. There was no suspension of these nurses from duty and the H Grade at Gosport War Memorial Hospital took over charge of the ward at that stage.

   A separate file note is available in relation to the decision not to suspend these nurses.

   The nurses were subsequently seen by their line manager on the Thursday 23rd, by which time Mr Hickman had died. The nurses fully acknowledged their error and agreed to undertake a programme of training to ensure their competence to undertake the administration of medicine. Christine Robertson also identified a desire to work at a lower grade while some re-training took place and this was acknowledged by the manager, Tony Scammell and will be set in place. Tony Scammell subsequently met with the family who acknowledged the error, but felt that everything had been done, that could have been done, and at this stage were happy with the outcome. Mr Hickman subsequently died in the mid-afternoon of the
   22nd October 2003 some five and half hours after the administration of the bolus dose of diamorphine.

Charnauds Ltd. PMP088

At no point did I inform any of my fellow directors and had not recognised the need for this to be raised with the strategic health authority as a serious untoward incident. This has been done retrospectively and a paper sent to the strategic health authority on 3rd November 2003.

DATED: ....day of 2003

....

Fiona Cameron
Director of Nursing & Clinical Governance

Serious Untoward Incident Briefing Paper

Following the incident on 22nd October 2003 on Dryad Ward, Gosport War Memorial the decision to not suspend the 2 nurses concerned was considered and rejected as it was felt that the remedial actions proposed would ensure they were compentent. In addition these actions would also not put other patients or staff in danger.

Actions Taken

- Both nurses are now being supervised with all drugs
- Drug competency packs to be completed with assessment on completion
- Syringe driver training by company rep being arranged for all staff on ward who have currently not undertaken this.
- Not working on same shifts together
- Attempting for them to be on shifts with senior nurses, so that they are not in charge.
- Chris has been downgraded (this was a mutual agreement, union approved) to D grade.
- Decision taken not to suspend to support the non-blame culture and a belief that both nurses understand the severity of the error.
- Competency plans in place based on Overseas Nurses Adaptation programme and additional issues raised by relatives, Clinical Manager and Chris herself.
- Reinforcing the chain of senior staff in an emergency.
- Mentorship for both nurses

A critical incident review was held on Wednesday 29th October 2003. From which an action plan will be developed.

Appendix 3

SERIOUS UNTOWARD INCIDENT (SUI) REPORTING PROCEDURE

This guidance was produced using the Portsmouth HealthCare NHS Trust Serious Adverse Incident Reporting Procedure (August 2001) and the Hampshire & Isle of Wight Health Authority (March 2002) guidance entitled Untoward Incidents.

It sets out the criteria for identifying serious adverse incidents that may occur within Fareham and Gosport Primary Care Trust, the reporting procedure, and ongoing communication, reporting and support arrangements.

1. Definition

How do I report a serious untoward incident?

The Strategic Health Authority Serious Untoward Incident Hotline can be contacted 24 hours a day, 7 days a week, 365 days a year on 07977 517637

During office hours this number will put you in touch with a strategic Health Authority Untoward Incident Duty Officer. Outside office hours this number is automatically diverted to the strategic Health Authority on-call manager.

What is serious untoward incident reporting?

From 1 April 2002 all serious untoward incidents that were previously reported to NHS Executive South East Regional Office should now be reported to strategic Health Authorities. All NHS Trusts and Primary Care Trusts are required to inform their strategic Health Authority of any serious untoward incident. This enables the strategic Health Authority to offer advice and support and to ensure that information about the incident is shared appropriately with other affected organisations. It also allows the strategic Health Authority to brief ministers and other people who need to be told. This is an essential part of the accountability of the NHS as a public service.

What is a serious untoward incident

There is no set definition of a serious untoward incident but, in general terms, it is something that is likely to have a significant impact on local health services or to attract public and media interest. This may be because it involves a large number of patients, there is a risk to public health, there is a question of poor clinical or managerial judgement, a service has failed or a patient has died in unusual circumstances.
Such incidents might include:

A number of unexpected of unexplained deaths, including apparent clusters of patients receiving psychiatric care. Impending major litigation, suspicion of large-scale theft or fraud. Any incident likely to lead to serious criminal charges including violent attacks on either staff or patients, hostage situations or abductions. Repeated serious complaints about a member of staff or contractor. Suspicion of a serious error by a member of staff or contractor that could lead to public concern, or a serious breach of confidentiality. The suicide of any person on NHS premises or under the care of a specialist team in the community. Accidental or suspicious death of, or serious injury to, any individual on NHS premises. Serious damage that occurs on NHS premises, particularly resulting in injury or disruption to services. Absence without leave by patients who may present a risk to themselves or others. A serious outbreak of an infectious disease, food poisoning or transmission of an infectious disease from a staff member to a patient, or any incident involving a healthcare worker infected with HIV or Hepatitis B or C. Serious chemical or microbiological contamination or radiation incidents. Suspension of a doctor. Critical care out-of-network transfers

If you are not sure whether or not you are dealing with a serious untoward incident, it is likely that you should report the incident.

What information should I provide?

Your report is likely to include:

The date of the report - The name of the reporting organisation - The name and contact details for someone who can be contacted for further information - The apparent impact and likely future impact of the incident in terms of harm (e.g. none, moderate, catastrophic) - When the incident occurred - Where the incident occurred (specialty, location) - Who was involved - What has happened (the sequence of events) - What action has been taken as a consequence of the incident., and what else the organisations is planning to do - The likely implications of the incident for other organisations (e.g. NHS, social services) - An indication of likely media interest and the lines taken / to be taken - Any other relevant information

The role of the strategic Health Authority

The strategic Health Authority will be able to provide information and advice about the handling of major incidents. For example, they may be able to put you in touch with other organisations where similar incidents have occurred. They are also responsible for ensuring that Ministers are briefed on major incidents in the NHS, an important part of the accountability of the NHS as a public service. The strategic Health Authority additionally has some operational responsibilities in the event of certain major incidents (e.g. commissioning independent inquiries following homicide committed by people in contact with specialist mental health services). These responsibilities are set out in the strategic Health Authority's *Interim Serious Untoward Incident Guidance*.

Further Information:

A full version of this reporting guidance has been published by the Hampshire and Isle of Wight Health

Authority as *Interim Serious Untoward Incident Guidance*. Further information is also available form the local Safer NHS website at **www.hiow.nhs.uk/safernhs.html**.

2. Reporting procedure

2.1 Incidents of this nature must be reported as Critical Incidents using the Risk Event reporting procedure and notified to the appropriate Operational Director and the PCT headquarters immediately.

2.2 The Critical Incident Review procedure should be invoked locally (as described in Section 4.2) by the Service concerned as soon as the incident happens.

2.3 Once details of the incident have been received at the PCT headquarters, an Executive Director will determine whether the incident is to be designated as a Serious Untoward Incident and if so, invoke this procedure.

2.4 A nominated Executive Director will take the lead in managing the incident, with support from other Executive Directors, Service Managers and Risk/Governance Advisers as required.

2.5 From the date of notification of the incident/s, the nominated Executive Director will ensure records are kept of all subsequent action taken as part of the process of managing the incident/s.

2.6 Depending on the nature of the incident, the following is a list of action which may require consideration. The nominated Executive Director will decide which action is appropriate and oversee the process by liaising with and delegating to relevant staff as required:

WHEN THE INCIDENT HAPPENS

(a) Ensure details are communicated immediately to other Executive Directors

(b) Ensure details are communicated immediately to the Strategic Health Authority, PCT Communications team and where appropriate, Primary Care PCTs and Portsmouth Hospitals.

(c) Ensure details of the incident are communicated to the Chairman and Non-Executive Directors of the PCT Board

(d) Where appropriate, make arrangements for details of the incident/s to be passed on to other involved parties – patients, relatives, the Police, Social Services, GPs, etc.

WITHIN 48 HOURS

(e) Agree the lead responsibility for the review with other agencies that may be involved. Where it is agreed the PCT will not be the lead agency, ensure that the PCT is represented on the Review Team and that relevant PCT staff are advised to give their full co-operation to the investigation

(f) As appropriate and in liaison with the Strategic Health Authority, Communications team and other agencies as required, agree arrangements for dealing with multiple enquiries from members of the public (e.g. which may arise from serial incidents) such as establishing telephone hot lines

WITHIN A WEEK AND LONGER TERM

(g) Arrange for legal advice to be sought if applicable

(h) In liaison with (as appropriate) Operational Directors and the Strategic Health Authority, convene a Review Team and appoint a suitably senior and experienced person to lead/chair the Review process

(i) If and when appropriate (possibly at the end of the investigation), liaise with the Personnel / Medical Director to ensure professional bodies are notified (e.g. UKCC, GMC)

UNTIL INCIDENT CONCLUDED

(j) Keep all relevant parties informed of investigation developments and review timescales

(k) Ensure the outcome of the CIR/Investigation is communicated to relevant parties including the PCT Board, Strategic Health Authority

(l) Ensure that action plans arising from the Review are implemented within agreed timescales

3. Review Procedure

3.1 A Review Team will be convened and a person of suitable seniority and experience appointed to Chair the review and co-ordinate the investigation process. The Review Team will comprise of internal staff and if appropriate, external staff where their input would be useful and relevant.

3.2 Where court proceedings relating to the incident have begun, legal advice should be sought to ensure the investigation does not prejudice those proceedings.

3.3 Internal reviews should also be sensitive to the timing of any coroners inquests.

However, delay in receiving the Coroners findings is not a reason for delay in setting up and conducting a review.

3.4 The Review Team should:
(a) be established within 2 weeks of notification of the incident
(b) begin sitting within 4 weeks of notification of the incident
(c) have the active co-operation and participation of other agencies (e.g. social services, criminal justice agencies and private providers), with representation depending on the weight of the agency's involvement in the case
(d) have clear terms of reference
(e) report within ten weeks of notification of the incident

3.5 The Review Team Chair should refer to the PCT documents ***"Guidelines for carrying out a Critical Incident Review"*** and "***Guidelines for Conducting Investigations***" when convening review meetings, arranging for witness statements to be taken, producing the review report, etc.

4. Concluding the Serious Adverse Incident

4.1 A single report on the incident presented to the PCT Board, Strategic Health Authority and Regional Office will conclude the Serious Adverse Incident Reporting Procedure.

4.2 Whilst, this concludes external reporting requirements, the nominated Executive Director remains responsible for leading the incident until all actions recommended as a result of the review have been completed and the incident will continue to feature in internal reports (e.g. at Quarterly Review) until that happens.

5. Role of the Strategic Health Authority

5.1 The role of the Strategic Health Authority is to:

(a) to offer support and guidance to the PCT in carrying out their local investigation of the incident
(b) to liaise with the nominated PCT Director in agreeing the terms of the review where appropriate
(c) where appropriate, to agree arrangements for dealing with enquiries from the media, making press statements and setting up Hot Line facilities
(d) to receive and where necessary, comment upon review reports and action plans
(e) to ensure follow-up action is taken and that lessons learned are usefully shared with the whole health economy

Further information can be found in the Strategic Health Authority's document entitled '*Interim Serious Untoward Incident Guidance*'.

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Health Authority

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Fax: 023 8072 5457

Serious Untoward Incidents

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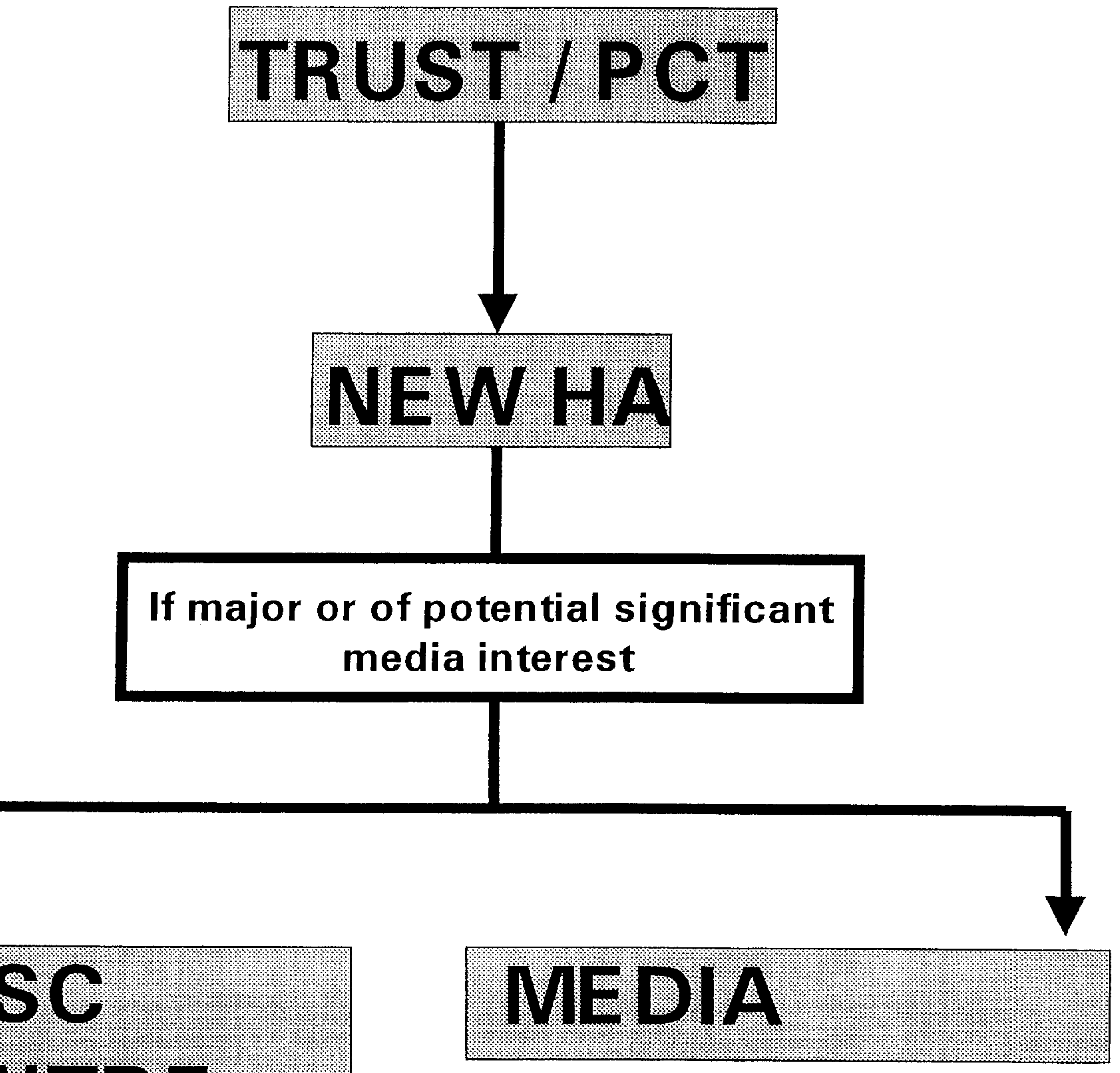
REPORTING OF SERIOUS UNTOWARD INCIDENTS FROM APRIL 1



DHSC CENTRE

1. **OFFICE HOURS**

Email to

Code A

2. **OUT OF HOURS**

Via Royal Berks Ambulance Control on 0118 936 5594 (ask for duty DHSC director)

MEDIA

1. **OFFICE HOURS**

Email MB-Health-Alert@ doh.gsi.gov.uk

If urgent: ring 020 7210 5331 or 020 7210 5010

2. **OUT OF HOURS**

Via pager - **Code A**

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Health Authority

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