To: MR W. HOOPER

1.4.96

WANSBROUGHS
WILLEY HARGRAVE
SOLICITORS

Re IVY SMITH (DECEASE)

Code A

TIM WRIGHT

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PRIVATE AND CONFIDENTIAL

Isobel Evans
Hospital Manager
Gosport War Memorial Hospital
Bury Road
GOSPORT
PO12 3PW

Date:
1 April 1996

Our Ref:
GOS212/AMB001
T Wright

Your Ref:

Dear Isobel

Ivy Smith (deceased)

Following the Inquest into the death of the above, the Coroner has now kindly sent me a copy of his Judgment. I attach the same which I presume you will require in connection with the UKCC matters.

I have sent a copy of this letter to Bill Hooper.

Yours sincerely

Code A

T WRIGHT

PM/0401TW1/2

Robert A Heslett
Kenneth C R Gibson
M Roger Parr
John C Blackwell
Robert L Beale
Paul N C Rowe
Christopher M Blythe
David J Rich
Nigel M Day
Paul W L Redfern
Valerie J West
Samuel G Hotchin
J Alison MacLennan
Nicholas C P Cockcroft
Geoffrey P Daunt
Paul C Murray
H L Michael Bothamley
Trevor K Chamberlain
John R Newman
Anthony Brown *
Stephen J Metcalfe
W D Andrew Roach
Diane Hallatt
Roohi Sheikh Collins
A Gordon R Walker
James Shepherd
John R Vasey
Julia M C Monteith
Andrew L Braithwaite
Peter Lee *
Christopher Horsefield
Neil J Forsyth
Dawn V Mullins
Timothy L Wright
Michael Doyle
Ann Goraj
Peter Rees
Tom G Corrigan
Glenn S Miller
Helen C Staines
F Michael Willis
Paul Townsend
Andrew C M Marsh
Sara E May
Paul F Parke
Mark J Speed
Julie Jackson
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Andrew K Smith
Jeremy J Roper

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Victoria Daniell
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Helen R Gent
David C R Lodge
Nicole G Myerson
Neil K Braithwaite
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Sally E Yuill
Nicole Little
Andrew Scott
Philip D Steel
Andrew D Reid
Anne Batanero
S Rachel Bolt
Duncan M Greenwood
Arline Lester
Simon L R Pickett
Duncan S Rutter
Jill C Wigginton
John Dyball
D. Alun Griffith
Michael Jennings **
Martin J Cannon
Marcus Campbell
Simon J H Barry
Philippa C Bell
Kiran K Bhogal
Phillip Brooks
John Hardman
Jane Hayden-Smith
Phillipa M C Kirkpatrick
Steven R Langton
Lisa Laurenti
Andrew M Pliener *

* Notary Public
* Barrister
** Not a Solicitor

Consultant
Anne Bevan *

Chief Executive
Christopher A Charles FCA

J. R. Kenroy

Her Majesty's Coroner
for
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CORONER'S OFFICE
16 Landport Terrace,
Portsmouth, PO1 2QT

Your Ref: GOS212/AMBOO1

28th March 1996

Messrs Wansbroughs Willey Hargrave
DX 2540
Winchester 1

Dear Sir,

Ivy Smith (deceased) : Inquest 19.3.96

Thank you for your letter of the 20th March.

As requested I enclose a copy of the Summary of Evidence.

Yours faithfully,

Code A

INQUEST INTO THE DEATH OF IVY SMITH, DECEASED
HELD ON TUESDAY 19TH MARCH 1996

Summing up by Mr J R Kenroy DL, H.M Coroner For Portsmouth & South East Hampshire

The facts in this case thanks to the commendable straightforwardness of the persons involved and the witnesses, are very clear. Code A was in error given drugs intended for another patient and some four days later she was to die.

We are told on this particular ward where the deceased was there were some 21 patients and on duty there was that night a trained Staff Nurse, Maureen Jarman and she had her two support helpers, Code A and Code A and one of the many things that had to be done that evening one gathers was to prepare the drugs and medicines for the patients and that taking place about 10.00 pm.

We have heard that Staff Nurse Maureen Jarman was preparing the doses and that the non-controlled drugs had all been administered and then she was preparing the controlled drugs which of course included the drug Oramorph and those drugs were checked and had to be checked with another person and in fact in this case it was Code A who was asked to check that drug with Staff Nurse Jarman and very unfortunately as it was to transpire there were two patients with the name Ivy in that ward. One of these was Code A for whom the drug was prescribed. In fact there were two patients on that ward that night who needed to be given that drug but neither of whom being Ivy Smith and it seems that both those patients were settling down for the night and it was wished, understandably, to give those patients their drug before they fell asleep rather than have to wake them out of their sleep. So as we have heard that the 80mg of Oramorph had been prepared. They had been measured out for Code A and then as the second patient had to have their drug and again hopefully before they had fallen asleep so we have heard that Staff Nurse Maureen Jarman asked Code A to administer her drug and she said "give it to Ivy". It is a drug administered orally but unfortunately at that particular moment "give it to Ivy" conveyed to Code A only one person. The reason she has told us she had focused on Ivy Smith, not Code A whose name appeared on the Register but on Ivy Smith was because she had been working with Ivy Smith: she had looked after her. She had vomited, she had attended to her and she had been concentrating on that end of the ward. So as she has very frankly told us, that was the reason why unfortunately she went presumably straight over to Ivy Smith, a 91 year old lady, and gave her that drug and it was not until some four and a half hours later that she realised what had happened. This was when she saw the name Code A Code A above that lady's bed. She immediately reacted, indeed all three on that ward reacted, and I think then at that point with commendable responsibility. First the Duty Doctor was contacted,
the Deputising Service, then when it was found that the antidote was not carried by that Doctor the ambulance was then called so that Mrs Smith could receive immediate attention which was available at Haslar Royal Naval Hospital and to which she was taken and furthermore, facing up to their responsibility as

to what had happened they did not shirk from immediately telephoning the family at that hour of the night to tell them what had occurred.

I think that in this very sad situation which occurred, the one thing that does shine through in this Inquest is the honesty of those involved. Few of us can say we have never made mistakes particularly when under some pressure. Fortunately for most of us those mistakes do not have serious consequences. The primary concern, and I do not think anybody would doubt it, of those involved on that ward that night would have been for the care of their patients. The last thing they would have wished was for any harm to come to anyone of them. Indeed one hopes that these very fine people dedicated to the care of the sick and the elderly will not allow themselves to be discouraged by what occurred from carrying on their very much needed and excellent work and that they, like all of us, will learn from what so unluckily and unfortunately happened.

It is of course for the family to decide and only for the family to do so, but it may be that they can draw some small comfort from the fact that sadly Mrs Smith's health was failing, we do not know when, but surely was beginning to bring her life to a close. Clearly that process was accelerated. There seems no doubt of that by the evidence given to us by Dr Carr so that life was terminated earlier than it would have been and I have no doubt that the hospital will be putting in place, indeed probably already has put in place, procedures to seek to avoid such human errors occurring such as, for one thing, ensuring that both names of a patient are used when referring to them. This was a very unfortunate happening which nobody would have wished would have occurred. So formally I find that Ivy Elizabeth Smith died at the Royal Naval Hospital Haslar on the 17th January 1996 from Bronchopneumonia following having on the night of the 13th January 1996 received when in Gosport War Memorial Hospital 80 mg of Oramorph intended for another patient named Ivy.

The medical cause of death was given to us by Doctor Carr as Bronchopneumonia and then he gives as secondary health conditions present, hypertensive renal disease, congestive cardiac failure and cerebral infarct.

The verdict in this case is one of Accidental Death.