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PRIVATE AND CONFIDENTIAL

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

Date:
26 March 1996

Our Ref:
GOS212/AMB001
T Wright

Your Ref:

Dear Isobel

Ivy Smith (deceased)

Following this Inquest I presume you saw the article in The News and the accompanying leader. I attach copies in case you missed them but these seem to be extremely helpful and supportive.

The Coroner did in fact telephone me to see whether I had seen them!

Yours sincerely

Code A

T WRIGHT

Enclosure

ST/0326TW1.ST

iquest told medication was given to wrong patient

OAP DIES AFTER DRUGS MIX-UP

too late.

Honesty replaces need for scapegoat

After a tragic error the important thing is to learn lessons from it.

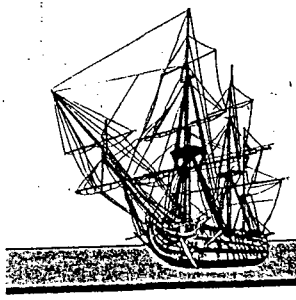
Perhaps the reaction would be different if the woman who died had been significantly younger than 91, but the administration of a drug to the wrong patient at a Gosport hospital has to go down as no more and no less than a tragic human error.

A non-medically trained support worker, told to 'give this to Ivy,' gave a morphine-based drug to the wrong Ivy – a mistake that 'almost certainly' speeded up her death from bronchial pneumonia four days later.

Yesterday the Portsmouth coroner recorded a verdict of accidental death, commenting on the honesty shown by all concerned. No-one needed telling of the seriousness of the error, yet no-one tried to cover it up.

We are confident that hospital staff, even under extreme pressure, generally act with care and propriety in patients' best interests. That is why 'serious disciplinary action' was rightly considered unnecessary in this case.

The important thing is not to look back and find scapegoats but to look forward and ensure procedural lessons are learned. And we are assured they have been.



Wednesday
March 20
1996

27p

By JAMES TAYLOR
The News

A 91-year-old Gosport woman died four days after she was given the wrong drugs in a hospital mix-up.

An inquest heard how a staff assistant asked to 'give this to Ivy' administered the morphine-based drug to the wrong patient of two with the same forename.

The mistake was not realised until four hours later, by which time Ivy Smith had lapsed into a coma at the War Memorial Hospital in Gosport.

The Portsmouth inquest was told yesterday that Mrs Smith was rushed to the nearby RN Hospital Haslar to be given an antidote.

She appeared to be recovering but died on January 17 from bronchial pneumonia.

Pathologist Dr Norman Carr said it was impossible to tell whether there was a direct link because Mrs Smith was already very ill. But he believed the drugs had almost certainly speeded up Mrs Smith's death.

Mrs Smith was admitted to the War Memorial Hospital in December last year after she suffered a stroke. Until then she had been living at Chester Court, Jamaica Place.

Staff nurse Maureen Jarman told the inquest she was preparing late night medication for ward patients on January 13.

She handed the morphine drug to staff support worker Philippa Jones, who was not medically trained, and told her: 'Give this to Ivy'.

Mrs Jones wrongly thought she meant Ivy Smith. She only realised her mistake four hours later when she was checking on patients and found Mrs Smith unconscious.

Recording a verdict of accidental death, Portsmouth coroner James Kenroy said: 'One thing that does shine through in this unfortunate incident is the honesty of those involved.'

After the inquest Tony Horne, director of operations for the Portsmouth Health Care NHS Trust, said procedures for dispensing drugs had been changed.

'Throughout the whole process the staff involved have been very open about what happened,' he said.

'They are very aware of the consequences of what happened and we have not seen it fit to carry out serious dis-

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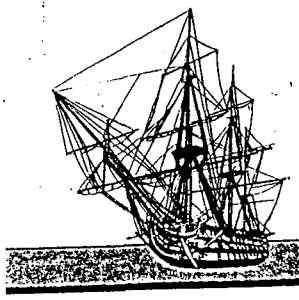

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