MM/YJM

Miss S. Norman,
Registrar and Chief Executive,
UKCC,
23 Portland Place,
LONDON.
WC1N 3AF

28 February 1996

4378

Dear Miss Norman,

Error in the Administration of a Controlled Drug by Registered Nurse M. Jarman on 13th January, 1996

I am writing to refer this case to you formally, following correspondence and telephone conversations with the relatives of the patient concerned. The relatives do not believe that the Trust has dealt with the nurse's professional conduct seriously enough, and from the Trust's perspective we are, of course, very willing for the Council to review the case and advise us on whether this is so.

I attach copies of:

1. The report of the investigation into the incident.
2. My letter of 8th February, 1996 to [redacted] (daughter of the patient).
3. Correspondence with [redacted] (daughter, granddaughter and grandson of the patient respectively) so that you are fully aware of the strength of the family's feelings about the matter.

The family see the nurse's actions as gross professional misconduct warranting formal disciplinary action under the Trust's disciplinary procedure. The Trust's view is set out in my reply to Code A the action taken being:

(a) Both the trained nurse and the health care support worker involved in the incident have been formally counselled.

(b) Local nursing policy with regard to drug administration is being reviewed in the light of this incident and will be circulated to all nursing staff.

(c) Ways of identifying hospital patients who require continuing care and who may not be able to identify themselves are being investigated. (Currently patients in long stay areas do not wear identity bracelets but it is hoped that a method of identification which preserves a person's dignity can be used.)

I am copying this letter to Code A

I should point out that the inquest has yet to be held.

If you require any further information please let me know.

Yours sincerely,

Code A

Max Millett
Chief Executive

Copy to: Code A

Silent copy to: Mr. W. Hooper
Mrs. I. Evans
Mrs. B. Robinson
Mrs. J. Parvin

MM/PAG/YJM

Code A

08 February 1996

4378

Dear Code A

I was very sorry to learn of the death of your mother, Mrs. Ivy Smith, in Haslar Hospital. I particularly regret that she was given medication intended for another patient in Gosport War Memorial Hospital on 13th January, 1996, four days before her death. This must have added to your distress and I would like to apologise to you for the mistake which occurred.

As you know, an investigation into the incident has been carried out and I thought that you might be interested in the investigation report, a copy of which I enclose. All the evidence points to simple human error but there are some lessons to be learned from this incident which we need to address. In particular we need to ensure that there is a clear policy for staff to work to and a reliable system for identifying patients.

The incident will be followed up with the staff concerned, not with a view to disciplinary action but to ensure that they have learned from what was for them a devastating experience. As you know the coroner's office has been informed of your mother's death, and a copy of the investigation report has also been sent.

I know that you have already talked to Dr. Lord, the consultant responsible for your mother's care, and to Mrs. Evans, the hospital manager, but if you would like any further discussion once you have read the report I would be very pleased to arrange a meeting. In any case, I would be interested in any comments or observations you may have.

Yours sincerely,

Code A

Max Millett
Chief Executive

Copy to: Mr. W. Hooper
Dr. A. Lord

MM/PAG/YJM

Code A

27 February 1996

4378

Dear Code A

Thank you for your letter of 16th February, 1996, and in particular for letting me have your reactions, as a member of Mrs. Smith's family, to the Investigation Report and to my letter of 8th February, 1996 to Code A As you may know, your brother, Code A telephoned to let me know of the family's concerns, and has subsequently written to me. I am very sorry that I have been the cause of such distress but it may be helpful if I set out the reasons why we acted as we did.

There is no question that the nurse responsible for the administration of a controlled drug to Mrs. Smith acted in breach of the UKCC Code of Professional Conduct, the Standards for the Administration of Medicines and the Trust's Drug Administration Policy as you say. These are extremely serious matters and I do not think there is any disagreement between us on this point. In using the phrase "simple human error" I did not mean to trivialise what had happened or to imply that it was not of major importance. The Investigation Report does not identify any reasons why the nurse acted as she did, although there may have been some contributory factors for which the Trust must bear some responsibility. The incident essentially appeared to result from the actions of one individual. That was what I intended to imply and I am sorry that the phrase I used has conveyed a different meaning to you.

As far as disciplinary action is concerned, we try to consider each case in the light of the evidence and the individual circumstances. The nurse responsible has previously had an unblemished professional record and had given 25 years' service with no evidence of any failure to adhere to professional standards. She was highly regarded as a practitioner and questioning of people who had worked with her over a period of time indicated that she had previously adhered to the required standards in administering drugs. We were not dealing with someone who was known to be either careless or uncaring. As soon as she realised what had happened she took the appropriate action in ensuring that Mrs. Smith received the treatment she needed. She reported the incident and took full responsibility for what happened. I also have to say that she was, and remains, full of remorse for her actions which she bitterly regrets.

In reaching a decision about what action should be taken we took these factors into account but there were also other considerations. As a Trust we are trying to promote an open culture in which, among other things, people are not afraid to admit to errors. One result of this is that we have seen an increase in reported drug errors which is important if we are to understand the reasons why errors occur and what the contributory factors are so that we can take preventive action. In situations where there has been evidence of repeated carelessness or dishonesty we do not hesitate to take strong disciplinary action. In this particular instance there were undoubtedly grounds for dismissal but we did not consider that that would be appropriate in these circumstances.

I understand why you may feel that we have been lenient but this is not from any lack of concern about what happened to your grandmother or because we did not consider the matter to be extremely serious. The fact that we did not dismiss the nurse concerned does not mean that we condone what she did or that we do not sympathise with members of the family in their desire to see that such a thing is not allowed to happen again.

I understand from your brother's latest letter that he intends to seek a second opinion from the UKCC on the professional conduct of the nurse in this case and the adequacy (or otherwise) of the Trust's response. We are very willing for such a scrutiny to take place and I have, therefore, now formally referred the case to the Council (see copy letter attached). As you will see, I have copied the correspondence from the family too so that they are fully aware of the strength of your concerns about how the Trust has dealt with the case.

/continued - page 3

I also suggested to your brother that if it would be helpful for you to meet with the nurse managers involved and/or myself and the nurse director on the Trust Board to talk through the professional issues involved directly, I would be pleased to arrange this.

Yours sincerely,

Max Millett
Chief Executive