PORTSMOUTH
HealthCare
NHS
TRUST

REPORT

The Administration of a Controlled Drug to the wrong patient - Mrs Ivy Smith.

Investigating Officer - Barbara Robinson
- Elderly Services Manager

Investigation Commissioned - 16 January 1996

Completed 30 January 1996

APPENDICES

Statements Taken

1	Code A	18 January 1996	Typed and original
2	Mrs Maureen Jarman	18 January 1996	.. ..
3	Code A	22 January 1996	.. ..

Other Documents

4 Treatment Cards a Code A (copy)
b Mrs Ivy Smith (copy)

5 Page from Controlled Drug Register (copy)

6 Untoward Incident Report (copy)

7 Patient Accident/Incident Report (copy)

8 Manager's report on Drug Error 13 January 1996

9 Letter to Code A (Daughter of Mrs Ivy Smith)

SECTION A

Details of Incident

A1 Date Time and Place of the Incident

Saturday 13 January 1996 between 10.15pm - 10.20pm, Daedalus Ward, Gosport War Memorial Hospital.

A2 Persons Present

Staff Nurse Jarman who prepared the Controlled Drug.

Support Worker Code A who gave the Controlled Drug to Mrs Ivy Smith who was the wrong patient.

Support Worker Code A present but did not witness the incident but witnessed the discovery of the mistake

A3 Nature of the Incident

That Maureen Jarman prepared the Controlled Drug ORAMORPH 80mgs and asked Code A to witness the preparation and then give the drug to Code A Code A. Code A gave the drug to Mrs Ivy Smith instead of Code A Code A

A4 Statements

The statements taken confirm that Mrs Ivy Smith received ORAMORPH 80mgs for which she was not prescribed and that Code A did not receive ORAMORPH 80mgs for which she was prescribed.

Neither Maureen Jarman nor Code A deny the incident took place.

A5 Comparison of Points of Similarity and Difference with Statement.

There is no conflicting evidence .
Full statements at Appendix 1 - 3

SECTION B

The Context

B1 On Saturday 13 January 1996 Staff Nurse Maureen Jarman, Support Worker Code A and Support Worker Code A were on Night Duty on Daedalus Ward, Gosport War Memorial Hospital.

B2 They settled the patients for the night. Staff Nurse Maureen Jarman worked with a relief Support Worker between 9.40pm and 10pm and Code A and Code A worked together on another area of the ward.

B3 At 10pm Maureen Jarman undertook the Medicine Round and gave all the Non Controlled Drugs.

B4 At 10.15pm Maureen Jarman went to the Treatment Room and asked Code A Code A to join her to witness the preparation of the Controlled Drug ORAMORPH for the two different patients.

B5 The ORAMORPH 80mgs for Code A was prepared by Maureen Jarman and witnessed by Code A.

B6 Maureen Jarman asked Code A to give the ORAMORPH to Code A while she drew up the next ORAMORPH.

B7 Code A took the container with ORAMORPH 80mgs in it and gave it to Mrs Ivy Smith who took it orally.

B8 At approximately 2.45am when Code A and Code A were doing a Ward Round Code A noticed that Code A catheter bag was not very full and suspected she had a blocked catheter. When she looked at her name on the head of the bed she realised that she was the lady who should have received the ORAMORPH 80mgs and not Mrs Ivy Smith who had received it.

B9 Code A and Code A called Maureen Jarman who was having a break and told her of the mistake. This was 4 1/2 hours after the drug had been given.

B10 Maureen Jarman examined Mrs Ivy Smith, found her to be unconscious with laboured breathing and rapid pulse and she rang the Deputising Service to see if the G.Ps carried NALOXONE , an antidote to Morphine. As they did not have the antidote she rang 999.

B11 The ambulance arrived in a short time (5-10 minutes) and Mrs Ivy Smith was taken to Haslar Hospital.

B12 Mrs Ivy Smith died in Haslar Hospital on 17 January 1996.

SECTION C

The Evidence

C1 Maureen Jarman admits to preparing the Controlled Drug ORAMORPH 80mgs for Code A which was witnessed by Code A

C2 Maureen Jarman admits to asking Code A a Support Worker, to give the drug to Code A

C3 Maureen Jarman admits to asking Code A give the drug to "Ivy" and to not using her full name.

C4 Maureen Jarman signed the Controlled Drug Register as the person who gave the ORAMORPH although Code A gave the drug and then signed the Register as a witness (Appendix 5).

C5 Code A stated that she asked Maureen Jarman if she was going to check the ORAMORPH with another Trained Nurse and Maureen said No.

C6 Maureen Jarman admits that she also asked Code A to witness the preparation of a dose of ORAMORPH for the Code A Maureen Jarman then asked Code A to administer the ORAMORPH to Code A Code A did this on her own and then signed the Controlled Drugs Register as the witness. Maureen Jarman signed the register as the person who had given the drug.

SECTION D

Hypotheses

D1 *The Ward was very busy*

D2 *Maureen Jarman was called to an Emergency situation just after preparing the dose of ORAMORPH for* Code A

D3 *There were no other Trained Staff in the hospital*

D4 *The patients who were waiting to receive the ORAMORPH were becoming distressed and Maureen Jarman wanted to ensure both patients received their medication as soon as possible.*

D5 *The patients were falling asleep and Maureen Jarman wanted to ensure both patients received their medication so they did not have to be wakened*

D6 *Maureen Jarman and/or* Code A *had worked several consecutive nights and were tired.*

D7 *Both patients' names were Ivy and* Code A *muddled them up.*

D8 *The mistake was not discovered for 4 1/2 hours because the patients were not checked.*

SECTION E

Weighing Evidence Against Hypotheses

H = Hypotheses

E = Evidence

E1

H *The ward was very busy*

E In their statements all three staff on duty said that at 10.15pm the majority of the patients had been settled for the night and there was nothing unusual happening on the ward.

E2

H *Maureen Jarman was called to an Emergency situation just after preparing the dose of ORAMORPH for* Code A

E This was not the case. The ward was calm and peaceful.

E3 H *There were no other Trained Staff in the hospital*

E There were other Trained Staff on duty on the night of the incident and so Maureen Jarman could have checked the ORAMORPH with another Trained member of staff.

E4

H *The patients who were waiting to receive the ORAMORPH were becoming distressed and Maureen Jarman wanted to ensure both patients received their medication as soon as possible*

E Maureen Jarman stated that both the patients Mrs Ivy Smith and Code A Code A were falling asleep.

E5

H *The patients were falling asleep and Maureen Jarman wanted to ensure both patients received their medication so they did not have to be wakened.*

E Maureen Jarman stated that this was so. Code A and Code A did not know as they had not been working with those patients.

E6

H *Maureen Jarman and /or* Code A *had worked several consecutive nights and were tired.*

E In their statements both Maureen and Code A stated they were not tired.

E7

H *Both patients' names were Ivy and* Code A *muddled them up*

E This was true and in her statement Code A said that because she had been working in Mrs Ivy Smith's area and she knew she had been unwell, having vomited earlier in the evening, she had her name on her mind. At the time of the incident she had not attended to Code A

E8

H *The mistake was not discovered for 41/2 hours because the patients were not checked regularly throughout the night.*

E All three staff said that because the ward is designed in cubicles as apposed to a 'Nightingale' style they keep walking round at night and look into the rooms.

E Code A who should have had the medication actually slept well and did not complain of pain. therefore there was no indication that she had not received her medication at 10.15pm.

E It was because the Support Workers were checking the patients and noticed Code A blocked catheter that Code A then realised, by reading her name on the bed head that she had given the drug to the wrong patient.

SECTION F

Suggestions to Avoid a Repetition of the Incident

F1 Two Trained Nurses check Controlled Drugs

F2 Two trained Nurses administer the Controlled Drugs

F3 Full Names are used when administering medication.

F4 Patients are identified more easily. It is the custom on wards for elderly patients that the patients do not wear 'Identity Bracelets'.

The way of identifying patients is first by their name at the head of the bed and this can rub off. Secondly, by a photograph which is affixed to the Treatment Card. The photograph is difficult to see at night and the patient may look very different from the time it was taken. Not all Treatment Cards are kept at the foot of the bed.

F5 Night Staff are Ward based and become part of a Ward Team. The staff then become familiar with the ward and the patients.

SECTION G

SUMMARY

G1 Staff Nurse Maureen Jarman admits the incident and says that she would not normally administer Controlled Drugs with a Support Worker.

G2 Evidence from the Controlled Drug Register show that it is Maureen's normal practice to check the drugs with another Trained member of staff

G3 Statements from all three staff corroborate each others evidence

G4 The difficulty of identifying patients together with staff not being part of the Ward Teams does increase the risk of making a mistake

G5 Staff Nurse Maureen Jarman was in breach of the Trust's Policy for Administering Medicines and the UKCC Standards for Administration of Medicines for allowing a Support Worker to administer a Controlled Drug on two occasions.

G6 Staff Nurse Maureen Jarman made two incorrect entries in the Controlled Drugs Register when she signed in the column "Given By" for the ORAMORPH which was actually given by Code A to Mrs Smith and to Code A Code A

G7 Staff Nurse Maureen Jarman signed that the ORAMORPH 80mgs for Code A Code A was given at 22.00 hours when it was actually given at about 04.45 hours . No alteration has been made to show the true time of administration.

G8 Staff Nurse Maureen Jarman was very honest and she did not try to conceal any facts. She admits that there were no mitigating circumstances and she has no idea why she acted in this way. She is extremely remorseful for the incident and for putting Code A in an intolerable position.

Code A Code A 30.1.96

1 2 3
APPENDIX

APPENDIX 1

STATEMENT

NAME Code A **DATE 18.01.96**

DESIGNATION Support Worker **WARD Daedalus**

HOSPITAL Gosport War Memorial

On what Ward did the incident happen?

Daedalus Ward

What was the state of the Ward at the time?

Just finished settling down after main drug round

When did the incident take place - date and time?

13.01.96 10.15pm

How many staff were on duty that night?

Myself and Code A with Maureen Jarman

How many trained staff?

Maureen Jarman

How many patients?

20

Who was present on the Ward at the time of the incident?

Myself and Code A in the Treatment Room and Code A was in the kitchen

---

Where were the other staff at the time of the incident?

Code A was in the kitchen

Who was the patient who received the wrong drug?

Mrs Ivy Smith

Who was the patient?

Code A

Why do you think Staff Nurse Jarman decided to give this drug?

Code A was prescribed the drug on a regular basis

Where are the Prescription Charts kept?

Under the Drug Trolley, I think

What drug did Staff Nurse Jarman prepare?

Concentrated ORAMORPH

How much did Staff Nurse Jarman prepare of the drug?

80mgs

Who witnessed the drawing up of medication?

I did

Who poured out the medication?

Maureen Jarman

Who gave the medication to the patient?

I gave the medication to Mrs Ivy Smith

What instructions did Staff Nurse Jarman give to you?

Handed me the medication and said give this to Ivy

Why do you think you were asked to administer the medication?

I do not know

Why didn't Staff Nurse Jarman administer the medicine herself?

I don't know

What did you say when she asked you to administer the medication?

I didn't say anything

By what route was the medication to be administered?

Oral

What events led to Staff Nurse Jarman not administering the medication herself?

I don't know. She was preparing the next patient's ORAMORPH

What did you say to her when you returned from administering the medication?

Nothing

What did she say to you when you returned from administering the medication?

Maureen checked the next ORAMORPH with me and then asked me to go and give it.

When did she sign the Prescription Chart?

Before the medicine was given

Where did she record what was given?

Controlled Drug Register

How long after the administration of the medicine did Staff Nurse Jarman check the patient who should have had the medicine?

Maureen constantly checks the patients

Was the patient not in pain?

Code A slept soundly all night and did not appear in pain

How was the mistake discovered?

Code A and I were doing a complete round of the Ward. I noticed there was not much urine in the bag. I looked up to the head of the bed and noticed her name. At this point I realised that this was the lady I should have given the drug to.

When did Staff Nurse Jarman discover the wrong patient had received the medication?

Maureen was at her break. Code A and I called her. I was in a bit of a state but when she came down to the Ward I told her what I had done. It was approximately 2.45am

---

Who discovered the mistake?

I did

What did Staff Nurse Jarman do when she realised the medication had been given to the wrong patient?

She went immediately to see Mrs Smith.

She rang the Deputising Service.

She rang for an ambulance

What was the condition of the patient when it was discovered?

I don't know

When did Staff Nurse Jarman notify the Doctor, Senior Nurse?

Immediately after examining Mrs Smith

Where did she go for help?

Deputising Service

999 call

How did you give the medication to the wrong patient?

I was focused in on Ivy Smith and had been working in her area of the Ward. There had been lots of beds to change . Lots of dirty laundry and clothes

---

How long have you worked on the Ward?

Work as a pool of staff and are not allocated to one Ward

How many consecutive nights had you worked?

This was my third night on duty but I was not tired

How do you identify patients in the Ward?

The name at the head of the bed

By Care Plan with bed

What procedure would you normally follow when administering controlled drugs?

Two Trained Nurses would check drug and both would administer

---

Where are the medicines kept?

Treatment Room

Where are the medicines prepared?

Treatment Room

Where is the Policy for Administering of Medicines kept?

Not Applicable

Why did this mistake happen?

Focused on Ivy Smith - her name was in my head. I had been working down Ivy Smith's part of the Ward. I tend to call the patients by their Christian name if that is what they want to be called

---

How could this incident have been prevented?

I should have refused to give them medicine

What happened to the patient who should have received the medication?

She slept well until she was given a bladder washout by Maureen after Mrs Smith had gone to Haslar. Even then she did not really disturb.

Comments

Before the Controlled Drugs were drawn up I asked Maureen if she was going to ask the other Staff Nurse to check the ORAMORPH'S. She replied no. Occasionally Support Workers do check Controlled Drugs but rarely give to the patient. I also gave ORAMORPH to a second patient called Code A I have never been happy checking or giving Controlled Drugs.

Signature .....

Code A
Support Worker

Signature.....

Barbara Robinson
Elderly Services Manager
Investigating Officer

APPENDIX 1

STATEMENT

NAME. Code A ..... DATE. 18.1.96

DESIGNATION. SUPPORT WORKER WARD. DAEDALUS

HOSPITAL. GOSPORT

On what Ward did the incident happen

Daedalus Ward

What was the state of the Ward at the time

Just finished settling down after main drug round.

When did the incident take place - date and time

13.1.96 10.15 pm

How many staff were on duty that night

Myself and Code A with Maureen Jarman

How many trained staff

Maureen Jarman

How many patients

20

Who was present on the Ward at the time of the incident

Myself and Maureen in the Treatment Room and Code A was in the kitchen

---

Where were the other staff at the time of the incident

Code A was in the kitchen

Who was the patient who received the wrong drug?.

Mrs Ivy Smith

Who was the patient

Code A

Why do you think Staff Nurse Jarman decided to give this drug

Code A was prescribed the drug on a regular basis.

Where are the Prescription Charts kept

Under the drug trolley I think

What drug did Staff Nurse Jarman prepare

Concentrated ORAMORPH

How much did Staff Nurse Jarman prepare of the drug

80mgs.

Who witnessed the drawing up of medication

I did

Who poured out the medication

Maureen Jarman

Who gave the medication to the patient

I gave the medication to Mrs Ivy Smith

What instructions did Staff Nurse Jarman give to you

Handed me the medication and said give this to Ivy.

Why did you think you were asked to administer the medication

I do not know

Why didn't Staff Nurse Jarman administer the medicine herrself

I don't know

What did you say when she asked you to administer the medication

I didn't say anything

By what route was the medication to be administered

Oral

What events led to Staff Nurse Jarman not administering the medication herself

I don't know. She was preparing the next patient's ORAMORPH.

What did you say to her when you returned from administering the medication

Nothing

What did she say to you when you returned from administering the medication

Maureen checked the nesct ORAMORPH with me and then asked me to go and give it.

When did she sign the Prescription Chart

Before the medicine was given

Where did she record what was given

Controlled Drug Register

How long after the administration of the medicine did Staff Nurse Jarman check the patient who should have had the medicine

Maureen constantly checks the patients

Was the patient not in pain

Code A slept soundly. all night and did not appear in pain

How was the mistake discovered

Code A and I were doing a complete round of the ward. I noticed there was not much wine in the bag. I looked up to the head of the bed and noticed her name. At this point I realised that this was the lady I should have given the drug to.

When did Staff Nurse Jarman discover the wrong patient had received the medication

Maureen was at her break. Code A and I called her. I was in a bit of a state but when she came down to the ward I told her what I had done. It was approx 2.45 AM.

Who discovered the mistake

I did

What did Staff Nurse Jarman do when she realised the medication had been given to the wrong patient

She went immediately to see Mrs Smith.
She rang the Depute-ing Service.
She rang for an ambulance.

What was the condition of the patient when it was discovered

I don't know

When did Staff Nurse Jarman notify the Doctor, Senior Nurse

Immediately after examining Mrs Smith

Where did she go for help

Deputising Service
999 call

How did you give the medication to the wrong patient

I was focused in on Ivy Smith and had been working in her area of the ward. There had been lots of beds to change lots of dirty laundry and clothes.

How long have you worked on the Ward

Work as a pool of staff and are not allocated to one ward.

How many consecutive nights had you worked

This was my third night on duty but I was not tired.

How do you identify patients in the Ward

The name at the head of the bed
By care plan with bed.

What procedure would normally befollowed when administering controlled drugs

Two trained nurses would check drug and both would administer.

Where are the medicines kept

Treatment room

Where are medicines prepared

Treatment room

Where is the Policy for Administering of Medicines kept

N/A

Why did this mistake happen

Focused on Ivy Smith - her name was in my head. I had been working down Ivy Smith's part of the work. I tend to call the patients by their Christain name if that is what they wish to be called.

How could this incident have been prevented

I should have refused to give them medicine.

What happened to the patient who should have received the medication

She slept well until she was given a bladder washout by Maureen after Mrs Smith had gone to Hoxlar. Even then she did not really disturb.

Comments

Before the Controlled drugs were drawn up I asked Maureen if she ~~was wanted me to ask~~ going to ask the other Staff Nurse to check the ORA MORPHS. She replied no. Occasionally Support Workers do check Controlled Drugs but ~~never~~ rarely give to the patient. I also gave ORAMORPH to a second patient called Bernie. I have never been happy checking or giving Controlled Drugs.

Signature **Code A**

Code A
Support Worker

Signature. **Code A** .....

Barbara Robinson
Elderly Services Manager
Investigating Officer

APPENDIX 2

STATEMENT

NAME Maureen Jarman **DATE 18.01.96**

DESIGNATION Staff Nurse **WARD Daedalus**

HOSPITAL Gosport War Memorial

On what Ward did the incident happen?

Daedalus Elderly Continuing Care

What was the state of the Ward at the time?

Completed Drug Round. Left Controlled Drugs until last.

Majority of work done and all but two patients were in bed. This was normal for this Ward.

When did the incident take place - date and time?

10.20pm 13.01.96

How many staff were on duty that night?

Myself and two Support Workers.

One more Support Worker came approximately 9.40pm until 10pm to help.

How many trained staff?

I was the only Trained member of staff.

How many patients?

20

Who was present on the Ward at the time of the incident?

Myself and the two Support Workers

Where were the other staff at the time of the incident?

The Support Worker, Code A was not with us when the medication was prepared.

Who was the patient who was presented the medication?

Code A was the patient who was prescribed the medication.

Why did you decide to give this drug?

Code A was prescribed ORAMORPH 80mg at 10pm - 20mgs/ml. This was given orally.

Where are the Prescription Charts kept?

In an individual plastic envelope in a folder on the bottom of the Medicine Trolley.

What drug did you prepare?

Went to Treatment Room took out the two Prescription Cards for two patients who were prescribed ORAMORPH .

Looked to see who was available to check the Controlled Drugs. I asked Code A Support Worker.

Prepared stronger ORAMORPH 20mg/ml.

How much did you prepare of the drug?

80mgs ORAMORPH

Who witnessed the drawing up of medication?

Code A Support Worker

Who poured out the medication?

I drew up the medication using a syringe

Who gave the medication to the patient?

Code A Support Worker

What instructions did you give her?

Would you mind giving Ivy this drug while I get the others out and then come back and check the other ORAMORPH

Why did you ask Code A to administer the medication?

To administer the medication sooner for the lady as she was falling asleep
Why didn't you administer the medicine yourself?

For the reason given that I was concerned the patient received her medication as soon as possible

---

What did she say when you asked her to administer the medication?

She didn't say anything except possibly - yes okay

By what route was the medication to be administered?

Oral

What events led to you not administering the medication yourself?

As above plus I had another dose of ORAMORPH to draw up

What did she say to you when she returned from administering the medication?

Nothing

She just came back and signed the Register

What did you say to her when she returned from administering the medication?

I did not say anything to Code A when she returned and we continued to prepare the next patient's ORAMORPH

When did you sign the Prescription Chart?

As soon as I had measured the ORAMORPH out into a container I signed the Register.

This was before the drug had been given

Where did you record what was given?

In the Controlled Drug Register and on the Treatment Card

How long after the administration of the medicine did you check the patient who should have had the medicine?

I saw Code A at approximately 10.30pm when she was asleep and on several occasions during the night. She slept until approximately 4am when I disturbed her to do a Bladder Washout for blocked catheter

---

Was the patient not in pain?

No she slept well . Catheter attended to at 4am when she was still not in pain

---

How was the mistake discovered?

I was at my break and the two Support Workers were doing a Round. At 2.40am Code A noticed the Urine Bag was still not very full. She looked up at the name on the bed and realised that this was Code A and therefore the patient who should have received the ORAMORPH

When did you discover the wrong patient had received the medication?

2.45am Approximately

Who discovered the mistake?

Code A Support Worker

What did you do when you realised the medication had been given to the wrong patient?

Code A fetched me from my break. Code A told me as Code A was so distraught . I checked Mrs Ivy Smith with the two Support Workers and I said we will quickly turn her over and see if she is conscious

---

What was the condition of the patient when it was discovered?

She was unconscious, laboured breathing, tachycardia, very pale, sweating

---

When did you notify the Doctor, Senior Nurse?

Approximately 3am phoned G.P (Deputising Service) to see if G.P carried Naloxone antidote to Morphine but they did not

---

Where did you go for help?

Dialled 999 came quickly.

Patient Mrs Ivy Smith was taken to Haslar. I then phoned relative, the daughter. I told her what had happened. She said " Well mistakes happen I'm glad you were honest".

How did Code A give the medication to the wrong patient?

I really don't know. She is young, intelligent one of the best Support Workers. Code A had been working with Ivy Smith earlier and perhaps had her fixed in her mind.

I said please give this to Ivy and she must have muddled them up.

How long have you worked on the Ward?

I work on any Ward where I am required and I work flexible hours. I have worked at the hospital for four and a half years.

How many consecutive nights had you worked?

First night after a break. I work two nights a week.

How do you identify patients in the Ward?

Name on the back of the bed.

Take notes from Hand Over with me on the Drug Trolley

Photos on Treatment Card

What procedure would you normally follow when administering controlled drugs?

1 Check with another nurse or Support Worker

2 I would then administer the drug myself

3 Call them by name usually by Surname

4 Sign Register before administering also second person signs at the same time.

Where are the medicines kept?

In Treatment Room

Where do you prepare medicines?

In Treatment Room

Where is the Policy for Administering of Medicines kept?

I don't know

Why did this mistake happen?

Wanted patient to have medication before she went to sleep.

Wanted to draw up next ORAMORPH

Both patients were called "Ivy"

Code A had been dealing with Ivy Smith prior to giving the ORAMORPH and Code A was not in her mind

---

How could this incident have been prevented?

By me giving the drug myself to Code A

By checking Code A had gone to the right patient

What happened to the patient who should have received the medication?

Code A appeared to be pain free all night. She received the dose of ORAMORPH at approximately 4.45am

---

Comments

This is not my normal practice to ask a Support Worker to administer a Controlled Drug.

Signature .....

Maureen Jarman
Staff Nurse

Signature.....

Barbara Robinson
Elderly Services Manager
Investigating Officer

APPENDIX 2

STATEMENT

NAME...Maureen JARMAN..... DATE..18:1:96

DESIGNATION...STAFF NURSE E WARD...DAEDALUS

HOSPITAL...GOSPORT WAR MEMORIAL

On what Ward did the incident happen

Daedalus Elderly Continuing Care

What was the state of the Ward at the time

Completed drug round. Left Controlled Drugs until last.
Majority of work done and all but two patients were in bed.
This was normal for this ward

When did the incident take place - date and time

10.20pm 13-1-96

How many staff were on duty that night

Myself and two Support Workers. One more Support Worker came approx 9.40pm until 10pm to help.

How many trained staff

I was the only trained member of staff.

How many patients

20

Who was present on the Ward at the time of the incident

Myself and the two Support Workers.

Where were the other staff at the time of the incident

The Support Worker, Code A was not with us when the medication was prepared.

Who was the patient [redacted] was the patient who was prescribed the medication.

Who was the patient who received the wrong medication

Mrs Ivy Smith was the wrong patient she had had a stroke. She was new to me that night. I met her for the first time when I gave her Temazepam for night sedation She had vomited since I came on duty and the Support Workers attended to her.

Why did you decide to give this drug

[redacted] was prescribed Oramorph 80mg at 10pm - 20mgs / ml. This was given orally.

Where are the Prescription Charts kept

In an individual plastic envelope in a folder on the bottom of the medicine trolley.

What drug did you prepare

Went to Treatment Room took out the two prescription cards for two patients who were prescribed ORAMORPH..
Looked to see who was available to check the Controlled Drugs. I asked [redacted] Support worker. Prepared stronger ORAMORPH 20mg/ml

---

How much did you prepare of the drug

80mgs ORAMORPH

Who witnessed the drawing up of medication

Code A Support Worker

Who poured out the medication

I drew up the medication using a syringe.

Who gave the medication to the patient

Code A Support Worker

What instructions did you give her

Would you mind giving Ivy this drug while I get the others out and then come back and check the other ORAMORPH

Why did you ask **Code A** to administer the medication

To administer the medication sooner for the lady as she was falling asleep.

Why didn't you administer the medicine yourself

For the reason given that I was concerned that the patient received her medication as soon as possible

---

What did she say when you asked her to administer the medication

She didn't say anything except possibly -yes okay-

By what route was the medication to be administered

Oral

What events led to you not administering the medication yourself

As above plus I had another dose of ORAMORPH to draw up.

What did she say to you when she returned from administering the medication

Nothing

She just came back and signed the register.

What did you say to her when she returned from administering the medication

I did not say anything to Code A when she returned and we continued to prepare the nesct patient's ORAMORPH.

When did you sign the Prescription Chart

As soon as I had measured to ORAMORPH out into a container I signed the register. This was before the drug had been given.

Where did you record what was given

In the Controlled Drug Register and on the Treatment Chart.

How long after the administration of the medicine did you check the patient who should have had the medicine

I saw Code A at approx 10.30 pm when she was asleep and on several occasions during the night. She slept until approx 4 Am when I disturbed her to do a bladder washout for blocked catheter.

Was the patient not in pain

No she slept well. Catheter attended to at 4 Am when she was still not in pain.

How was the mistake discovered

I was at my break and the two Support Workers were doing a round. At 2.40 AM Code A noticed the urine bag was still not very full. She looked up at the name on the bed and realised that this was Code A and therefore the patient who should have received the ORAMORP

When did you discover the wrong patient had received the medication

2.45 AM Approx

Who discovered the mistake

Code A, Support Worker.

What did you do when you realised the medication had been given to the wrong patient

Code A fetched me from my break Code A told me as Code A was so distraught I checked Mrs Ivy Smith with the two Support Workers and I said we will quickly turn her over and see if she was conscious.

What was the condition of the patient when it was discovered

She was unconscious, laboured breathing, tachycardia, very pale, sweating

When did you notify the Doctor, Senior Nurse

Approx 3AM phoned G.P. (Deputising Service) to see if GP carried Naloscone antidote to Morphine but they did not.

Where did you go for help

Dialled 999 came quickly.
Patient Mrs Ivy Smith was taken to Haslar. I then phoned the relative, the daughter. I told her what had happened she said "well mistakes happen I'm glad you were honest

How did Code A give the medication to the wrong patient

I really don't know. She is young, intelligent one of the best Support Workers. Code A had been working with Ivy Smith earlier and perhaps had her fixed in her mind. I said please give this to Ivy and she must have muddled them up.

How long have you worked on the Ward

I work on any ward where I am required and I work flexible hours.
I have worked at the hospital for 4 1/2 years

How many consecutive nights had you worked

First night after a break. I work two nights a week.

How do you identify patients in the Ward

Name on the back of the bed.
Take notes from hand over with me on the drug trolley.
Photos on Treatment Cards.

What procedure would you normally follow when administering controlled drugs

(1) Check with another nurse or Support Worke
(2) I would then administer the drug myself
(3) Call them by name usually by surnam
(4) Sign register before administering also second person signs at the same time.

Where are the medicines kept

In Treatment Room

Where do you prepare medicines

In Treatment Room

Where is the Policy for Administering of Medicines kept

I don't know

Why did this mistake happen

Wanted patient to have medication before she went to sleep.
Wanted to draw up next ORAMORPH.
Both patients were called 'Ivy'
Code A had been dealing with Ivy Smith prior to giving the ORAMORH and Code A was not in her mind.

How could this incident have been prevented

By me giving the drug myself to Code A
By checking Code A had gone to the right patien

What happened to the patient who should have received the medication

Code A appeared to be pain free all night. She received the dose of ORAMORPH at approx 4.45 AM.

Comments

This is not my normal practice to ask a Support Worker to administer a Controlled Drug.

Signature .. Code A

Maureen Jarman
Staff Nurse

Signature... Code A.

Barbara Robinson
Elderly Services Manager
Investigating Officer

STATEMENT

NAME... Code A **DATE..22.01.96**

DESIGNATION... Support Worker **WARD...Night Duty**

HOSPITAL..Gosport War Memorial

On what Ward did the incident happen?

Daedalus Ward

What was the state of the Ward at the time?

Usual Night

How many staff were on duty that night?

3 Myself - Support Worker
Code A - .. ..
Maureen Jarman Staff Nurse

How many trained staff?

One

Maureen Jarman

Who was present on the Ward at the time of the incident?

3 Staff

I was in the kitchen washing up cups from the night drinks

Did you see Code A give the Drug to Mrs ivy Smith?

No

I was in the kitchen which was out of view of Mrs Smith's bed

---

How was the mistake discovered?

Code A and I were doing a Ward Round. Maureen Jarman was at break. We were in with Code A and noticed that her catheter bag was empty. Code A suddenly noticed Code A s name on the bed head. I thought she was going to collapse and said I have given the ORAMORPH to the wrong Ivy.

When did you discover the wrong patient had received the medication?

As in previous question

Approx. 2.45am

Who discovered the mistake?

Code A when she looked at the name on the bed

What did you do when you realised the medication had been given to the wrong patient?

We asked Maureen Jarman to come back from her break. When she came back Code A explained she had given the ORAMORPH to the wrong patient

---

What was the condition of the patient when it was discovered?

Mrs Ivy Smith was on her side because she had vomited earlier in the evening before the ORAMORPH. she was not rousable although Maureen tried to rouse her

---

How many consecutive nights had you worked?

Third night on duty

How do you identify patients in the Ward?

With difficulty. Helped by somebody who has worked on the ward recently. Names at head of bed sometimes fall off or are rubbed off. There are photographs but they are kept on the Treatment Card which is kept on the Drugs Trolley not even on the end of the bed. It may be one or two days before a photo is taken of a new patient.

Comments

I would like to be Ward based. This I think would be safer because we would know the patients better.

During the first part of the evening Code A and I worked together and had seen to Mrs Ivy Smith but had not seen Code A at the time of the incident.

Signature .....

Code A
Support Worker

Signature.....

Barbara Robinson
Elderly Services Manager
Investigating Officer

STATEMENT

NAME..Code A..... DATE...22.1.96

DESIGNATION...SUPPORT WORKER WARD..NIGHT... DUTY

HOSPITAL..GOSPORT WAR MEMORIAL

On what Ward did the incident happen?

Daedalus Ward

What was the state of the Ward at the time?

Usual night

How many staff were on duty that night?

3 - Myself - Support Work

Code A - " "

Maureen Jarman - Staff Nurse

How many trained staff?

One

Maureen Jarman

Who was present on the Ward at the time of the incident?

3 staff
I was in the kitchen washing up cups from the night drinks.

Did you see Code A **give the Drug to Mrs ivy Smith?**

No
I was in the kitchen which was out of view of Mrs Smith's bed.

How was the mistake discovered?

Code A and I were doing a ward round. Maureen Jarman was at break. We were in with Code A and noticed that her catheter bag was empty. Code A suddenly noticed Code A name on the bed head. I thought she was going to collapse and said I have given the ORAMORPH to the wrong Ivy.

When did you discover the wrong patient had received the medication?

As in previous question

Approx 2-45 AM.

Who discovered the mistake?

Code A when she looked at the name on the bed.

What did you do when you realised the medication had been given to the wrong patient?

We asked Maureen Jarman to come back from her break. When she came back Code A explained she had given the ORAMORPH to the wrong patient.

What was the condition of the patient when it was discovered?

Mrs Ivy Smith was on her side because she had vomited earlier in the evening before the ORAMORPH. She was not rousable although Maureen tried to rouse her.

How many consecutive nights had you worked?

Third night on duty

How do you identify patients in the Ward?

With difficulty. Helped by somebody who has worked on the ward recently. Names at head of bed sometimes fall off or are rubbed off. There are photographs but they are kept on the Treatment card which is kept on the Drugs Trolley not even on the end of the bed. It may be one or two days before a photo is taken of a new patient

Comments

I would like to be Ward based. This I think would be safer because we would know the patients better.

During the first part of the evening Code A and I worked together and had seen to Mrs Ivy Smith but had not seen Code A at the time of the incident.

Signature Code A ...

Code A
Support Worker

Signature.. Code A

Barbara Robinson
Elderly Services Manager
Investigating Officer

MR 411 Sheet No.

CONSULTANT D Lord

ALLERGIES AND DRUG SENSITIVITIES

Hospital CWMH

Ward Daedalus

Unit No.

SURNAME (Block letters) **Code A**

First Names **Code A**

Date of Birth Wt.

FIX CONTINUATION MR411 (E) HERE

Date	Time	ONCE ONLY AND PRE-MEDICATION DRUGS	Route	Dose	Signature	Giv

AS REQUIRED PRESCRIPTION (including Post-Operative Drugs valid for 48 hours only)

Administration Record FIX CONTINUATION MR 411 (B) HERE

Date	Time	Dose	Given	Date	Time	Dose	Given	Date	Time	Dose	Given	Date	Time	Dose

DRUG (Approved Name) TEMAZEPAM 10mg

Route	Dose	Date	Pharm
ORAL	10mg	10-7-96	S

SIGNATURE **Code A**

SPECIAL DIRECTIONS

DRUG (Approved Name) CHLORPROMAZINE 25mg/5ml SYRUP

Route	Dose	Date	Pharm
S.C	12.5mg	10-7-96	NCN STOCK

SIGNATURE **Code A**

SPECIAL DIRECTIONS

DRUG (Approved Name) CHLORPROMAZINE 10mg/5ml SYRUP

Route	Dose	Date	Pharm
ORAL	5-10mg	12-7-96	

SIGNATURE **Code A**

SPECIAL DIRECTIONS IF PAIN.

DRUG (Approved Name)

Route	Dose	Date	Pharm

SIGNATURE

SPECIAL DIRECTIONS

APPENDIX 4

REGULAR PRESCRIPTION

Administration Record

FIX CONTINUATION MR 411 (C) **HERE**

19 96 Month → JAN 96.

Date → 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20

DRUG (Approved Name): ASPIRIN

Route: O | Dose: 75 | Date: 10/7/96 | Pharm: S

SIGNATURE: **Code A**

Time | ✓

08.00 | ✓ | CE | SR. | SAJ | SAJ | CE | SAJ | MC

DRUG (Approved Name): NIFEDIPINE

Route: O | Dose: 5mg TDS | Date: 10/7/96 | Pharm: NON STOCK

SIGNATURE: **Code A**

Time

08.00 | ✓ | X CE | SR. | SAJ | SAJ | CE | SAJ | MC

13.00 | ✓ | SR. | MC | SAJ | MC | SAJ | CE | SAJ

18.00 | ✓ | CE | SR | SR | SR | MC | SAJ | SR

DRUG (Approved Name): CO-AMILOFRUSE

CO-AMILOFRUSE = FRUSEMIDE 40mg + AMILORIDE 5mg

Route: O | Dose: 1 00 | Date: 10/7/96 | S

SIGNATURE: **Code A**

Time

08.00 | ✓ | X CE | SR | SAJ | SAJ | CE | SAJ | MC

DRUG (Approved Name): LACTULOSE

Route: O | Dose: 10ml 00 | Date: 10/7/96 | Pharm: S

SIGNATURE: **Code A**

Time

08.00 | ✓ | CE | SR | SAJ | SAJ | CE | SAJ | MC

18.00 | ✓ | CE | SR | SR | SR | SAJ | SR

DRUG (Approved Name): ORAMORPH 20mg/1ml

Route: Oral | Dose: 2ml 4hrly | Date: 10/7/96 | Pharm: S

SIGNATURE: **Code A**

Time

06.00 | SR | SR | MT | MT | MT | MT | MT

10.00 | CE | SR | SAJ | SAJ | CE | SAJ | MC

14.00 | CE | SR | SAJ | SAJ | CE | SR | SR

18.00 | CE | SR | SR | SR | CE | SAJ | SR

DRUG (Approved Name): ORAMORPH 20mg/1ml

Route: Oral | Dose: 1ml PRN | Date: 10/7/96 | Pharm:

SIGNATURE: **Code A**

Time

22.00 | ✓ | AD | PT | PT | MT | MT | MT | MT | MT | MT

APPENDIX 4 b

MR 411 | Sheet No.

Hospital	Ward
G.W.M.H	Daedalus.

CONSULTANT

ALLERGIES AND DRUG SENSITIVITIES

Unit No.

SURNAME (Block letters) SMITH

First Names Ivy

Date of Birth | Wt.

FIX CONTINUATION MR411 (E) HERE

Date	Time	ONCE ONLY AND PRE-MEDICATION DRUGS	Route	Dose	Signature	Give

AS REQUIRED PRESCRIPTION
(including Post-Operative Drugs valid for 48 hours only)

Administration Record FIX CONTINUATION MR 411 (B) HERE

Prescription	Date	Time	Dose	Given	Date	Time	Dose	Given	Date	Time	Dose	Given	Date	Time	Dose
DRUG (Approved Name): Paracetamol 500mg Route: O; Dose: [illegible]; Date: 7-7-96; Pharm: SIGNATURE: Code A SPECIAL DIRECTIONS: 6+ - 8 hourly															
DRUG (Approved Name): Diamorphine 40-80mg Route: SC; Dose: 24h; Date: 9-7-96; Pharm: SIGNATURE: Code A SPECIAL DIRECTIONS:															
DRUG (Approved Name): Hyoscine 200-400mg Route: SC; Dose: 24h; Date: 1-7-96; Pharm: SIGNATURE: Code A SPECIAL DIRECTIONS:															
DRUG (Approved Name): Midazolam 20-80mg Route: SC; Dose: 24h; Date: 1-7-96; Pharm: SIGNATURE: Code A SPECIAL DIRECTIONS:															

REGULAR PRESCRIPTION

Administration Record

FIX CONTINUATION MR 411 (C) **HERE**

19 Month → JAN.

Date → 8. 9 10 11 12 13 14 15 16 17 1

DRUG (Approved Name): Temazepam | Time | ✓ | 22:00 ✓ | Route: O | Dose: 10-20mg | Date: 8/1/96 | Pharm: S | SIGNATURE

Code A

DRUG | Time | Route | Dose | Date | Pharm | SIGNATURE

DRUG (Approved Name) | Time | Route | Dose | Date | SIGNATURE

DRUG (Approved Name) | Time | Route | Dose | Date | Pharm | SIGNATURE

DRUG (Approved Name) | Time | Route | Dose | Date | Pharm | SIGNATURE

DRUG (Approved Name) | Time | Route | Dose | Date | Pharm | SIGNATURE

MOUNT(S) OBTAINED

AMOUNTS ADMINISTERED

Date Received	Serial No. of Re-quisition	Date	Time	Patient's Name	Amount Given	Given by (Signature)	Witnessed by (Signature)	STOCK BALANCE
		9.1.96	18.15	Code A	40mg / 2mls	Code A	Code A	85.5 mls
		9/1/96	22.05	Code A	80 mgs / 4mls.			83.5 mls
		10/1/96	0600	Code A	40mg / 2mls.			79.5 mls
		10.1.96	1010		40mg / 2mls			77.5 mls
		10.1.96	1420..		40 mg / 2mls			75.5 mls
		10.1.96	17.50.		40 mg / 2mls			73.5 mls
		10/1/96	21.45		80mg / 4mls			71.5 mls
		11/1/96	0600		40mg / 2mls			67.5 mls
		11.1.96	10.25.		40mg / 2mls.			65.5 mls
11.1.96	54	Received from pharmacy						63.5 mls
		11.1.96	14.00		40mg / 2mls			183.5 mls.
		11.1.96	1830		40mg / 2mls			181.5 mls.
		11.1.96	2200		80mg / 4mls			179.5 mls
		12.1.96	0600		40mgs / 2mls			175.5 mls.
		12.1.96	1000		40mg / 2mls			173.5 mls.
		12.1.96	1400		40mg / 2mls.			171.5 mls
		12.1.96	1800		40mg / 2mls.			169.5 mls.
		12.1.96	2130		80mg / 4mls.			167.5
		13.1.96	0600		40mgs / 2mls			163.5 mls
		13.1.96	1020		40 mgs / 2mls.			161.5
		13.1.96	1400 hrs		40 mgs / 2mls.			159.5
		13.1.96	18.35 hrs.		40 mgs / 2mls.			157.5
		13/1/96	22.15		80 mg / 4ml			155.5 mls
		14.1.96	0500		40 mg / 2mls			151.5
		14.1.96	010.00hrs		40 mg / 2mls			149.5
		14.1.96	1410.		40mg / 2mls			147.5 mls

APPEN DIX 5

APPENDIX 6

PORTSMOUTH HealthCare TRUST

UNTOWARD INCIDENT REPORT

Date of Occurrence: The night of the 13th/14th January 19

Ward/Department: Daedalus Ward.

Locality: Gosport War Memorial Hospital.

Brief Description of Incident: Medication given to wrong patient Oral Oromorph 80mgms was given to Mrs. Ivy Smith a 90yr old lady in error. at 10.15PM on the 13.1.1996. The mistake was not realised until 02.45am on the 14.1.95 at which time the patient was found to have difficulty breathing.

Immediate Action: Attempts made to rouse patient. The on call Doctor was contacted and patient was Transfered to Haslar Hospital on a 999 call. Relatives were informed of events and patients transfer.

Result/Outcome: Patients adverse reaction to the medicatio caused her condition to be critical.

Patient Mrs Smith died on the 17.1.96 in Haslar Hospital

Inquiry Established? YES ☑ NO ☐

If Yes undertaken by Mrs. Barbara Robinson.

Information to Press YES ☐ NO ☑

Manager Responsible: Mrs. Isobel Evans.

TO BE RETURNED TO TRUST CENTRAL OFFICE, ST JAMES' HOSPITAL AS SOON AS POSSIBLE

APPENDIX 7

CONFIDENTIAL

PORTSMOUTH & S.E. HAMPSHIRE HEALTH AUTHORITY

PATIENT ACCIDENT/INCIDENT REPORT

NOT to be used for staff

Please use a ballpoint pen and PRINT ALL NAMES. Complete boxes as appropriate

1. LOCATION DETAILS Hospital/Health Centre GOSPORT WAR MEMORIAL.

Ward Department/Clinic/Other DAEDALUS.

2. PATIENT/CLIENT/VISITOR DETAILS (Delete as appropriate) Hospital or GP Record number

Surname SMITH. Date of Birth 26/12/04 Age(Years) 91

Forenames IVY. Male ☐ Female ☐ Consultant D LOND

Address Code A G.P. D HANTON.

Post Code

Number of previous accidents over last month ☐ Mental Health Act Status. Section ☐☐☐ (See note 2)

3. ACCIDENT/INCIDENT DETAILS Date 13/01/96 Time 2215

Location details (e.g. bathroom, main ward) MAIN WARD ROOM 9

Reported by Code A TO S/N JARMAN Number of other witnesses — (give details overleaf)

Describe what was seen and what was reported ONE MORPH BOX given to Mr IVY SMITH instead of to Code A at 21.15. Mistake not realised until 02.45 when patient found to be having difficulty breathing. 999 call at 0315 approx. Relatives informed. Transferred to Haslar.

Immediate care given

Name of doctor informed Referring service Date 14/01/96 Time 0245

4. MEDICAL/NURSING REPORT (To be completed by examining doctor/nurse. See note 4)

Injuries found or suspected No ☐ Yes ☐ Brief description (site, severity)

Action Treatments/Investigations ordered

Signature of doctor Date Time

Results of X-Rays/Investigations

5. LOCAL ACTION

Was equipment involved? NO ☐ YES ☐ → Description

→ Sent for repair? → Yes ☐ No ☐ → Withdrawn from use? NO ☐ YES ☐ Retained for inspection? YES ☐ NO ☐

Details of occurrence recorded in Nursing Record/Kardex YES ☐ NO ☐

Next of kin/relative/carer informed? YES ☑ Date 14/01/96 NO ☐ Why not

→ Who was informed DAUGHTER. How? (e.g. telephone. in writing) TELEPHONE

Manager informed? NO ☐ YES ☑ How? TELEPHONE (MRS EVANS)

Report completed by: Name M A JARMAN

Signature Code A Date 14/01/96

Job Title STAFF NURSE

Date completed form sent to Service Manager 14/01/96

6. MANAGEMENT ACTION Date report received

Name Job title

Further investigation of the occurrence required? NO ☐ YES ☐ (Give details of investigation overleaf if necessary)

Occurrence notified to the Health and Safety Executive YES ☐ NO ☐

Signature Date

APPENDIX 8

PORTSMOUTH HEALTHCARE NHS TRUST

Managers Report on Drug Error 13th January 1996

On Saturday the 13th January S.N. M. Jarman was the trained nurse on Night Duty for Daedalus Ward. On duty with her was Code A

At that time there were 20 elderly patients on the Ward. These patients are all highly dependant requiring a large nursing input.

Two patients on the Ward required controlled drugs to be administered at 10 pm - Code A and Code A

S.N. Jarman asked Code A to check these drugs with her. First they prepared Code A medication, carefully checking details on the Drug Chart and recording details in the Controlled Drug Register as they progressed. Code A was boarded for 80 mgms of Oromorph Elixer. S.N. Jarman signed the book as the administrating nurse as this was her normal practice, but then asked Code A to give Code A the Oromorph while she put away the Oromorph Elixer used for Code A and took out the mixture for Code A

At this time S.N. Jarman states she was conscious that it was getting late and the patients were already falling to sleep, her normal practice would have been to give the patient the medication herself and then return to prepare for the second patient.

Code A returned from giving the medication and they continued to check Code A medication.

Neither nurses at this time realised a mistake had been made.

Mrs. Ivy Smith had vomited several times that evening and the nurses had spent a considerable time with her due to this. Both Mrs. Ivy Smith and Code A were referred to by the nurses by their Christian name, which may have a reflection on why the error was made.

Until that evening S.N. Jarman had not had any contact with Mrs. Ivy Smith. At 10 pm when she gave Mrs. Smith her Temazepan she found her sleepy.

S.N. Jarman's normal practice is to do a round on completion of the evening duties to make a final check on patients and update Care Plans before putting all the lights out. When she did her round that evening at approximately 11 pm she made a point of checking Mrs. Smith closely as she had been vomiting and she appeared to be sleeping peacefully.

The nurses do regular checks on the patients as not all are capable of summoning help if they require it.

It is their normal practice between 2 am and 3 am to do a thorough round of the patients, checking to ensure beds do not need changing etc.

At approximately 2.45 am Code A and Code A approached Mrs. Smith to check her, on seeing her name on the bed Code A realised she had given Mrs. Ivy Smith the medication intended for Code A On switching on the light they noticed her breathing was abnormal and asked S.N. Jarman to come to see Mrs. Smith - S.N. Jarman was at her break at this time and returned to duty.

S.N. Jarman found Mrs. Smith to be very pale, her respirations were shallow, slow and laboured. Attempts to rouse Mrs. Smith were unsuccessful. The Duty Doctors number was rung and found to be the Deputising Service. The Doctor on call rang and suggested transferring Mrs. Smith on a 999 call as he did not carry any antidote.

Mrs. Smith left the Ward at approximately 3.13 am.

Mrs. Smiths daughter, Code A was contacted and informed of Mrs. Smiths transfer and that she had been given another patients medication in error.

The Staff Nurse in Charge of the Hospital S.N. Webb was informed of events.

S.N. Webb rang me at home at approximately 3.15 am and informed me of events. Considering the time of night I decided there was little point in ringing the Duty Manager until later. I rang at approximately 9 am and reported the incident to Rosemary Salmon the Manager on duty.

On my return to the Hospital at approximately 2 pm on the 15th January 1996 I was informed Code A Code A had called in that morning to see me. I later saw her at approximately 4.30 pm on Daedalus Ward where she had come to see Dr. Lord, Code A daughter was also present with her.

I confirmed events known to me at that time, including the amount and drug used. They had not been told initially that the drug was Oromorph.

I apologised for the incident and ensured them that it would be investigated thoroughly, but until I had seen Mr. Abbots, I could not confirm if an external investigator would be appointed or otherwise.

They asked if they could be sent the results of the investigation when available.

I agreed to write to them when I had seen Mr. Abbotts and confirm our decision.

I interviewed S.N. Jarman on the evening of the 15th January 1995 who gave me details of the events.

Both she and Code A have been completely devastated by the incident. To use S.N. Jarman's words "It was the worst day of my life"

S.N. Jarman acknowledges the responsibility for this incident is totally hers and is distraught, not only for the suffering of Mrs. Smith and her family, but also for the distress she has caused Code A Code A

Both the nurses in question have proved themselves to be reliable, caring and conscientious staff in the past, not giving me any reason to doubt their ability or judgement. I therefore saw no reason to suspend either staff.

I met with Mr. Abbott on the morning of the 16th January 1995 at which time we agreed that an external investigator should be appointed, Mrs. Barbara Robinson was requested to undertake this role.

It was also agreed at this meeting that S.N. Jarman should not be allowed to administer medications until the outcome of the investigation.

Mrs. Jarman was informed of this decision and agreed to it without objection.

On phoning Haslar Hospital on the 17th January 1996 we were informed that Mrs. Smith had died earlier that morning.

Code A

I. Evans
Hospital Manager

APPENDIX 9

Code A

IE/LP

17 January 1996

2228

Dear Code A

Further to our conversation of the 15th January 1996 I write to confirm the arrangements for the investigation into the incident which resulted in your Mother, Mrs. Ivy Smith, being given medication in error.

We have decided the investigation should be undertaken by an external investigator and a Manager with experience in Hospital Management is to be appointed for this role. The investigation will look at this incident and the current practice of administrating medication in this Hospital.

I will write to you again on completion of this investigation.

Meanwhile, if I can be of further assistance to you please do not hesitate to contact me again.

I was very sorry to hear of the death of your Mother this morning and forward our condolences to all the family.

I can only re-enforce our regret over this incident and assure you that we will be co-operating fully with this investigation to ensure our procedures are as safe as possible.

Yours sincerely,

Mrs. I. Evans
Hospital Manager

Copy to Trevor.