GOSPORT

REVIEW OF EVIDENCE – MIDDLETON

NMC FILES (folder 4)

Bulbeck letter of complaint 19.6.02

Complaint re: care received at GWMH 29.5.01 – 16.8.01

Suffered stroke 10.5.01 – stablized at Haslar Hospital and transferred to GWMH for rehabilitation

On one visit, found mother sitting up with meal and call bell too far away for her to reach and no cutlery

Given too much fluid despite being on a drip and having a catheter, and as a result, suffered congestive cardiac failure 4.7.01

Transferred back to Haslar for PEG to be installed

On one visit, found mother sitting in chair with sick bowl in front of her, another full bowl by her, choking, covered in sweat, unable to call for help because bell out of reach – called nurse, who called doctor and carried out x-ray showing blocked bowel

Made to wait 45 minutes for a bed pain

When Mrs Middleton told a nurse she was worried about smelling because of catheter, the nurse said "don't worry all old ladies smell"

Often found mother in bare feet/legs without blankets

Worried about drugs given as she behaved very strangely some days

Some nurses uncaring and had unprofessional attitude to patients

Some nurses failed to carry out doctors' orders

NMC letter to PCT 3.7.02

Enclosing Mrs Bulbeck's letter of complaint

Bulbeck letter 12.8.02

Complainant confirmed that she cannot name individual nurses responsible for the matters complained of

Bulbeck letter 2.9.02

Names **Code A** as responsible for appalling care in light of his role as clinical manager

PCT letter 14.10.02

Carried out investigation into Mrs Bulbeck's complaint – enclosed investigation report and letter to Mrs Bulbeck – no individual nurses named, some general deficiencies identified

POLICE FILES

Officer's report 9.1.03 (police review file 4)

Interview with Mrs Middleton – account consistent with letter of complaint to NMC

Expert conclusions

Ferner	A1 - optimal care given, death by natural causes
Lawson	A1 - doses of analgesia appropriate, died of natural causes
Naysmith	A1 – abdominal pain, aspiration pneumonia and very frail (on continuous oxygen) started on oral diamorphine PRN, then moved to continuous syringe driver when pain more severe – very reasonable treatment. Breakthrough pain, so diamorphine dose increased, also midazolam because agitated and distressed

(NB Irene Waters' notes incomplete)

Summary for report

In June 2002, Mrs Bulbeck wrote to the NMC to complain about the general level of care her mother Mrs Middleton received at the Gosport War Memorial Hospital from initial admission on 29 May 2001 to August 2001, when she was transferred to another hospital shortly before her death.

Mrs Bulbeck gave a number of examples of her concerns:

- *On one visit, she found her mother sitting up with her meal and call bell too far away for her to reach and no cutlery;*
- *Her mother had a "fluid overload" despite being on a drip and having a catheter, and as a result of this, suffered congestive cardiac failure on 4 July 2001;*
- *On another visit, she arrived to find her mother sitting in chair with a bowl in front of her and another bowl full of vomit by her. Her mother was being sick and choking. She was covered in sweat, and was unable to call for help because bell out of reach. Mrs Bulbeck called a nurse, who in turn called doctor. The doctor carried out an x-ray showing blocked bowel;*
- *Mrs Middleton had to wait 45 minutes for a bedpan;*
- *When Mrs Middleton told a nurse that she was worried about smelling because of catheter, the nurse said "don't worry all old ladies smell";*

- *Mrs Bulbeck often found her mother sitting up in a chair, with bare feet/legs and no blankets;*

- *Mrs Bulbeck was worried about the drugs her mother was given because she "behaved very strangely some days";*

- *Some of the nurses were uncaring and had an unprofessional attitude to the patients;*

- *Some of the nurses failed to carry out doctors' orders.*

Mrs Bulbeck was asked if she could provide further detail, but confirmed that she was unable to name individual nurses. She could only name Code A *the clinical manager, as having responsibility for her mother's care.*

The NMC forwarded a copy of Mrs Bulbeck's letter of complaint to the Fareham and Gosport NHS PCT. The PCT commissioned an investigation and provided the NMC with a copy of the investigation report, and its letter to Mrs Bulbeck. Some generic issues were identified, but none of these were attributed to named nurses.

As part of the second police investigation, this case was reviewed by the panel of experts. Their conclusions were as follows:

- *Irene Waters (Nurse)*

  No opinion expressed about the quality of nursing care (although her notes are incomplete).

- *Robin Ferner (pharmacologist)*

  Mrs Middleton received optimal care and died from natural causes.

- *Peter Lawson (geriatrician)*

  Mrs Middleton was given appropriate doses of analgesia and died from natural causes.

- *Anne Naysmith (palliative care expert)*

  Mrs Naysmith had abdominal pain and aspiration pneumonia, and was very frail (on continuous oxygen). She was started on oral diamorphine PRN, then moved to continuous administration via a syringe driver when the pain became more severe. This was very reasonable treatment. Mrs Middleton had breakthrough pain, so the dose of diamorphine was increased. She was also prescribed midazolam because she became agitated and distressed.

<u>Middleton – conclusions</u>

Given the expert conclusions, it is clear that there is no prospect of establishing a case based on failure to challenge inappropriate prescribed.

Mrs Bulbeck has made allegations about specific incidents, but is unable to name the nurses involved and has not provided any dates. Accordingly, there is no prospect of proving allegations relating to any particular incident against any named nurse.

The only nurse she has named is Code A *on the basis that he was responsible for poor care because he was the clinical manager. To establish this, we would have to prove poor care, in addition to proving that* Code A*, as manager, was culpable. Given the material we have received to date, and the passage of time, the PPC may take the view that there is no realistic prospect of proving this.*