**Preliminary Proceedings Committee**

**13 April 2010**

**NMC, Centrium, 61 Aldwych, London**

**Panel**

**Code A**

**Legal Assessor:** Code A

**Committee Clerk:** Code A

Code A **[Paste in legal assessor's advice to the panel]**

**Code A**

Part 1 - Registered Nurse (Adult)

The panel considered the allegations very carefully and evaluated the information before it including the letter of complaint from Mrs Jackson, the clinical and nursing notes, the drug chart and the response made by Mr Chris Green (RCN Solicitor) on behalf of the registrant. The panel note that pursuant of Rule 8 (1) a. of the 1993 Rules Council's staff, have particularised eight allegations which have been put before the registrant in this case. The panel are grateful for this preliminary work. However, the panel have noted that Mrs Jackson in her complaint letter to the Council has identified concerns about why her mother was commenced on a syringe driver when the staff were seemingly unaware of her mother's pain. The panel believe that for completeness they should consider this allegation at this time. The additional allegation is therefore:

In respect of Patient A, that

9. On the 20 August 1998 you commenced a syringe driver containing Diamorphine and Midazolam without establishing the patient's pain level

**In respect of Patient A**

1a. Decision: Declined to proceed with this allegation

Reasons:

On the 17 August 1998 it appears that Mr Beed made an entry in the nursing record to say that "daughter seem aware that mum's condition is worsening, agrees active treatment not appropriate and to use syringe driver if Mrs Wilkie is in pain". Mr Beed accepts that this is his contemporaneous record.

The panel note that the complaint in this matter was made in 2002 and that the alleged incident occurred in 1998. The passage of time will have a bearing on the Council's ability to discharge its responsibilities around the burden of proof in this case. In addition, there are no independent witnesses to the discussion between Mr Beed and Mrs Jackson.

The panel considers that it is clear from Mrs Jackson's own letter that she was made aware that Mrs Wilkie was dying and this corresponds with the clinical notes which state on the 21 August 1998 that there was "marked deterioration over the last few days". The medical practitioner who made this entry also refers to the family being "aware and happy".

Mrs Jackson in her letter of complaint indicates that she did say to Mr Beed that she did not want her mother to suffer. While this may not be entirely in keeping with the record made the panel are of the opinion that the statement that she did not want her mother to suffer could indicate that analgesia including up to the use of a syringe driver could be appropriate to achieve this aim.

In any event, legally, Mrs Jackson's consent to the use of a syringe driver would not have been required as the staff would be required to apply the best interests test once Mrs Wilkie was not in a position to consent for herself.

The panel are of the opinion that even if proven, this allegation would not amount to removal from the register. Accordingly, the panel have declined to proceed with this matter.

1b. Decision: Declined to proceed with this allegation

Reasons:

On the 21 August 1998 **Code A** made an entry in the clinical records to confirm death and also made a record in the nursing notes. In both entries Mr Beed reports that the family were present at the time of confirmation of death rather than at the specific point where Mrs Wilkie died.

Mrs Jackson suggests that this record indicates that she was present at the moment of death. However, the panel believe that the record does not suggest this.

The panel are of the opinion that even if proven, this allegation would not amount to removal from the register as it has no bearing on the clinical care of the patient. Accordingly, this allegation is closed and the panel have declined to proceed with this matter.

2. Decision: Declined to proceed with this allegation

Reasons:

On the 20 August 1998 Code A was asked to come and see Mrs Wilkie by Mrs Jackson because she was reportedly in pain. Code A arrived shortly before 13.50 hrs and then a short time later administered pain relief via a syringe driver. The panel are of the opinion that Code A practice with regard to pain assessment and record keeping may have fallen short of the required standard. However, he did take action to address Mrs Wilkie's pain within a short timescale once he had seen Mrs Wilkie and had spoken to Mrs Jackson.

The panel are of the opinion that even if proven, this allegation would not amount to removal from the register as action was taken to address the pain as soon as Mr Beed was aware of the problem. Accordingly, this allegation is closed and the panel have declined to proceed.

3. Decision: Declined to proceed with this allegation

Reasons:

Mrs Jackson alleges that on the 21 August 1998 Mr Beed failed to monitor Mrs Wilkie appropriately and keep the family informed of her condition. The panel note that the window when Mrs Jackson was not present would have been approximately 2 hours in duration. There is no evidence that Code A did not observe Mrs Wilkie during this period. It is difficult for any registrant to say for certain when a patient is about to die and therefore even with monitoring it would not be possible for Code A to inform Mrs Jackson of the impending event. Code A said to Mrs Jackson that Mrs Wilkie had only just died when she arrived at the ward. Given that all nursing staff were trained to confirm death and that this confirmation had not at this time taken place it is likely that there was a short period between death and Mrs Jackson arriving at the ward. Thus notifying her by telephone of the death may not have been possible.

The panel are of the opinion that even if proven, this allegation would not amount to removal from the register as there is no question of misconduct from this allegation. Accordingly, this allegation is closed as the panel have declined to proceed.

4. Decision: Declined to proceed with this allegation

Reasons:

Mrs Bulbeck in her complaint letter details how on one occasion during a two and half month period while she was visiting the ward she found that Mrs Middleton's meal was placed out of her reach and had no cutlery. Code A alleges that Code A as the clinical manager, failed to ensure that the meal provided was within reach. Code A Code A in his response to the allegation details that at the time he had concerns about the ward staffing level and had exercised accountability in accordance with the UKCC's Code of Professional Conduct by raising these concerns through four risk event forms drawing attention to the risks caused by poor staffing.

The panel believe that Code A acted entirely appropriately by exercising such accountability with regard to staffing levels and the impact they were having on patient care. Accordingly, the panel believe that this allegation is incapable of amounting to misconduct and they have therefore declined to proceed with the matter.

5. Decision: Declined to proceed with this allegation

Reasons:

Code A in her complaint letter details how on many occasions during a two and half month period while she was visiting the ward she found that Mrs Middleton's call bell was out of reach preventing her from calling for assistance. Mrs Bulbeck alleges that Code A as the clinical manager, failed to ensure that the call bell was within easy reach. Code A in his response to the allegation details that at the time he had concerns about the ward staffing level and had exercised accountability in accordance with the UKCC's Code of Professional Conduct by raising these through four risk event forms drawing attention to the risks caused by poor staffing levels.

The panel believe that Code A acted entirely appropriately by exercising such accountability with regard to staffing levels and the impact they were having on patient care. Accordingly, the panel believe that this allegation is incapable of amounting to misconduct and they have therefore declined to proceed with the matter.

6. Decision: Declined to proceed with this allegation

Reasons:

Code A in her complaint letter refers to how staff failed to ensure that Mrs Middleton lower body and in particular her legs were kept warm while she was sitting out of bed. Code A in his response states that this may have been the result of the patient moving and the blanket falling off. He goes on to acknowledge that it is possible that Mrs Middleton's care was poor in this respect.

The panel are of the opinion that even if proven, this allegation would not amount to removal from the register as the alleged misconduct is not sufficiently serious. The likelihood of harm from the patient's legs being exposed was negligible. Accordingly, this allegation is closed as the panel have declined to proceed.

7. Decision: Declined to proceed with this allegation

Reasons:

Code A in her complaint letter raises concerns about the standard of nursing care and the attitude of some staff towards vulnerable helpless patients. In her letter Code A does cite specific examples of what she believes is poor care. Code A is cited as the registrant in this allegation as he was the clinical manager with overall responsibility for the care delivered. Code A in his response acknowledges that there might have been occasions when Mrs Middleton's care was poor. To some extent this is born out by the Trust's report by Ms Jane Williams which looked into the complaints raised by Code A Steps were taken following this report to resolve the issues and address areas of poor practice. This allegation is set at a time when there were concerns about the staffing levels on the ward. Code A exercised accountability in accordance with the UKCC's Code of Professional Conduct by raising concerns about staff levels and completing four risk event forms.

The panel believe that Code A acted entirely appropriately by exercising such accountability with regard to staffing levels and the impact they were having on patient care. Accordingly, the panel believe that this allegation is incapable of amounting to misconduct and they have therefore declined to proceed with the matter.

8. Decision: Declined to proceed with this allegation

Reasons:

Mrs Carby in her complaint letter alleges how Mr Beed was negligent in the care provided to Mr Carby. This complaint was made on the 22 August 2002 some time after the events of the 26 and 27 April 1999. Mrs Carby has not been specific with regard to her allegations. However, as these allegations arise from a police investigations into unexplained deaths at Gosport War Memorial Hospital the panel have decided to consider Code A role in the commencement of the syringe driver. The panel note that the syringe driver was commenced by Code A and Code A and not Code A

With regard to the wider issues of negligence the Primary Care Trust commissioned a report from Professor Hooper (Nursing expert) on the 21 October 2002. Professor Hooper concludes that she is unable to find any specific reason to indicate that the nurses were negligent.

The panel believe that this allegation is not capable of amounting to misconduct. Accordingly, the panel have declined to proceed with the matter.

9. Decision: Declined to proceed with this allegation

Reasons:

On the 20 August 1998 Code A was asked to come and see Mrs Wilkie by Mrs Jackson because she was reportedly in pain. Code A arrived shortly before 13.50

hrs and then a short time later administered pain relief via a syringe driver. The panel are of the opinion that Code A practice with regard to pain assessment and record keeping may have fallen short of the required standard. However, he did acknowledge that Mrs Wilkie's was in pain by taking action to obtain analgesia.

Code A administered the prescribed drugs and commenced the syringe driver at the lowest level from within the prescribed range. In any event, it would not be possible for a panel of the Professional Conduct Committee to establish whether the level of pain was such, not to warrant the use of sub-cutaneous opiates. Therefore, it would not be possible for the Council to discharge its responsibilities around the burden of proof in respect of this allegation.

The panel are of the opinion that even if proven, this allegation would not amount to removal from the register as action was taken in relation to Mrs Wilkie's pain. Accordingly, this allegation is closed and the panel have declined to proceed.

# Code A

Part 1: Registered Nurse (Adult and Learning Disabilities)

The panel considered the allegations very carefully and evaluated the information before it including the letter of complaints from Mr Page and Code A the clinical and nursing notes, the drug chart for Mrs Page, the evidence given at the Coroner's inquest, together with the response made by Mr Chris Green (RCN Solicitor) on behalf of the registrant.

The panel note that pursuant of Rule 8 (1) a. of the 1993 Rules Council's staff, have particularised three allegations which have been put before the registrant in this case. The panel are grateful for this preliminary work. However, the panel have noted that Mr Page's letter to the Council arises from concerns about a police investigation into deaths at Gosport War Memorial Hospital. The police allegations relate to the administration of medication via syringe drivers. The panel believe that for completeness they should consider the matter of the commencement of the syringe driver in relation to the care of Mrs Page as part of allegation 1.

The panel note that the Council wrote to Mr Page to ask him to provide specific allegations against the registrant and no response was received.

1. Decision: Declined to proceed with this allegation

Reasons:

In respect of the registrant's involvement in the establishment of the syringe driver, the drug chat shows that the registrant was not involved in the administration of the syringe driver on the 3 March 1998. The panel have considered all of the available material and have concluded that there are no other allegations related to the care of Mrs Page. For this reasons the panel have declined to proceed with this matter.

2. Decision: Declined to proceed with this allegation

Reasons:

The registrant was not involved in the care of Mrs Devine until the 19 November 1999 when she was the nurse in charge of the late shift. It appears that the registrant met with Code A when she arrived on the ward. There is no evidence that the registrant did provide Mrs Devine with an explanation about Code A medication. While the allegation may be capable of proof the fact that the registrant did not provide the information has to be considered in the context that the registrant did arrange for Code A to be seen by Dr Barton. This happened a short time later. Taking this into consideration the panel have concluded that the allegation is not capable of resulting in removal from the register. Accordingly, the panel have declined to proceed with this matter.

3. Decision: Declined to proceed with this allegation

Reasons:

The registrant was not involved in the care of Mrs Devine until the 19 November 1999 when she was the nurse in charge of the late shift. It appears that the registrant met with Code A when she arrived on the ward. There is no evidence that the registrant did provide Mrs Devine with an explanation about Code A deterioration. While the allegation may be capable of proof the fact that the registrant did not provide the information has to be considered in the context that the registrant specifically arranged for Code A to be seen by Dr Barton to discuss Mrs Devine's deterioration. This happened a short time later and after the discussion between Code A and Dr Barton the registrant remained with Code A to answer any further questions. Taking this into consideration the panel have concluded that the allegation is not capable of resulting in removal from the register. Accordingly, the panel have declined to proceed with the allegation.

# Code A

Part 1: Registered Nurse (Adult)

The panel considered the allegations very carefully and evaluated the information before it including the letter of complaint from Mrs Carby, the nursing notes, the drug chart and pages from the Controlled Drugs Register, the report prepared from Professor Hooper for the Primary Care Trust together with the response made by Mr Chris Green (RCN Solicitor) on behalf of the registrant.

The panel note that pursuant of Rule 8 (1) a. of the 1993 Rules Council's staff, have particularised two allegations which have been put before the registrant in this case. The panel are grateful for this preliminary work. However, the panel have noted that Mrs Carby's letter to the Council arises from concerns about a police investigation into deaths at Gosport War Memorial Hospital. The police allegations relate to the administration of medication via syringe drivers. The panel believe that for completeness they should consider the matter of the commencement of the syringe driver in relation to the care of Mr Carby as part of allegation 2.

1. Decision: Declined to proceed with the allegation

Reasons:

On the 27 April 1999 the registrant made an entry in the nursing notes in respect of Mr Carby. This entry was not timed and the omission has been admitted by the registrant. While this is a breach of the UKCC's Standards for Records and Record Keeping the panel are of the opinion that this allegation is not capable of resulting in the removal of the registrant from the register. Accordingly, the panel have declined to proceed with this matter..

2. Decision: Declined to proceed with the allegation

Reasons:

The nursing records of the 27 April 1999, written by the registrant, indicate that Mrs Carby felt that her husband was in pain. The records show that Mr Carby was seen by Dr Barton and a decision was made to keep Mr Carby comfortable. The registrant commenced the prescribed Diamorphine and Midazolam at the lowest possible dose within the prescribed range.

With regard to the wider issues of negligence the Primary Care Trust commissioned a report from Professor Hooper (Nursing expert) on the 21 October 2002. Professor Hooper concludes that she is unable to find any specific reason to indicate that the nurses were negligent.

The panel believe that this allegation is not capable of amounting to misconduct. Accordingly, the panel have declined to proceed with the matter.

**Code A**

Part 1: Registered Nurse (Adult)

The panel considered the allegations very carefully and evaluated the information before it including the letter of complaint from Mrs Carby, the nursing notes, the drug

chart and pages from the Controlled Drugs Register, the report prepared from Professor Hooper for the Primary Care Trust together with the response made by Mr Chris Green (RCN Solicitor) on behalf of the registrant.

The panel note that pursuant of Rule 8 (1) a of the 1993 Rules Council's staff, have particularised two allegations which have been put before the registrant in this case. The panel are grateful for this preliminary work. However, the panel have noted that Mrs Carby's letter to the Council arises from concerns about a police investigation into deaths at Gosport War Memorial Hospital. The police allegations relate to the administration of medication via syringe drivers. The panel believe that for completeness they should consider the matter of the commencement of the syringe driver in relation to the care of Mr Carby as part of allegation 1.

1. Decision: Declined to proceed with this allegation

Reasons:

With respect of the syringe driver the records show that the registrant was not involved in setting up the syringe driver. On the 27 April 1999 the registrant was on a late shift and arrived for duty at 12.15pm and she entered the ward around 12.40pm. Mr Carby died some 20 minutes after the registrant came out of the handover.

The registrant was not on the ward on the 26 April 1999 when Mr Carby was admitted as she was off duty by this time.

With regard to the wider issues of negligence the Primary Care Trust commissioned a report from Professor Hooper (Nursing expert) on the 21 October 2002. Professor Hooper concludes that she is unable to find any specific reason to indicate that the nurses were negligent.

The panel believe that this allegation is not capable of amounting to misconduct. Accordingly, the panel have declined to proceed with the matter.

**Code A**

Part 1: Registered Nurse (Adult), Part 2: Registered Midwife (Lapsed)

The panel considered this matter very carefully and evaluated the information before it including the letter of complaint from Mrs Reeves, the nursing notes together with the response made by Mr Chris Green (RCN Solicitor) on behalf of the registrant.

The panel note that pursuant of Rule 8 (1) a. of the 1993 Rules Council's staff, have particularised no specific allegations to be put before the registrant in this case. It is noted that the Registrar has been unable to articulate any allegation in respect of this registrant.

The panel have noted that Mrs Reeve's letter to the Council arises from concerns about a police investigation into deaths at Gosport War Memorial Hospital. The police allegations relate to the administration of medication via syringe drivers. The panel

believe that for completeness they should consider the matter of the commencement of the syringe driver in relation to the care of Mrs Devine.

Decision: Declined to proceed with this matter

Reasons:

The panel can find no evidence that the registrant was involved in the administration of any pain relief medication or in the establishment of the syringe driver in relation to the care of Mrs Devine. Accordingly, the panel believe that this matter is not capable of amounting to misconduct and the panel have decided not to proceed with this matter.

Code A

Part 1: Registered Nurse (sub part 2) (Adult)

The panel considered this matter very carefully and evaluated the information before it including the letter of complaint from Code A the nursing notes together with the response made by Mr Chris Green (RCN Solicitor) on behalf of the registrant.

The panel note that pursuant of Rule 8 (1) a of the 1993 Rules Council's staff, have particularised no specific allegations to be put before the registrant in this case. It is noted that the Registrar has been unable to articulate any allegation in respect of this registrant.

The panel have noted that Code A letter to the Council arises from concerns about a police investigation into deaths at Gosport War Memorial Hospital. The police allegations relate to the administration of medication via syringe drivers. The panel believe that for completeness they should consider the matter of the commencement of the syringe driver in relation to the care of Mrs Devine.

Decision: Declined to proceed with this matter

Reasons:

The panel can find no evidence that the registrant was involved in the administration of any pain relief medication or in the establishment of the syringe driver in relation to the care of Mrs Devine. Accordingly, the panel believe that this matter is not capable of amounting to misconduct and the panel have decided not to proceed.

Code A

# Code A

Part 1: Registered Nurse (Adult)

The panel considered the allegations very carefully and evaluated the information before it including the letter of complaints from Mr Page and Code A the clinical and nursing notes, the drug chart for Mrs Page, the evidence given at the Coroner's inquest, Professor Ford's and Professor Black's expert reports together with the response made by Mr Chris Green (RCN Solicitor) on behalf of the registrant.

The panel note that pursuant of Rule 8 (1) a. of the 1993 Rules Council's staff, have particularised seven allegations which have been put before the registrant in this case. The panel are grateful for this preliminary work. However, the panel have noted that Mr Page's letter to the Council arises from concerns about a police investigation into deaths at Gosport War Memorial Hospital. The police allegations relate to the administration of medication via syringe drivers. The panel believe that for completeness they should consider the matter of the commencement of the syringe driver in relation to the care of Mrs Page as part of allegation 1.

The panel note that the Council wrote to Mr Page to ask him to provide specific allegations against the registrant and no response was received.

1. Decision: Declined to proceed with this allegation

Reasons:

According to the clinical records Mrs Page was having Fentanyl patches on the 2 March 1998. On the 3 March 1998 she was commenced on a syringe driver containing Diamorphine and Midazolam. The syringe driver was commenced by the registrant and had been prescribed by Dr Barton who reviewed the patient on the 2 March 1998. The drugs were commenced at the lowest possible dose in the prescribed range. It is not clear whether or not the Fentanyl patch was discontinued at the point where the syringe driver commenced.

The question is whether the registrant should have questioned the prescribing by Dr Barton. The panel are mindful that there is conflicting evidence from Professor Ford and Professor Black about whether the continuation of Fentanyl is appropriate when administering Diamorphine and Midazolam via a syringe driver. Given the conflicting opinion amongst experts the panel of the view that it would be unreasonable for a registrant to ascertain whether the prescribing was inappropriate.

2. Decision: Declined to proceed with this allegation

Reasons:

It is alleged that the on the 19 November 1999 the registrant failed to act in the best interests of Mrs Devine by not removing a Fentanyl patch until three hours after the syringe driver had commenced. The panel note that Dr Barton in evidence to the Coroner had indicated that she specifically requested that it remain in place.

Professor Black again as part of the Coroner's proceedings describes how he considers that there was no negligence, culpability and that the administration of the medicines represents good palliative care.

The panel considers that this allegation is not capable of amounting to misconduct and therefore the panel have declined to proceed with this matter.

3. Decision: Declined to proceed with this allegation

Reasons:

It is alleged that on the 19 November 1999 that the registrant failed to provide accurate information to Code A indicates that this call occurred at 8.15am and that it was initiated by the registrant. The panel note that this call took place before any sedation or analgesia had been given. In addition, given that the registrant initiated the call it is unlikely that the registrant would call to provide false information about the patient. There is no evidence to suggest that the registrant should have advised the complainant and her family to visit before 1pm at the time of the telephone discussion.

The panel considers that this allegation is not capable of resulting in removal from the professional register and therefore the panel have declined to proceed with this matter.

4. Decision: Declined to proceed with this allegation

Reasons:

It is alleged that the registrant returned clothing to Code A saying they were "too good" for a hospital stay as they were dry clean only. The registrant in her response details how the ward had facilities to launder clothing but not dry clean only items. While this allegation may be capable of proof the panel are of the opinion that it would not result in removal from the register and they have therefore declined to proceed with this matter.

5a. Decision: Declined to proceed with this allegation

Reasons:

It is alleged that the registrant made an incorrect statement in the records to state that Mrs Devine could not climb stairs. In her response the registrant indicates that this probably related to a physiotherapist and occupational therapist assessment of her ability to manage at home. Even if this allegation was proven if could not result in removal from the register and the panel have therefore declined to proceed with this matter.

5b. Decision: Declined to proceed with this allegation

Reasons:

The panel note the allegation that details that the kidney infection and the prescription of antibiotics had not been written up. While it may be good practice to note in the nursing record that the review by the doctor had taken place. The primary responsibility for the recording of diagnosis and prescribing decisions lies with the doctor. For this reason the panel are of the opinion that even if proven this allegation would not result in removal from the register and the panel have therefore declined to proceed with this matter.

6. Decision: Declined to proceed with this allegation

Reasons:

The panel note the allegation that the registrant suggested that Mrs Devine was agitated on the morning of the 19 November 1999. The contemporaneous nursing record suggests confusion and aggression. The family were not present at this time and are therefore not in a position to say one way or another than Mrs Devine was not agitated. Accordingly, the panel feel this allegation is not capable of amounting to misconduct. The panel have therefore declined to proceed with this matter.

7. Decision: Declined to proceed with this allegation

Reasons:

The panel note the allegation concerning unprofessional comments about tensions between **Code A** The registrant in her response states that "nursing staff sensed some tension between **Code A** It is important that registrant's note family dynamics as they can play a part in the care of patients. This is an observation which the panel do not consider to be unprofessional. The panel are of the opinion that this allegation is not capable of amounting to misconduct and they have therefore decided to decline to proceed with this matter.