Royal College of Nursing

Fax

To: Code A Nursing & Midwifery Council

From: Chris Green, RCN Legal Services

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Date: 9 April 2010 **Fax to:** **020 7242 9579**

Number of pages (including this one): 8

Message: Re: Gosport matter
Code A

Dear Code A

Further to my fax to you earlier, please find attached a further letter on the above named member in this matter.

Kind regards

Mala Wardell

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Code A

Our Ref: CG/cg/0690/10
Your Ref: 12053.1
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Code A

Nursing & Midwifery Council
Level 1, Centrium House
61 Aldwych
London WC2B 6LH

Dear Code A

Re: Code A
Preliminary Proceedings Committee meeting, 12th-13th April 2010

I am representing Code A, and also the other 6 practitioners whose cases are being considered at the PPC meeting on 12th-13th April 2010. This letter is our formal response to the allegations set out in your letter dated 17th March 2010.

I shall make submissions in respect of each practitioner in a separate letter. There will necessarily be a lot of repetition between these letters. I have prepared a single, indexed bundle of documents, for all these cases. I shall refer to the documents in this bundle, as necessary, in my submissions.

Legal criteria for starting proceedings

The Committee has the benefit of the advice by Johanna Cutts QC (pages 352-356) as to the legal criteria for starting proceedings against a practitioner. I have no arguments with this advice, but would like to comment as follows:

The *Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993*, Rule 9(1) states:

> ***Commencement of proceedings***
> *9. (1) The Preliminary Proceedings Committee shall consider allegations of misconduct and shall, subject to any determination under rule 8(3), and where it considers that the allegations may lead to removal from the register, direct the Registrar to send to the practitioner-*
>
> *(a) a Notice of Proceedings;*

Thus, the PPC should start proceedings *'where it considers that the allegations may lead to removal from the register'*.

This is, in essence, a 3 stage test. In my submission, Committee members should ask themselves:

1. Is there a real (as opposed to fanciful) prospect of the facts of the allegations being proved?
2. If proved, would these facts lead to a finding that the practitioner is guilty of misconduct?
3. Is there a real prospect that the practitioner will therefore be removed from the register?

If the answer to all these questions is yes, the Committee should start proceedings against the practitioner. If the answer to any of these questions is no, the Committee should close the case.

Legal criteria for ordering further investigations

In the event that the answer to question 1 above is not clear, and there is a real prospect that further investigations would be of assistance, then the Committee has the option of ordering further investigations (Rule 8(3)(b)).

I wish to comment that the Gosport cases have continuously been investigated since the late 1990s. There have been numerous witness statements, expert reports and inquiries, including internal Trust inquiries, a 7 year police inquiry, a GMC inquiry and a long inquest. There is also a comprehensive summary of the evidence by the NMC in-house legal team. It is hard to imagine that, so many years after the events, any further investigations would now be helpful.

The nurse's responsibility when administering prescribed medication

In some of the Gosport cases, the question arises as to whether the nurse should have challenged Dr Barton's prescription, and refused to administer the prescribed medication. I wish to make the following comments on this issue:

Nurse training includes little pharmacology, and does not include a course in prescribing. Nurse prescribers have to do a post-registration course. None of the Gosport nurses was, or is, a nurse prescriber.

In contrast, a doctor has extensive training in pharmacology and prescribing, and practises prescribing ever day of his or her working life.

For this reason, doctors generally are given responsibility for prescribing and nurses generally are not. Nurses are expected to administer the drugs prescribed by the doctor.

Clearly a nurse should challenge a doctor's prescription, and not administer the prescription, if the doctor has manifestly made a mistake – e.g.

- If the doctor has prescribed an adult dose of medication for a child; or
- If the doctor has prescribed a manifestly incorrect dose; or
- If the doctor has prescribed a drug to which the patient is known to be allergic.

It will also be generally agreed that if a drug is being administered and the patient suffers a dangerous side effect, or shows signs of overdose, the nurse should immediately stop the drug, and report back to the doctor.

However, a nurse is rarely justified in setting up her clinical judgment against that of the doctor. She is not qualified to make clinical judgments about prescribing. As a member of a multi-disciplinary team, it is generally the nurse's duty to trust the care and skill of other members of the team, not to continuously challenge them. As stated in the UKCC Code of Conduct, the nurse should *'work in a collaborative and co-operative manner with health care professionals and others involved in providing care and recognise and respect their particular contributions within the care team'* (see page 359).

For the above reasons, I would ask the Committee to be very slow to conclude that a nurse who has administered a drug as prescribed is guilty of misconduct. In my submission, this will only be the case if the doctor's misjudgement was so great that it should have been obvious to a nurse. In most cases, nurses should not be held responsible for the misjudgement of a doctor.

It is also relevant that Dr Barton, who was responsible for all the questioned prescriptions, has not been struck off by the GMC. The criteria for starting proceedings against a nurse is that *'the allegations may lead to removal from the register'*. Given that the doctor was not struck off for prescribing the drug, it would be manifestly disproportionate to strike a nurse off for administering the drug as prescribed.

Response to the allegations

That you, while employed as Clinical Manager, Daedalus Ward, Gosport War Memorial Hospital

In respect of Patient A (Alice Wilkie):

1. *Failed to maintain accurate patient records:*
   - *(a) on 17 August 1998, by writing a note suggesting that her daughter, Mrs Jackson, had agreed to a syringe driver for Patient A and that active treatment was not appropriate;*
   - *(b) on 21 August 1998, wrote in Patient A's clinical notes that her family had been present when she died when they had not been;*
2. *on 20 August 1998, failed to ascertain the level of pain Patient A was in;*
3. *on 21 August 1998, failed to monitor Patient A appropriately and keep her family informed of her condition;*
4.

In respect of Patient B (Dulcie Middleton), on dates between 29 May 2001 – 16 May 2001 [sic]

5. *failed to ensure that meals were provided within her reach and on an occasion on an unknown date, without cutlery;*
6. *failed to ensure that her alarm bell was within her reach so that she could call for assistance;*
7. *failed to ensure that Patient B was kept warm;*
8. *failed to ensure that Patient B received basic nursing care or was treated with dignity;*

In respect of Patient C (Stanley Carby):

9. *between 26-27 April 1999, were negligent in the care provided to Patient C.*

Code A instructs me as follows:

Due to the passage of time, he has no memory of Alice Wilkie. He notes from the medical records on page 285 that, while her daughter was under the impression that she was sent to Gosport for 'rehabilitation', Dr Lord (consultant geriatrician) has written 'prognosis poor' and describes her placement at Gosport as for 'continuing care'. Sadly, sometimes relatives were given unrealistic hopes when patients were sent to Gosport from acute hospitals.

Not surprisingly, he has no recollection of his conversation with Mrs Jackson, Alice Wilkie's daughter, on 17th August 1998. However, he made a contemporaneous note – see page 287. The only reason that he would have made this note is that the conversation happened as described. He would have had no possible motive to make a false record.

He does not specifically recall any conversation with Mrs Jackson on 20th August 1998 about her mother's pain. He could not always respond instantly to a request from a relative, since he had 23 other patients to care for, but would always take a relative seriously if the relative thought that a patient was in pain. He notes that the syringe driver was set up at 13:50 (see page 293). This suggests a fairly quick response. Assuming that Dr Barton had already written an anticipatory prescription, he would still have had to telephone her to confirm that the syringe driver should be started.

He does not specifically remember Alice Wilkie's death on 21st August 1998. Generally, if a patient deteriorated, the nursing staff would ring the family. However, it is very hard to predict the likely time of death with any accuracy, and sometimes patients deteriorated very rapidly. By Mrs Jackson's own account (page 282) she left for some food and a change of clothes and returned 'a short time later'. In the circumstances, he might not have had time to ring her, or she might not have been in when he rang.

He would not have misled Alice Wilkie's relatives as to the time of her death. Nurses are required to maintain professional objectivity at a death bed; for example, they will observe shallow breathing and other quite subtle signs of life. Distraught relatives are less likely to apprehend the exact time of death.

He did not make an incorrect note of her death. His note on page 287 actually states that her relatives were present when death was *confirmed*, not that they were present when Alice Wilkie died.

He remembers Stanley Carby. Mr Carby was admitted in the afternoon of 26th April 1999 following a very dense stroke. He was a diabetic, overweight and a smoker, and was therefore at very high risk of a recurrence. On the morning of 27th April, Code A observed that his condition had deteriorated. He received care as detailed in Christine Joice's records in the nursing notes, page 331-332. Christine Joice rang Dr Lord, the consultant, and arranged for Dr Barton to attend. She also called in the family. Dr Barton concluded that he had had a second stroke, and spoke to the family. In view of Mrs Carby's concern that her husband was in pain, Dr Barton prescribed a syringe driver. Sadly, Stanley Carby died at 1pm. Philip Beed believes that the nursing care which Stanley Carby received was appropriate.

He remembers Dulcie Middleton. She was transferred to Daedalus Ward for rehabilitation following a severe stroke. As a result of her hemiplegia, she was very dependent, requiring a hoist and 2 nurses for all transfers. She was naturally very worried about soiling; staff often found themselves hoisting her on and off the commode or bed pan repeatedly throughout a shift, sometimes at 30 minute intervals, often with no result. Each transfer was distressing to Mrs Middleton, and time consuming.

Staff were aware that Mrs Middleton needed help at meal times, and would feed her as necessary. Code A remembers feeding her himself on several occasions. However, even with much support and encouragement, she would only eat minimal quantities of food. There were several patients who needed to be fed. If Mrs Middleton was reluctant to eat, it was reasonable for staff to leave her food for a while, go to feed another patient, and return later to try to persuade Mrs Middleton to eat some more.

Her daughter, Mrs Bulbeck, was naturally very concerned about her mother. She would ask to speak to a nurse every time she visited, and to the consultant after every round. She would keep a nurse in conversation for 30 minutes to an hour, and would ask different nurses the same questions, perhaps hoping for different answers. Sadly, she had difficulty accepting how gravely ill her mother was. She never made a complaint while her mother was on the ward.

On a date in August 2001, Mrs Middleton became acutely ill with gastro-intestinal bleeding. She was transferred to Queen Alexandra Hospital. She subsequently died.

The period of Mrs Middleton's admission was a period of severe staff shortages on Daedalus Ward. Code A submitted 4 risk event forms during this period, drawing attention to the risks caused by low staffing (see Tab 3 of the Respondents' Bundle of Documents). On occasions, staff worked shifts with no break, or worked day and night shifts consecutively.

Following Mrs Bulbeck's complaint in June 2002, the NMC asked the Trust to investigate. Code A willingly co-operated with this investigation. The notes of

his meeting with Jane Williams are at Tab 2 of the Respondents' Bundle of Documents. He realised that there had been a breakdown in communication between the ward and Mrs Bulbeck, and was eager to learn any lessons that could be learned from this experience, as the notes show. The Trust investigation did not result in any disciplinary action.

For the reasons given above, he denies all the allegations against him.

With regard to Allegations 4-7, he would add that there might have been occasions when Mrs Middleton's care was poor. However, there are other possible explanations for what Mrs Bulbeck observed. For example, if food was left on her table, this might have been because she had refused food, and the carer intended to return later to try again. If the call bell was out of her reach on one occasion, she might have dropped it. If her blanket was on the floor, she might have moved such as to cause it to fall off.

As a Ward Manager, his duty was to investigate any complaint made of poor care by his staff; and he always did so. However, Mrs Bulbeck's complaints were all undated, and received long after Mrs Middleton had left the ward. In the circumstances, it was not possible to investigate the specific complaints by finding out who was on duty on the days in question and questioning them. He could only try to learn general lessons from the apparent breakdown in communication with the patient's daughter.

Submissions

With regard to Allegation 1(a), I submit that this allegation could not be proved to the required standard. Code A would have had no incentive to make a false record of a conversation. It is much more probable that Mrs Jackson had a poor recollection of the conversation, since she was naturally distressed and, naturally, did not make a contemporaneous note.

Allegation 1(b) is clearly false, since the note on page 287 states that relatives were present when death was *confirmed*, not when death took place.

With regard to Allegation 2, it might have been Mrs Jackson's subjective impression that Code A did not assess Mrs Wilkie's pain. However, the objective record shows that he was given prescribed pain relief at 1:50pm. This suggests that Code A acted fairly promptly on Mrs Jackson's concerns. He would have had to discuss the situation with Dr Barton before starting a syringe driver. (One clear lesson from this case is that a nurse should not be too hasty to administer opiates.)

With regard to Allegation 3, Mrs Jackson's distress at not being present during the last hour or so of her mother's life is very understandable. However, a nurse cannot be expected to predict with complete accuracy the exact time when a patient will die. To have prevented Mrs Jackson from leaving for *'some food and a change of clothes'* could hardly have been justified. By her own account, Mrs Jackson returned *'in a short while'*, and it is unlikely that she could have been contacted by phone while travelling.

With regard to Allegations 4-7, none of these allegations are against Code A personally. They are allegations of poor care on the ward. I ask the Committee to consider that Mrs Bulbeck's observations do not necessarily indicate poor care. It is not always the fault of staff if the call bell is out of reach. A carer might be justified in leaving food for a period if a patient is very reluctant to eat – it is never appropriate to try to force food down a patient, and rarely appropriate simply to give up. Coming back later is a strategy often employed by care staff. As Ward Manager, Code A had a responsibility to investigate any complaints – however, these complaints were not made until long after the events.

Since none of the complaints are against him personally, I suggest that he could not be considered guilty of misconduct in respect of Allegations 4-7.

With regard to Allegation 8, there is no specific allegation against Code A in respect of the care of Stanley Carby, and the evidence shows no basis for saying that he is guilty of misconduct. He was not responsible for setting up the syringe driver. This was set up by Code A nd Code A see pages 329 and 330).

For the above reasons, I submit that there is no prospect of any of the allegations against Code A being proved. This is also the advice of the NMC in-house legal team, as summarised in paragraphs 75-78 of their report (regarding Alice Wilkie), paragraphs 63-65 (regarding Dulcie Middleton) and paragraphs 56-57 (regarding Stanley Carby).

I refer the Committee to Code A CV at Tab 6 of the Respondents' Bundle of Documents, and to the references at Tab 7. He has been a registered nurse since 1984, 26 years. He has impressive post registration qualifications, including a Diploma in Professional Studies in Nursing and a Degree in Health Care Studies. He has never faced any disciplinary proceedings or capability proceedings. He achieved great distinction as a specialist ophthalmic nurse, becoming a 'Lecturer Practitioner' in ophthalmic nursing in 1992. In 1997, he had a change of direction, and took up the post of Clinical Manager on Daedalus Ward, specialising in stroke rehabilitation and care of the elderly. He is now working in the community in the Multi-Disciplinary Response Team, providing care to people at home, as an alternative to hospital admission. His references show that he is highly valued in this post.

In my submission, there is no question of now removing Philip Beed from the register, on the basis of these allegations. I respectfully ask the Committee to close this case.

Yours sincerely

Code A

Chris Green

RCN Legal Services