22.10.02.

Code A

Chief Executive
Fareham and Gosport PCT.

Dear Ian,

I am pleased to enclose the report of my review of the records of the late Mr. Carby in relation to the complaint which Code A has lodged with the Nursing and Midwifery Council against nursing staff at Gosport War Memorial Hospital. Please contact me if I can be of further assistance.

Yours sincerely

Jean Hooper.

Professor Jean Hooper CBE, Hon. Dsc, MSc, RGN.

CONFIDENTIAL REPORT FOR FAREHAM AND **GOSPORT** PRIMARY CARE TRUST OCTOBER 21ST 2002.

Review of the nursing records of the late Mr. Stanley Carby.

Background. Mr. Stanley Carby died at 13.00 on Code A following an extension of his cerebrovascular accident, having suffered an earlier episode on 14th April 1999. He had been an inpatient at Royal Hospital Haslar prior to his transfer to Gosport War Memorial Hospital on 26th April 1999 for rehabilitation, following assessment by Dr. Tandy, consultant geriatrician, on 20th April 1999.
Mr. Carby had multiple pathology, in addition to his recent cerebrovascular accident, and both his Barthel and Waterlow assessments confirmed that he was a high risk patient in terms of his nursing needs.
According to the notes available to me, it appears that Mrs. Carby lodged with the Nursing and Midwifery Council, the allegation that Mr. Carby died as a result of "complete negligence" by Staff Nurse Joice, Philip Beed and J. Neville. The letter from the NMC of 5th September 2002 to Mrs. Cameron, Operational Director at the PCT, indicates that there had been earlier communication with the NMC from Mrs. Carby, but there is no record of this in the file.
Mrs. Carby's letter of 22 August 2002 states that she has "all the proof" of the alleged "complete negligence" by the three nursing staff, in her late husband's medical notes.
These notes form the basis of my review of the nursing records.

REVIEW.

The staff would have been at a disadvantage from the onset as it appears that no records were sent from Royal Hospital Haslar with Mr. Carby at the time of his transfer, apart from a nursing review by D. P. Wilcock, Registered Nurse,dated 26 April,1999. The Haslar records were not requested until Mr. Carby's sudden deterioration on 27 April.

1. Mr. Carby's summary on admission was written by his named nurse, Janet Neville, but his detailed assessment sheets were completed by another nurse. None of these sheets are signed; it is therefore not possible for me to identify them with any of the nurses against whom the complaint is lodged.
The outcome of his initial assessment confirms a very low Barthel score and a very high Waterlow score, indicating that Mr. Carby was a patient with high nursing dependency. His Mental Study was not undertaken, but

in view of his speech difficulties this seems to be a reasonable decision at the time of admission.

2. Mr. Carby's blood sugar records were maintained regularly and remained within normal limits until the 10.a.m. recording on 27 April, at which time he had become acutely ill.

3. There is some discrepancy in relation to the state of Mr. Carby's skin and pressure areas on transfer. There is no reference to this in the transfer letter from Haslar. On the Waterlow sheet his skin is recorded as "discoloured";on the Nutritional Assessment tool, as 4 = red/ broken/ wound; on P. Beed's record on the Handling Profile as"intact"

4 Nursing reports

These records have discrepancies. The initial summary is written on the 26April and not signed. The next entry is dated 27 April ,the signature is illegible and the content indicates that it refers to Mr. Carby's first day in the ward ie. 26 April. There is no identifiable nursing report for overnight care on 26- 27 April. The next written report by ? S-N Joice, dated 27 April but with no time recorded, indicates that Mr. Carby was less well, with marked swallowing difficulties. This nurse correctly contacted the oncall doctor, Dr. Barton at 10 a.m., who was due to attend within one hour. The family were also notified of Mr. Carby's condition.
Dr. Barton attended and assessed Mr. Carby's very serious condition and discussed his care with the family who were present. She prescribed drugs to "make him comfortable" as Mrs. Carby felt that her husband was in pain. It is recorded that she thought that he would not survive this episode.
A nurse ( not clear from initials who this was) administered diamorphine 40mgm and mixazolan 40mgm at 12.15 p.m. and Mr. Carby was confirmed dead by S.N. Neville and S.N. Joice at 13.00 hours. The family were present and were "very distraught and distressed".
It should be noted that these drugs are recorded as being administered on 26 April at 12,15p.m. Clearly it must have been on the 27th.

CONCLUSION

I am unable to find any specific reason through review of the notes to indicate that the nurses were negligent in their care and management of Mr. Carby during the 24 hours that he was an inpatient at Gosport War Memorial Hospital. Mrs. Carby herself did not feel that her husband would survive this second episode. However Mr. Carby was given a very significant dose of sedative shortly before he died, and this may now be

influencing Mrs. Carby in her assessment of her husband's care. It is unusual that there has been such a long time lapse if this is so.

I am concerned at the discrepancies in the records in terms of dates and times. This must reduce the level of confidence of relatives having access to the files.
I therefore strongly recommend that:
Staff be required to complete all records with date and time when making any recording;
Names should be signed legibly and in full;
Drugs must be recorded in the correct space;
Two signatures should be recorded in situations such as this where the patient was clearly close to death when the drugs were administered.

Code A

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