Private and confidential
Mrs RE Carby

Code A

1 June 2010
PRE/ Code A /12053.1/12053.4/12053.5/
Direct line: Code A

Code A

DX: 37970 Kingsway

Dear Mrs Carby

Registered nurses at Gosport War Memorial Hospital:

Code A

I am writing about the above named whose case was placed before the Preliminary Proceedings Committee of the NMC at its meeting on 12 and 13 April 2010.

The Preliminary Proceedings Committee gave careful consideration to the papers before it and decided to decline to proceed with the complaints against both of the above named registrants.

Decisions and reasons in respect of Code A

The panel considered the allegations very carefully and evaluated the information before it including [….] 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 [complainant's name deleted] 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.

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 investigation 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 Nurses Joice and Couchman 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.

Decisions and reasons in respect of Code A

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.

Decisions and reasons in respect of Janet Neville

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.

In considering this matter, the committee sat with a legal assessor.

Legal assessor's advice to the Preliminary Proceedings Committee:

The role of this PPC (under Rule 9 (1) of the 1993 Rules) is to consider allegations of misconduct and, subject to any determination under Rule 8(3), 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;

(b) copies of statements obtained by Council during the investigation of the allegations and any other documents the Preliminary Proceedings Committee considers appropriate which are in the Council's possession unless such documents have already been sent to the practitioner under Rule 8(2) or otherwise;

(c) a request that the practitioner respond, in writing, to the Notice of Proceedings;

The PPC should bear in mind that the public have an interest in the maintenance of standards and the investigation into complaints of serious professional misconduct against practitioners; that public confidence in the NMC and the nursing profession requires, and complainants have a legitimate expectation that such complaints (in the absence of some special and sufficient reason) will be publicly investigated by the PPC and that justice should in such cases be seen to be done. This must be most particularly the case where the practitioner continues to be registered and practise.

The stage which has been reached is that

(a) the Registrar has sent to each practitioner concerned a summary of the allegations against him/her;

(b) each practitioner has been given a chance to submit a preliminary response to summary of allegations, which response has been made available to this PPC.

The PPC has a filtering role. The test to be applied is somewhat lower than a real prospect of success. The PPC will only be able to form a preliminary view as to whether there is a reasonable prospect of success on the material before it.

The PPC's is to decide whether the complaint ought to proceed. The PPC may *evaluate the available evidential material in order to determine whether, in its opinion, such material appears to raise a question as to whether the allegations may lead to removal from the register.* It may conduct an investigation into the prospects of the allegations and may refuse to refer if satisfied that, *in its opinion, such material does not appear to raise a question as to whether the allegations may lead to removal from the register,* but it does so with the utmost caution bearing in mind the one sided nature of their procedures under the Rules which provide that, whilst the practitioner is afforded access to the complaint and is able to respond to it, the complainant has no right of access or to make an informed reply to the response, and the limited material likely to be available before the PPC.

It is not the role of the PPC to resolve conflicts of evidence. The PPC must bear in mind its limited filtering role and must balance due regard for the interests of the practitioner against the interests of the complainant and the public and must bear in mind the need for reassurance of the complainant and the public that complaints are fully and properly investigated and there is no cover up. Any doubt should be resolved in favour of the investigation proceeding.

It is apparent that the exercise which is contemplated is one in which available material is to be *evaluated* to determine whether that material appears to raise a question of *whether the allegations may lead to removal from the register*. "Evaluation of material" must refer to consideration of the evidential material, not simply to an analysis of whether the complaint itself (if supported by evidence) would amount to serious professional misconduct.

If the PPC is considering exercising its powers under Rule 8(3) (b) of the Rules, it should first have regard to the matters set out in paragraphs 56 and 95 of Standlen J.'s judgement in The Queen on the application of Michael McNicholas.

I apologise for the delay in conveying the committee's decision to you. Thank you for bringing this matter to our attention.

Yours sincerely

Code A