‘I did nothing wrong but I can’t even look at my uniform now without fear it will cause a panic attack’

Nurse wrongly blamed for patient death traumatised

By Marion Scott
CHIEF REPORTER

A nurse has accused a troubled health board of making her a scapegoat after a locum failed to send a psychiatric patient to A&E following a morphine overdose.

A catalogue of failures, including allowing the patient to go home and failing to search her for drugs when she returned to hospital despite a 20-year history of overdoses, led to the 50-year-old patient's death at Dundee's Carseview psychiatric unit in 2019. But staff nurse Gail Taylor, who did not even come on duty until hours after the patient admitted to medical teams that she had taken 30 slow-release morphine tablets, was suspended for years by NHS Tayside before finally being cleared and offered her job back.

The internal appeal tribunal which examined her case raised “significant concerns” about the documentation presented by NHS Tayside and questioned whether some of it was even “factual”.

The nurse, who had a 22-year unblemished record of employment with NHS Tayside, has been left so traumatised after being ostracised and denied support by the health board, that she cannot face seeing her uniform again without having a panic attack.

Gail, 67, from Dundee, said: “I was made a scapegoat for the dreadful catalogue of failures by others, including a locum psychiatrist who failed to ensure the patient was taken the few yards from the ward at Carseview to the A&E department of Ninewells on the same campus.

“I spent four long years with the tragic, avoidable death of this patient hanging over my head. It has left me deeply traumatised. Even though I’ve been cleared, given an out of court settlement and offered a return to work, I could not face going back. The job I once loved and was so proud to do would never have been the same. A patient who could have been saved lost her life, and my unblemished career was destroyed when I was not to blame.

“I cannot even look at my uniform now without panicking and feeling ill, never mind putting it back on. The doctor who failed that patient has been back at work treating other patients for years, while I’ve been treated like a criminal and pariah.”

Gail, above, says she was made a scapegoat; an appeal panel criticised NHS Tayside’s handling of the case at Carseview in Dundee.

The internal appeal panel criticised NHS Tayside over how they handled the case, finding their investigatory and disciplinary processes to be flawed, excessive and unfair. The same health board is facing a public inquiry over how rogue brain surgeon Sam Eljamel was able to continue operating for years on patients who suffered catastrophic injuries.

The patient who died at Carseview after being admitted on December 7, 2019 for threatening to take her own life, was well known to staff at the psychiatric unit. She had been treated there following numerous suicide attempts after being diagnosed with Emotionally Unstable Personality Disorder (EUPD).

Despite the suicide threats, locum psychiatrist Dr Vanaja Puli had allowed the patient to go home for a few hours after she promised to return. When she did return, nobody checked whether the patient had brought drugs into the hospital.

The patient eventually admitted to staff around 7.20pm that she had taken 30 slow-release morphine tablets. A tribunal found Dr Puli failed to take the steps required to ensure the patient was taken to Ninewells A&E, just yards from the Carseview unit, and failed to ensure regular checks were made every 15 minutes.

Staff nurse Taylor came on duty later that night just before 9pm.

She insists: “I was never told the woman had taken 30 slow-release morphine pills. If I had been, I would have had the patient sectioned and taken to A&E where treatment could have saved her life. The observation documents that should have alerted any nurse or doctor that there was any concern about the patient had not ben filled in by the shift before I came on duty. Another staff nurse on duty that night had kept checking on the patient throughout the night while I checked on the other 22 patients in the unit.”

Taylor went off shift almost two hours before the patient was found unresponsive and paramedics were called. The time of death was given as 9.45am on December 8. Afterwards, police officers arrived at Carseview and discovered empty packets of pills in the her pockets.

Two years ago, the Medical Practitioners Tribunal Service suspended Dr Puli for three months “to maintain public confidence in the profession” after ruling she had committed “serious failings”.

The other staff nurse on duty that night was fired. Despite the nursing watchdog the Nursing and Midwifery Council finding they did not have concern about her fitness to practice, NHS Tayside also sacked Taylor who was the nurse in charge on the night of the tragedy.

She appealed and the panel found it was “unjustifiable” of NHS Tayside to find Taylor personally accountable for what they described as lots of errors with many staff involved over a period of three shifts. They also said: “We are significantly concerned about the documentation presented. The apparent omissions and additions relating to the patient record left the Panel unsure what documentation was actually factual.”

Gail Taylor never went back to the job she once loved and retired earlier this year.

NHS Tayside said: “Our appeals policies and procedures are designed to ensure that staff have the opportunity to present their case and appeal any decision made.”

Craig Snee, a partner with Thompsons Solicitors Scotland, said: “This case has clearly had a massive impact on Ms Taylor who has had this disgraceful state of affairs hanging over her for the last four years.”