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Lost notes and illegible records 'risking lives of NHS patients'

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Coroners have warned the NHS on dozens of occasions that its record-keeping is so poor that patients' lives are at risk, an investigation by *The Times* has found.

At inquests into patients' deaths across England and Wales they identified cases where records were illegible, had been sent to the wrong GP or lost.

Coroners have issued 62 warnings since 2013 in which they identified failings in record-keeping that could lead to the deaths of other patients.

In one case, an anorexic teenager who killed herself in 2017 after doctors had not properly documented her mental state was "failed by everyone", her mother, Nicki Long, told *The Times*.

"It is clear staff were just not talking to each other. They just didn't have a true picture of how unwell Ellie really was, and missed that she was self-harming," Ms Long, 48, said.

The coroner, Jacqueline Lake, found that Norfolk and Suffolk NHS Foundation Trust staff had failed to upload important handwritten records about Ellie's state of mind to her electronic file.

"I know the NHS is understaffed but using that as an excuse to a mother who has just lost a child is not good enough," Ms Long said. Knowing that opportunities to look after her daughter better had been missed made losing her even harder, she added.

Staff at Stockport NHS Foundation Trust failed to carry out a blood calcium test on Gary Bradshaw, who died of a heart attack in 2012, because a laboratory staff member mistook a handwritten note requesting the test as reading "cancer" rather than calcium and disregarded it. Another inquest involving the trust had to be adjourned because medical staff were unable to read a patient's records. The coroner was surprised that the trust had failed to spot that the records for Geoffrey Ellis, 88, a retired Baptist minister, were illegible during his care or when preparing for the inquest.

After the deaths, the trust noted in a board report last year that NHS Improvement had raised new concerns about the quality of its record-keeping.

Krishna Kasaraneni, of the British Medical Association, said that patients would not get the best care if doctors did not have a full picture of their health. "It's incredibly frustrating when you don't have all the records to hand, when you are still relying on letters in the 21st century, or when you can't understand what a hospital's handwritten records say," Dr Kasaraneni said.

Mark Porter, a GP, said that there were hundreds of occasions when he had struggled to read what a specialist meant to record about a patient.

NHS Trusts in England reported that at least 43 patients were seriously injured and 20 died because of record-keeping failings between October 2017 and September 2018, according to separate data from NHS Improvement.

Sir Norman Lamb, the former Liberal Democrat health minister, said it was bizarre that the NHS was stuck in a situation where information was missed because of bad handwriting when in most industries this could be shared at the touch of a button.

A spokesman for Stockport NHS Trust said it had taken steps to improve its record-keeping, and that its most recent CQC inspection did not raise any issues on the topic.

Simon Eccles, of NHSX, which is responsible for improving digitisation, said that all of England should be covered by digital records by 2024 so staff could access the information needed to provide patients with the best possible care.