

## Elaine Williams - Complaints and Litigation Manager

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**From:** Elaine Williams - Complaints and Litigation Manager  
**Sent:** 24 November 2005 08:49  
**To:** Karen Guy - Locality Manager; Angela O'Brien - Clinical Nurse Specialist; Susan Lawes - Risk & Governance Manager; Fiona Cameron - Director of Professional Development & Clinical Governance  
**Subject:** RE: Request for Report from Coroner's Office - ML  
**Importance:** High

Hello Karen

Please find attached the request for reports, although not addressed to anyone in particular, it applies to all who are appropriate. Would you please forward as appropriate. Susan says that one of the consultants is about to go on Maty leave. We need a report before she leaves so could I ask you to liase with her about that. I have also attached the guidance and template which should be forwarded to anyone writing reports. Can I please have all the draft reports emailed to me before the 15th Dec. There will probably need to be a brief report from the staff who found her, they will probably need line manager support through this process.

do ring if you have any queries or if it emerges that we need legal advice.

Thanks

Elaine



CO request GUIDELINES Template for  
 Nov 05.doc /RITING A REducing a coro

-----Original Message-----

**From:** Karen Guy - Locality Manager  
**Sent:** 22 November 2005 14:26  
**To:** Elaine Williams - Complaints and Litigation Manager; Angela O'Brien - Clinical Nurse Specialist; Susan Lawes - Risk & Governance Manager; Fiona Cameron - Director of Professional Development & Clinical Governance  
**Subject:** RE: Request for medical record from Coroner's Office

Thanks Elaine - my understanding is that the observations were being carried out hourly as per protocol, on this occasion the worker checked and thought the patient was asleep but this was subsequently found not to be the case. I agree it may be better not to say human error.

-----Original Message-----

**From:** Elaine Williams - Complaints and Litigation Manager  
**Sent:** 22 November 2005 11:43  
**To:** Angela O'Brien - Clinical Nurse Specialist; Susan Lawes - Risk & Governance Manager; Fiona Cameron - Director of Professional Development & Clinical Governance  
**Cc:** Karen Guy - Locality Manager  
**Subject:** RE: Request for medical record from Coroner's Office

It may be problematic if we are saying there was human error and we might need a meeting to finalise the Coroner's report. Please let me know if we need legal advice on this one.

Thanks

Elaine

-----Original Message-----

**From:** Angela O'Brien - Clinical Nurse Specialist  
**Sent:** 22 November 2005 11:13  
**To:** Susan Lawes - Risk & Governance Manager; Fiona Cameron - Director of Professional Development & Clinical Governance; Elaine Williams - Complaints and Litigation Manager  
**Cc:** Karen Guy - Locality Manager  
**Subject:** RE: Request for medical record from Coroner's Office

There is nothing untoward here, the patients are checked hourly through the night, this was human error in so much as they checked her, and thought she was sleeping soundly, but did not wait to see a movement (breath), this was because the patients get upset if the staff (esp. male) wake them up on the hourly checks. This has now been addressed and staff are checking for breath movement on the hourly checks,

in pairs if only male staff on duty.  
Is this sufficient  
Angela

-----Original Message-----

**From:** Susan Lawes - Risk & Governance Manager  
**Sent:** 22 November 2005 10:21  
**To:** Fiona Cameron - Director of Professional Development & Clinical Governance; Angela O'Brien - Clinical Nurse Specialist; Elaine Williams - Complaints and Litigation Manager  
**Cc:** Karen Guy - Locality Manager  
**Subject:** FW: Request for medical record from Coroner's Office  
**Importance:** High

Fiona this is the case I mentioned, initially nothing said to be untoward.

Angela, You commented on the form 'local review of procedures for checking patients at night to be reviewed'. Is there any aspect of this patient's care that may be judged to be less than the required standard? Can you confirm nothing untoward here and a formal incident review not required?

Elaine

Over to you to coordinate any required response to the coroner please, I will copy AER to you - 6935

Regards  
Susan

-----Original Message-----

**From:** Susan Lawes - Risk & Governance Manager  
**Sent:** 22 November 2005 10:20  
**To:** Code A Operational Co-ordinator  
**Subject:** FW: Request for medical record from Coroner's Office  
**Importance:** High

Code A

I have an Adverse Event Form concerning this patient, she was an inpatient on Fernhurst Assessment Ward, died 09/11/05  
Please ensure any response to the Coroner goes via Elaine Williams, not direct from yourself.  
Thank you  
Susan  
Susan Lawes  
Risk & Governance Manager  
East Hampshire Primary Care Trust and Fareham & Gosport Primary Care Trust

Code A

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-----Original Message-----

**From:** Ben Smith - Risk Manager  
**Sent:** 22 November 2005 09:35  
**To:** Code A Operational Co-ordinator  
**Cc:** Susan Lawes - Risk & Governance Manager  
**Subject:** Request for medical record from Coroner's Office  
**Importance:** High

Dear Von

Paul from the Coroners Office called yesterday requesting the medical records of a:

Margaret Lacey (DOB - Code A)

I suspect that this lady was probably not a Portsmouth City tPCT patient. I understand the

Coroners office are asking for these records following the report of a sudden death on 9th November 2005.

The only other information is that this lady had been an outpatient from Petersfield and was at St James to receive ECT.

Paul's number is **Code A** Please could you give him a call if you have the records for this patient.

Many thanks

Ben

Ben Smith  
Risk Manager  
Portsmouth City Teaching PCT  
Trust Central Office

Tel: **Code A**  
Fax: