## INQUEST OUTCOME REPORTS

**Code A** – 17 November 2005

Verdict – Death due to natural causes (infection following surgical procedure).

**Code A** **Code A**

- Code A not given sufficient morphine. Explained that can't give large amounts of morphine to patients with dementia as it makes them even more confused and adds to risk or pneumonia. Must use sparingly.
- **Code A** body was swollen up. Two causes of swelling, firstly a type of anaemia as a result of Code A poor physical condition and Code A poor heart function.
- Some nurses did not seem to know how to manage patients with Alzheimers. Code A explained that they are doing a lot of ward-based training in order to improve the standards of care in this respect.

**Code A** – 22 November 2005

Verdict – death due to known and unavoidable complication of necessary surgical procedure.

Main family concerns were communication. They were not told until a few hours prior to Code A death that Code A was going to die, although doctors knew at least by the day before. **Code A** apologised to the family for this. As he had been operating all night, he asked the Senior Registrar who was taking over in the morning to talk to the family about the seriousness of Code A condition but it does not appear that he did.

The family also said that they were not informed by the Bereavement office that the death had been reported to the Coroner and that the body had gone to London for the Home Office Pathologist to do the PM.

I have checked with **Code A** Bereavement Services Manager, who confirmed from Code A records that there is a tick in the column in Code A register that confirms that the death was reported to the Coroner and that the family were informed by the doctor. Doctors who report deaths to the Coroner are obliged to also tell the family.

**Code A** – 30 November 2005

Verdict – Accidental death

Main family concerns were communication – they did not understand what was going on and did not realise how ill Code A was and that Code A might not come out of hospital.

Also on several occasions they found Code A tablets by Code A bed because Code A had not taken them and they started making sure that they visited at meal times as they had found Code A food untouched by Code A bed on occasions.

Explanations by **Code A** seemed to allay their concerns that there had been a delay in making diagnosis and treating Code A Code A condition was extremely complex and although the site of the infection was not found for some time, Code A had been put on the appropriate antibiotic while the investigations were going on.

**Code A** – 6 January 2006

Verdict – Accidental death

Family had some concerns about treatment of head wound (not cleaned etc.) and they believed that the head wound had something to do with Code A death, but understood after evidence of Pathologist and Code A was given, that Code A death was due to the fact that Code A was immobile in hospital following Code A fall, which led to Code A developing pneumonia. Although the haematoma in the brain was quite large, it was in a very thin layer and therefore did not put any pressure on the brain and cause neurological problems.

**Code A** – 11 January 2006

Verdict – death due to recognised complication of necessary procedure

Dr Goggin went on his own to Inquest. No family concerns.

**Code A** – 25 January 2006

Verdict – Accidental death

Straightforward case of an elderly Code A (91), who had fall at home, fractured Code A femur, successful surgery, but developed bronchopneumonia and died.

**Code A** – 26 January 2006

Verdict – Accidental death

**Code A** had concerns about fracture not being diagnosed on first visit to A & E. Code A had reviewed the x-rays and no fractures could be seen, probably because it was undisplaced. It therefore either became displaced at a later date or Code A had another fall and the fracture occurred then.

**Code A** also concerned that Code A was discharged too early. Mr McLaren explained that Orthopaedically Code A had been fine to be discharged to the Nursing Home, but that the sickness was nothing to do with that and Code A was taking medication for it. He appreciated though why the **Code A** felt that Code A was discharged too soon. Nevertheless, Code A did not think that the date of discharge was a factor in Code A developing the pulmonary embolism. He thinks that that would have happened on the same day even if Code A had still been in hospital.

**Code A** – 27 January 2006

Verdict – Accidental death

Family concerns re delay in doing CT brain scan. Ed Neville explained that they now have a protocol containing specific criteria for grading the urgency of CT brain scans. Coroner pleased to hear that action had been taken as he would have followed it up with the Trust if it had not been done. Sheena to follow up whether the protocol has improved the situation.

Not certain whether the brain haemorrhage was due to the fall or not. Could have been just a small knock in view of Code A INR level because Code A had been taking the wrong dose of Heparin.

Family also felt that communication with the family about **Code A** condition was not very good.

**Code A** Pre-Inquest Hearing – 30 January 2006

Further reports required from **Code A** by 28 February. See file for Coroner's letter setting out directions agreed at the Hearing.

**Code A** – 1 February 2006

Death due to complication of necessary clinical and surgical procedures.

Family had questions about the experience of the nurse who took the blood gas sample where the haematoma arose afterwards and about the surgical procedure undertaken to reduce the pressure in the hand being cause by the haematoma. Dr Code A plained that both staff were experienced and the surgical procedure was done under aseptic conditions. He had never known a case like this before. Contributing factors were long term high dose steroids and Code A very high blood pressure.

As **Code A** was unwell and could not attend the Inquest today, Dr Code A offered the family the opportunity to bring **Code A** to see Code A at any time if they would find it helpful.

**Code A** – 7 March 2006

Verdict – died as a result of a complication of a necessary Orthopaedic procedure (traction) which was required following a fall on 10 October 2003 while Code A was a patient on Ward D2 at Queen Alexandra Hospital.

The Coroner raised 3 concerns that arose from the evidence and which the family had also raised and asked if any actions had been taken by the Trust about these:-

1. He thought the procedures for handover between Orthopaedic Consultants were sloppy and resulted in confusion.

Code A assured that the Coroner that this had improved now because the position with Service personnel is more stable. Also the situation had changed with regard to junior doctors. They were now attached to the Ward rather than to a particular Consultant which had made a difference.

2. The fluid charts were not properly filled in.

   Code A responded that there is no excuse for this and staff are constantly reminded about good record keeping. Since this case, one of the nurses on the Orthopaedic ward has done a study of chart completion and as a result, a patient review sheet has been instigated which is completed by the nurse undertaking the drug round. This system is currently being reviewed again and a new fluid chart if to be introduced Trust-wide.

   In addition, a new Nutritional policy is about the ratified by the Trust which it is hoped will also improve standards.

3. Liaison between the Consultant Orthopaedic Surgeons and the Physicians could be improved. It appears that the decision about removing the traction was delayed because of poor communication.

   Mr Hodkinson assured the Coroner that the Orthopaedic/Elderly ward is now a much more cohesive unit. At the time of Code A stay, it was in it's infancy and not working as well as it does now. He was sure that communication between the two specialties was much improved.

The Coroner was satisfied therefore that the Trust had done all it could to learn from Code A Code A experience.

Code A – 24 March 2006

Verdict – Natural causes

Family unhappy about bed sore that developed in nursing home. They think it was present before the date admitted by nursing home staff. Nursing home manager said that they had clear documentation of when the sore first appeared. Coroner agreed that the nursing home should arrange to show these records to the family after the Inquest as they did not have them in Court that day.

Code A – 29 March 2006

Verdict – Natural causes

Giving evidence for the Trust were Code A (Ward Manager D2) and the Pathologist was Dr Code A (SpR in Histopathology). Statements were also read from Sue Metcalfe (Modern Matron), Dr Code A (Consultant Physician) and Code A e (SpR in Orthopaedics). In attendance from the Trust were Code A (Head of Risk Management) and Code A Code A (Modern Matron).

Four members of the Code A family were in attendance: daughter, son-in-law and two male grandchildren. The Portsmouth News was also represented.

Although the family was, understandably, distressed the inquest was uneventful and the Coroner brought in a verdict of death by natural causes. I spoke to the family afterwards, to offer my sympathy and also to inform them that if they had any outstanding concerns to contact the Trust and we would make every effort to resolve those concerns.

The family's main concerns with Code A treatment at Portsmouth Hospitals NHS Trust seem to revolve around:

- The fact that Code A had waited so long for a CT scan (note: Code A was admitted on 1 April and the scan performed on 7 April)
- That if Code A had had the scan earlier and then been discharged immediately after that, Code A would not have fallen and subsequently contracted MRSA.

The family were also concerned

- That Code A GP would not come and visit Code A as Code A was staying with Code A Code A and that was 'out of area'.
- That when a GP did visit, very little was done
- When they called an ambulance it took over 8 hours to arrive and the family ended up taking Code A to RHH Accident Treatment Centre in their own car.

Code A Inquest – 31 March 2006

Coroner's Preamble:-

Code A was terminally ill with a comparatively short time to live. Steps needed to be taken to improve the quality of Code A remaining life. Code A had developed jaundice and was likely to die very soon if this was not resolved. There are two possible procedures that can be carried out in these circumstances, firstly ERCP which unfortunately could not be undertaken in Code A Code A case, and secondly, PTC. Although there were more risks with the second procedure, if it had not been undertaken Code A life would have been much shorter than without it. There was therefore no alternative. The procedure did have risks associated with it, such as bleeding. Dr Code A had explained today that the risks could be reduced by proper preparation. Unfortunately, Code A INR result was an old one. If the result of Code A blood test taken that morning had been known, the procedure would not have gone ahead. I believe it was reasonable for Dr Code A to assume that the result was up to date and that he could go ahead with the procedure and in my view, I believe that the two doctors have been let down by a defective system in that there was no place on the x-ray form for the date of the INR test and this information was vital.

Narrative Verdict

Code A was terminally ill with cancer. Code A underwent a PTC on 11 October 2004. This procedure was necessary to reduce Code A symptoms of jaundice and to extend Code A life and improve Code A quality of life. A recognised complication of PTC is internal bleeding, which is increased if the patient has poor blood clotting which is assessed by an INR blood test. Code A had a blood test on 6 October and the result was satisfactory for the PTC to be carried out. Prior to

the PTC, Code A underwent another INR test on 11 October. The result of this would have rendered the procedure unsuitable. The clinician carrying out the procedure had in front of Code A a checklist including the INR test result which he consulted before proceeding. In fact, the test result was from 6 October but the form did not have a date. Code A did not know that another test had been carried out that day and therefore did not know of its result. The PTC resulted in internal bleeding as a result of which Code A died on 16 October 2004.

Actions taken

The Coroner asked about actions taken and it was explained that all patients undergoing PTC are now housed on the Gastroenterology Ward, rather on an outlying ward as Code A was. This it was hoped, would improve communication and ensure that staff who had a good knowledge of procedures for these patients were close at hand. Secondly, the x-ray form now has a space for the date next to the blood test result and in the X-ray dept they have a large white board with all patients listed for the list that day with their test results and dates clearly displayed.

Likewise in the Gastroenterology dept, when they are performing ERCPs, the test results are actually printed out from the computer for the clinicians to view before the procedure is undertaken.

The Coroner was satisfied, therefore, that all appropriate steps had been taken to reduce the risks of such a situation occurring again.

Apology letter prepared to be sent to family by Chief Executive.

Code A – 12 April 2006

Verdict – Natural Causes

No contributory negligence on the part of the Trust. Code A offered a meeting with the family if they wished.

Code A – 21 April 2006

Verdict – died as a result of a complication (MRSA infection in wound site) of a necessary surgical procedure.

The Coroner commented that he felt Code A treatment was entirely appropriate.

Code A, Modern Matron for Orthopaedics gave evidence, along with Dr Logan and Dr Code A (Elderly Care) and Dr Code A (GP) and Dr Code A Pathologist.

Code A family made the statement that they were not critical of any individual member of staff but with the NHS as an organisation, as although Code A physical needs were met, Code A was not looked at as a whole person and Code A mental health needs in particular were not met. Also unhappy with communication. Staff must make sure that the information that is given to patients and their families is understood. They thought that doctors' did not visit sick patients at Jubilee House often enough. They were also concerned that their Code A developed MRSA .

They were also very distressed that they were not able to grant their Code A wish that Code A should not die alone as they were not given the opportunity to be there with Code A

**Code A** - 9th May 2006

Verdict – Natural Causes

Our witness – Dr **Code A**, DCC. Also Cardiology Surgeon from Southampton gave evidence about cardiac surgery that Code A had at Southampton before Code A admission to Portsmouth as an emergency. Family had concerns about treatment at Southampton and asked many questions, but no concerns about treatment at Portsmouth immediately prior to Code A death.

**Code A** - 12 May 2006

Verdict – Death due to a complication (infection) of a necessary surgical procedure.

Family had concerns about delay in changing antibiotics and dealing with the infection but Coroner did not think that these delays constituted a gross act of negligence.

**Code A** - 15 June 2006

Verdict – Natural causes

Family raised several concerns about GP and QAH treatment. Seemed to accept after the evidence was given that because of the rarity of **Code A** condition, the failure to diagnose the condition by the GP was understandable. Also that although there were concerns about hospital treatment, they did not contribute to Code A death.

Concerns were:-

- Communication – couldn't find out what was going on. On one occasion Code A operation was cancelled at short notice and they could not find out why for several days. They also received conflicting information/advice from nurses, doctors and physios.
- There was a nurse on the ward who could not speak English. She could not understand them and they could not understand her.
- Dressings were changed daily through the week, but not at weekends because the ward was mainly staffed by agency staff at weekends
- Code A Sotalol medication was not given on more than one occasion for different reasons (they did not have any at Haslar) which send Code A into tachycardia.
- On 16 August Code A was put on a heart monitor and the family noticed after some time that it wasn't working.

Gave **Code A** the address of Complaints Manager as Code A said to the Coroner that we wanted to follow up these issues with the Trust.

**Code A** - 30 June 2006

Verdict – Natural Causes

Family had concerns about appt when Code A was asked if Code A wanted the Chemotherapy that day or not as Code A blood count was low. Felt that Code A should have been advised whether or not to have it and not for Code A to make decision. Dr **Code A** agreed, but said that in the same circumstances, he would have given the chemotherapy, so the Registrar was correct to do so.

Explained that Code A died of bronchopneumonia and that Code A immune system would have been suppressed because of the cancer and the chemotherapy. Code A was therefore more susceptible to infection. Dr **Code A** could not say whether or not earlier admission to hospital would have made a difference **Code A** did not want to come into hospital), but said that it is always preferable to treat any infection asap.

**Code A** - 6 July 2006

Verdict – Natural Causes

Family voiced concerns about the nurses on the ward when **Code A** was calling for help and panicking. They apparently told Code A to calm down and that they had really sick people to attend to. It was later explained to Code A by a doctor that Code A was panicking because of fluid in Code A lungs which was making Code A feel as if Code A was drowning. The family wondered why the nurses did not realise this.

**Code A** had questions about the pulmonary oedema and asked if this hastened Code A death in any way. Dr G explained that Code A had not been given too much fluid and later when there was discussion about the cause of death with the Pathologist, it was made clear that **Code A** organs were in fact very much larger than they should be, not because Code A had been given too much fluid but because the lymphoma had spread to all Code A organs and the tumours were blocking the flow of fluid which could not escape. The cause of death was therefore changed on the death certificate to 1a Multiple Organ Failure 1b T Cell Lymphoma

After the Inquest **Code A** apologised to the family again if the nurses had upset **Code A** and suggested that they contact her personally if they thought of any other questions or wanted to discuss things further. She had already explained in her evidence that if a patient becomes anxious and it affects their breathing, it is very important that the nurses take control of the situation by getting the patient to focus on the nurse's voice to regain control of their breathing. They had of course been very sorry to hear the concerns of the family about their attitude.

**Code A** asked me to pass on the family's thanks to **Code A** for all the support he gave **Code A** which I did later that day.

**Code A** – 22 August 2006

Verdict – Natural Causes

Nine members of family present. They raised concerns about treatment:-

- The family did not know that Code A had an ulcer
- If Code A had an ulcer why didn't they treat it before it burst? It was explained that Code A was on the appropriate medication for Code A ulcer and that the timing of perforation of an ulcer cannot be anticipated. The family asked why Code A wasn't followed up to see if the medication was working. Explained that the only other treatment is surgery which is very rare nowadays. **Have checked in records since Inquest and Code A was actually given a Gastroscopy follow up appt for 26/8 but sadly Code A died before this on 21st.**
- Why was Code A discharged from hospital from previous admissions? **Have checked notes –**
    - **28/4/2004 discharged from medical bed, QAH – records say that Code A was much better and was eating well and was no longer vomiting.**
    - **25/6/2004 discharged from Phillip Ward (PCT) but in the notes it says that Code A could be discharged with a follow up to Trevor Howell Day Hospital for spirometry. Discharged with Frusemide, beta blockers and biphosphorate.**
    - **26/7/2004 discharged from F3 following Gastroscopy. Follow up appt made for 26/8/2006. Medication for ulcer prescribed. Discharged by Specialist Registrar who recorded that Code A was apyrexial and was keen to go home. Code A could go home after a blood transfusion.**
- If Code A diarrhoea had been treated earlier Code A might have been stronger and have stood a better chance of survival. Concerned that Code A picked up the infection when Code A was on the "amputation" ward. It was explained that the bug that Code A had was caused by the antibiotics Code A was taking for Code A chest infection. The antibiotics effect the balance of natural bugs in the gut and sometimes the bad bugs take over, particularly in elderly patients.
- During Code A last admission, Code A was left with no food and was really hungry. Mr Armstrong explained that Code A was being fed IV as any food would have inflamed the ulcer and made it worse.
- Code A was not given Code A heart medication while in hospital as far as they are aware (not sure which admission they were talking about.
- On one occasion, Code A feet and ankles became very swollen and were weeping fluid (not sure which admission). Despite asking staff on several occasions, the family could not get anyone to look at them. Eventually a doctor did look at them and prescribed medication which reduced the swelling.
- When admitted to MAU, Code A was left in a room with Code A and did not see a doctor for a long time. Code A had to carry Code A to the toilet and wait some time before nurses came to change the gown and bedding which Code A had soiled.

Following discussion, Dr Poller agreed that the cause of death was

1. Perforated ulcer
2. Pseudomembranous colitis

**Code A** – 6 September 2006

Verdict – Unavoidable complication following necessary surgical procedure

Family asked questions about medical terminology and reasons for various treatment but raised no concerns.

**Code A** – 26 September 2006

Verdict – death following necessary surgical procedure

Family asked whether it would have been better to have amputation than graft? Code A felt graft was the best option. There are risks with amputation as well, in view of Code A heart condition. Some concerns by family about communication, Coroner explained that this was not relevant to cause of death. One daughter was also concerned about the infection. Thought it was MRSA, but was not.

**Code A** – 5 October 2006

Verdict – death due to unforeseen complication of chemotherapy drug

Family concerned that Code A was told to continue taking the drug when Code A was showing signs of side effects from the drug. Dr Code A explained that the mild rash that Code A described over the phone after about 3 days of taking the drug was not an indication to stop the treatment. However, when she saw Code A in clinic later on (on Monday) and Code A symptoms were much worse, she advised Code A not to take the final dose that evening. Code A should therefore have had 5 tablets left (one dose) on the Monday. However, Code A wife said that he continued to take two lots of 5 tabs a day until the Thursday evening and Code A died on the Friday. Therefore, it was concluded that Code A had either been given too many tablets (but the pharmacy records confirmed that this was not the case) or Code A had not been taking the tablets according to instructions. Although Code A said that Code A was the type of person to make sure that Code A took tablets as instructed, it could only be concluded that Code A had made a mistake somehow.

The GP visited Code A on the Tuesday and said that Code A would be alright the next day. The family did not contact the GP or the hospital again until Code A became very ill on the Friday and Code A died at home a short while later.

This complication is very rare and Dr O'Callaghan has reported the death to the drug company and appropriate authorities.

**Code A** – 5 October 2006

Verdict – accidental death

Unfortunately even with hindsight, Dr Neville could not see a fractured rib on any of the films taken of Code A after Code A admission (plain films, ultrasound and CT scan), neither was the fact that Code A had had a fall before admission brought to the attention of the staff by Code A or Code A family. Several doctors examined Code A and did not see bruising in the rib area or find any

significant pain when examining Code A. Because Code A was treated for chest infection and/or PE, Code A was given a blood thinning drug which would not have been given had they known about the fractured rib.

**Code A** – 11 October 2006

Verdict – Open Verdict. In the absence of PM evidence, the Coroner could not determine whether the RTA played a part in the death, or whether the death was due to natural causes.

Family raised concerns about the hospital care ie

- the fracture in **Code A** foot was not diagnosed for some time after the accident
- they felt that the treatment of the foot was inadequate, and that on the last occasion Code A was discharged and **Code A** found Code A foot and leg up to the knee to be black
- they felt that they had been misinformed about the time of death and believe that Code A died earlier (possibly not noticed by staff?)

Also present at the Inquest was a solicitor representing Patient Transport Services' insurers, although she did not play an active part in the Inquest but was purely taking notes.

There is a possibility that **Code A** may pursue litigation against the Trust in respect of Code A hospital care and/or bring us into a claim against Patient Transport Services as the body that contracts the service with them.

**Code A** – 26 October 2006

Verdict – natural causes

No concerns raised about hospital treatment. Family's concerns were about the error made by Boots chemists with Code A prescription which led to overdose of Digoxin. Evidence suggested that the drug error was not a factor in Code A death.

**Code A** – 15 December 2006

Verdict – death due to known complication of a necessary surgical procedure.

**Code A** had concerns about the speed with which the second operation was carried out. Mr Code A explained that Code A felt the surgery needed to be done quickly in order to stabilise the spine so that they could sit Code A up in bed and mobilise Code A to prevent the complications that elderly patients develop when bed bound.

**Code A** was also concerned about the failure to identify the large abscess. Mr Harvey and Dr Al Badri, the Pathologist, both felt that this was a very rare occurrence. Mr **Code A** had only seen it twice in his 20 year career and Mr **Code A** had not seen it before. Mr **Code A** felt that **Code A** was not showing the usual signs of having an abscess and that this was probably because it was masked by all the other symptoms Code A was displaying caused by all Code A other medical problems. Dr **Code A** agreed that there were no signs of such a large infection from outside the wound, which would normally be expected to be red and discharging pus.

Code A - 29th January to 6th February (Jury Inquest)

Verdict – Natural causes

Witnesses – Code A Dr Kayode Adeniji

The Trust had no concerns about the treatment provided but the family had obtained an expert report which said that Trust staff should have diagnosed and treated Code A herpes simplex encephalitis and that had they done so, Code A would not have died. However, the Jury clearly favoured the evidence given by Trust clinicians and the expert opinion from Professor Wade (an independent expert obtained by the Coroner).

Code A - 26th March 2007

Verdict – Death due to industrial disease

Witnesses – Dr Code A & Pathologist, Dr Code A

Dr Poller originally felt that Code A bronchopneumonia was due to heart failure but having heard Dr Code A evidence at the Inquest hearing, he concurred with Dr Chauhan's views and changed the cause of death to:-

1a Bronchopneumonia
1b Pleural effusion
1c Asbestosis

Code A - 10 April 2007

Trust represented by Counsel, Sarah Simcock.

Narrative verdict:-

On 28th November 2005, Code A underwent an operation for removal of Code A gallbladder at the Royal Hospital Haslar in Gosport. Code A gallbladder was successfully removed and some oozing of blood from the gallbladder bed was dealt with before the conclusion of the surgery. However, internal bleeding at the site of the surgery recommenced when Code A returned to the ward. This was not recognised by a clinician and Code A died as a result of internal bleeding at about 4.20 am on 29th November 2005.

Witnesses – Code A Dr Manish Patel

Code A - 24 April 2007

Verdict – Died as a result of a necessary surgical procedure

Code A gave evidence.

**Code A** - 25 April 2007

Verdict – Accidental causes – death was unforeseen and unpredictable.

Mike Thompson, Consultant Surgeon, gave evidence.

**Code A** - 25 April 2007

Verdict – Natural causes. Neither the fall, which occurred on the ward, nor the speed with which medical staff acted, contributed to the death. The bleed was spontaneous in nature and could have occurred at any time.

Dr Graves and **Code A** gave evidence.

**Code A** - 8 May 2007

Verdict – Natural causes.

Witnesses – Dr Code A Consultant Gastroenterologist
- Ms Anne Taylor, Senior Nurse/Modern Matron, Medical Wards, QAH

Coroner said that the law says he has to be convinced that on the balance of probabilities the drug error contributed to the death. The evidence was not therefore sufficient to support that and so a natural causes verdict was the only one open to him. He was concerned about the drug error but was pleased to hear that the Trust had taken steps to improve training and were working hard to reduce drug errors, although he acknowledged that there was some way to go with this.

There was also concern raised that there seemed to have been a delay of 21 hours from the time of the knowledge of the drug error before a blood test was taken.

The family felt that the drug error definitely induced their **Code A** coma which meant that they were robbed of the last few weeks/months of Code A life and did not have the opportunity to say goodbye to Code A Dr **Code A** i, the independent Pathologist, felt that Code A condition was such that Code A could have deteriorated in this way at any time without the drug error, although they could not say for certain that it did not hasten **Code A** death.

**Code A** - 15 May 2007

Verdict – Accidental death

Witness – **Code A** Consultant Surgeon

Family accepted **Code A** report and seemed to understand why the operation was not carried out sooner. They were a little concerned that things were not explained to them at the time and they had not understand what was going on. After the Inquest, **Code A** apologised to the family for not arranging to see them immediately after the death to go through the course of events with them. It is a problem when the patient goes to ITU, as the family do not see the surgeon afterwards. He thinks it is something that they should make more effort to do.

**Code A** – 23rd May 2007

Verdict – death due to recognised complication of a necessary procedure.

Witness – **Code A** Consultant Gastroenterologist

No family concerns or issues raised. Case discussed at Audit meeting, no concerns raised.

**Code A** – 23rd May 2007

Verdict – Accidental death (as a result of an innocent act).

Witnesses – Dr M Roland, Consultant Respiratory Physician
Dr J Thompson, House Officer

No family concerns. **Code A** thought that the combination of Aspirin and Clopidogrel may have played a part in the amount of bleeding that occurred in this case. He has searched the literature and found no other cases, but a colleague of his is going to write this case up and possibly another case that has happened locally involving a patient on Aspirin and Clopidogrel who bled.

**Code A** – 25 May 2007

Verdict – death due to recognised complication of necessary spinal surgery
Witnesses – **Code A**

Family's main concerns were that Code A was sent home after the first A & E attendance, that a neck fracture was not suspected at Code A second A & E attendance so Code A was not put in a brace and thirdly that the nurses on MAU forced Code A head down so that Code A was laying flat which they think made the fracture worse.

SUI form has been completed but investigation has not taken place to my knowledge. Checking on this.

**Code A** – 21 June 2007

Verdict – natural causes
Witness – Dr Paul Sadler, Consultant in Critical Care & Anaesthesia

Family concerns about infections (MRSA & clostrium difficile). Explained that Code A was very vulnerable to infection as Code A had multi medical problems (diabetes mellitus, hepatitis and liver cirrhosis. Code A had already been colonised with MRSA from previous hospital attendances (Kings College Hospital) and Code A could also have had the clostrium difficile bug before admission which may have been activated by the antibiotics Code A was on for the urine infection, although we cannot be certain. Every effort was made by CCU staff to bring through this illness but unfortunately they were unsuccessful.

**Code A** 26 June 2007

Verdict – natural causes
Witness – Code A Specialist Reg, Medicine

No family concerns at all.

**Code A** 4 July 2007

Verdict – Natural causes

Trust Witnesses – **Code A**

Other witnesses – GP and **Code A** Pathologist

Family were legally represented and raised concerns about:-

- treatment prior to admission and possible delay in diagnosis of endometrial cancer.
- Whether or not surgery was appropriate
- Why when Code A seemed to be recovering well from the surgery, did Code A have a cardiac arrest. Was this due to poor post-op care
- Time of death – seemed to feel that staff were covering something up

Satisfactory responses to concerns given by witnesses (including the GP and Pathologist). Coroner satisfied that there was no evidence of neglect.

**Code A** 18 July 2007

Verdict – death due to complication of necessary surgical procedure

Trust witness – Code A Consultant Nephrologist

Family had some concerns about the amount of pus found in the abdomen and wondered why the infection had not been picked up earlier. Dr Lewis explained that diabetics with gastroparesis do not feel pain as their nerves are dead. Pain is the most important sign of infection.

They also thought there was a delay in taking Code A to the operating theatre but Dr Lewis explained that there was very little chance of Code A surviving an operation and the surgeons only agreed to operate following persuasion from the Physicians. Unfortunately, Code A died as Code A went into theatre before the surgery took place.

Family also had some concerns about nursing care which the Coroner suggested they should take up with the Trust as they were not related to the cause of death.

**Code A** – 18 July 2007

Verdict – natural causes

Trust witness – Code A, Consultant Respiratory Physician

Family thought that the death was related to the wheat and grain Code A was exposed to in the Dockyard and therefore wanted a verdict of Industrial disease, but both the Pathologist and Dr Dakin agreed that the findings at PM did not support this verdict.

**Code A** – 9 August 2007

Verdict – Coroner gave a narrative verdict when he said that ambulance breakdown was a mechanical fault which could not have been foreseen, and that all the ambulance and hospital staff did everything they could to save Code A If this had happened in Code A home Code A would give the verdict of Natural causes. Code A planned to write to Mercedes Benz about the mechanical fault in case it is was caused by a manufacturing fault, as the mechanic witness said that he had seen it happen before, albeit only once.

Trust witness – Code A Clinical Fellow, A & E Dept.

**Code A** 14 August 2007

Verdict – death due to complication of necessary surgical procedure. He added that there was no gross failure or neglect.

Trust witnesses – **Code A**

Main family concern was the multiple attempts that the junior doctor made to insert the neck line and the subsequent bleeding. They felt that Code A deteriorated quickly after that and that it may have hastened Code A death. They were reassured that the doctor in question had the necessary expertise to perform the procedure and that it is not unusual to have to make more than one attempt. There is also no guideline to say that if the procedure fails on one side of the neck, that the other side of the neck should not be tried. Dr Leach felt it was impossible to say whether or not the neck line insertion had made any difference to the outcome but he added that there were signs that Code A Code A was deteriorating before the neck line inserted.

**Code A** – 22 August 2007

Verdict – natural causes

Trust witnesses – **Code A** Consultant Respiratory Physician
ssociate Specialist, Medicine for Older People
, Modern Matron, General Medicine, SMH

One Code A had concerns about nursing staff not helping Code A to eat and also about the Oromorph which Code A felt had hastened Code A death. Code A believed that Code A was treated for cancer which the Pm report found Code A did not have and that the drugs for that (Oromorph) killed Code A Dr Code A explained that the amounts of Oromorph that Code A was given was entirely appropriate for Code A as although Code A did not have cancer, Code A was terminally ill. The pain that Code A was in is quite common for someone who is dying as all the organs are shutting down which causes pain.

Although mesothelioma was not found, the Pathologist accepted Dr Chauhan's views that the pleural effusion was caused by Code A light asbestos exposure and agreed to add at 1b Asbestos exposure.

Rest of family were happy with the outcome of the Inquest and had no concerns (spoke to another Code A outside the Inquest). Not sure if the Code A with concerns will pursue a complaint with the Trust.

Code A 29 August 2007

Verdict – natural causes

Trust Witnesses – Code A pecialist Registrar
- onsultant Cardiologist
- , Consultant Physician & Nephrologist

Other witnesses Code A athologist
Consultant Cardiologist, Southampton

Family had concerns which they explained to me after the Inquest had been answered by the Inquest. They now understood and did not think they would be taking their complaint any further.

Code A – 27 September 2007

Verdict – Open

Trust witnesses Code A Consultant Surgeon
Davies, Ward Sister, E2 Ward, QAH

Other witnesses Code A, Pathologist
Psychiatrist, Hampshire Partnership PCT

The Coroner thought that the process for the Trusts obtaining a psychiatric assessment was very cumbersome and unclear. He thought the Trusts involved should look at improving this, to include the availability of the Hospital Self Harm Team based in A & E Dept.

The family thanked Code A for his efforts to try to obtain a psychiatric assessment and thought that Dr Code A was wrong not to visit Mark just on the say so of a nurse on the surgical ward who was not a trained psychiatric nurse.

Code A - 10 October 2007

Verdict – Accidental death

Trust witnesses – Code A A & E Consultant

Other witnesses – Police Sergeant
Code A

No concerns. Family wanted to thank all the hospital staff for everything they did for Code A also thanked the GP.

Code A - 16 October 2007

Verdict – Accidental death

Trust witnesses – Sue Metcalfe, Modern Matron, Medicine

Family explained that Code A was a very independent Code A and they quite believed that Code A would get up and go to the toilet on Code A own without her zimmer frame. The only concern they raised was that the doctor who told them that Mrs D was to be moved to Ashdown 1 ward spoke to them like children and did not explain properly what sort of ward Ashdown 1 ward was. They did not understand until they reached the ward that it was a palliative care ward.

They praised the staff on Ashdown 1 ward and asked for this message to be taken back to the Trust. They thought the staff were "angels".

William Yalden – 7th November 2007

Verdict – Accidental death

Trust witness – Code A Consultant Orthopaedic Surgeon

No family concerns. No questions asked.

Code A - 23 November 2007

Verdict – Natural causes

Trust witness – Code A Consultant Orthopaedic Surgeon

No family concerns

**Code A** – 28 November 2007

Verdict – Natural causes. The Coroner said that he was satisfied that Code A had appropriate treatment and that there had been no neglect.

Trust witness – **Code A**, Consultant Endocrinologist

Coroner's question:-

1. If the diagnosis had been made during 1st admission, what difference would it have made?

   IC responded that if the scan identified the abscess during the first admission, the treatment would have been the same ie antibiotics, but Code A would have stayed in and probably been on them longer, but that might have led to fungal infection as well which could have made things worse. Code A would not have been fit for surgery on the first admission.

Family questions:-

1. They referred to IC's mention that Code A had had a history of fungal infections but they were not aware of that, apart from shortly before Code A admission. IC explained that because of Code A diabetes and high BP Code A would have a lower resistance to infection. It was Code A understanding that Code A had had two courses of antibiotics and one course of antifungal medication prior to Code A admission.

2. What are normal inflammatory markers? IC said that that would be less than 5, but "normal" is different for different people and in someone with Code A health problems, he would expect normal to be in the 20 – 40 range.

3. During the 2nd admission, the family said that they had had a discussion with a Microbiologist who had told them that they were going to put Code A on antibiotics. When the family responded to Code A that Code A had already had antibiotics, she said that she knew that but that there had been a gap when Code A went home after the first admission. They wanted to know what different the gap in antibiotics had made. IC responded that in all honesty Code A could not say whether there would have been a different outcome had Code A continued on antibiotics but Code A suspected not.

**Code A** – 4 December 2007

Verdict – Natural causes

Trust witnesses – **Code A** Consultant & Anaesthetist
Consultant Vascular Surgeon

No family concerns other than communication. Surgeon came out of theatre and said Code A was stable and would be going to ITU. He told them that they should go home and see their Code A in the morning. However, 10 minutes after arriving home, they were telephoned and told that their Code A had died. It was explained that the Surgical Registrar had left theatre immediately following the surgery to speak to the family but that while he was doing that, Code A deteriorated very rapidly and he would not have been aware of that. Apologies were offered to the family for this as it was appreciated that they would have stayed if they had known how poorly their Code A was.

**Code A** – 4th Decemebr 2007

Verdict – death due to a complication of a necessary procedure (neck catheter).

Trust witnesses – **Code A** Registrar
Consultant Nephrologist

No family concerns.

**Code A** – 5 December 2007

Verdict – Natural causes

Trust witness – Code A, Consultant Cardiologist

Code A partner recalled that they visited Haslar Treatment Centre when Code A was feeling unwell and Code A had been given a GTN spray. Code A collapsed shortly after taking this and Code A felt that Code A never really recovered after that. Code A wondered if the GTN spray had caused Code A general decline. Dr Code A said that with hindsight, as Code A blood pressure was quite low when Code A attended Haslar, the GTN spray should not perhaps have been given to Code A or maybe only a lower dose. However, he was fairly certain that this did not have a long term effect on Code A as by the next morning when he saw Code A Code A was back to Code A old self again and Code A BP was back to normal.

**Code A** – 8 January 2008

Verdict –

Trust witnesses – **Code A** Consultant Paediatrician
Paediatric Registrar