4th
SUIs.
CG.

Fareham and Gosport NHS
Primary Care Trust

Serious Untoward Incident Report

What happened: A male patient (MJ) died at 17.00 hours on Saturday, October 2nd 2004 in Gosport War Memorial Hospital within 24hours of his move from St Christopher's Hospital, Fareham.

Background information:

Due to environmental conditions, the PCT Board made the decision to discontinue providing in–patient services at St Christopher's Hospital, Fareham from October 1st 2004.

The two patients remaining on this date were transferred to Gosport War Memorial Hospital by private ambulance.

MJ was 86 years old and was a Category 2 continuing care patient awaiting a Nursing Home placement. He had multiple pathologies - severe disability and handicap. He had a history of refusing food and seizures, which were managed with medication. He had a suprapubic catheter in place.

Timetable of events:

27.09.04 MJ was reviewed by Professor Severs his Consultant

29.09.04 MJ was reviewed by Clinical Specialist. Considered fit to transfer.

01.10.04 MJ was fed a good breakfast
The check list of procedures to undertake prior to the transfer of frail elderly patients was completed and is filed in the medical notes.
MJ was transferred to Gosport War Memorial Hospital by ambulance.
MJ was reviewed by Dr Wahdati SHO on arrival at 12.40pm – nothing untoward reported.
18.00pm MJ had a seizure and medication was given as prescribed. Family were telephoned but did not visit.
MJ became noisy and was transferred to a side room. (MJ's behaviour was normally loud and when agitated he would shout out constantly.)

02.10.04 MJ deteriorated over night – low blood pressure and blood pressure had dropped. It was noted that MJ was not for resuscitation.
08.50am MJ vomited

The family were informed and visited the ward in the morning.
Clinical Specialist was informed and also visited in the morning.
After discussion with the Specialist Registrar at Queen Alexander's Hospital- -and MJ's family a palliative regime was started.
A syringe driver was set up at **12.45pm** and 10 mg of diamorphine prescribed over 24hours.
MJ continued to deteriorate and died at 17.00pm.
The family were informed at 17.15pm and returned to the ward at 17.40pm.
The cause of death was septicaemia/urinary tract infection/sub dural haemorrhage and exhaustion.

04.10.04 The family collected the Death Certificate.
Coroner advised that a new death certificate be issued as the registrar was unable to accept the stated causes of death. The original death certificate had been issued under the supervision of Professor Martin Severs, who knew MJ well. Professor Severs felt that given his age, the number of pathologies (15), his profound disability, the low blood pressure and the vomiting, the most likely cause of death was septicaemia. The second certificate was written following consultation with the Staff Grade and Dr Althea Lord
CEO and Chair of the PCT were informed.

05.10.04 An apology was given to the family for the necessity of reissuing the death certificate and they collected it in the evening.
Executive Team, Medical Director were briefed.
Communications team were informed.
SUI declared and StHA was informed.

Analysis:

Patient factors: 86 frail disabled man with multiple pathologies, a suprapubic catheter in place, a history of seizures, refusal to eat and loud behaviours. It is noted that he was not for active resuscitation and after discussion with specialist colleagues and the family, the clinical specialist prescribed a palliative regime.

Individual factors: None

Team Factors: The clinical teams at both St Christopher's Hospital and Gosport War Memorial Hospital carefully observed the procedures for the transfer of frail elderly patients and MJ was given exemplary care and the family fully informed at all times. The ward was fully staffed and the out of hours clinical specialist ward rounds in progress on Saturday am.

Communication: The reporting of the incident to the executive team was slow and the designation of the incident to a SUI was late.

Task Factors: The procedure for the transfer of frail elderly was observed correctly.

Education and Training Factors: Not relevant

Equipment and Resource factors: The suprapubic catheter was recently replaced at Queen Alexander's Hospital.

Working Conditions: As of October 1st 2004 St Christopher's Hospital no longer provides in patient facilities as the environmental infra-structure is considered to be too unpredictable.

Prior to this date a major project of reprovision has been implemented and 28 patients have been moved, according to their needs, into Nursing Homes, their own homes or transferred to Gosport War Memorial Hospital.

MJ was one of the last two remaining on October 1st 2004. He was considered fit to move and was transferred in a private ambulance.

Should he have been considered unfit to move, contingency arrangements would have been made to keep him at St Christopher's over the weekend. However it would not have been practical or suitable for him to remain at St Christopher's alone for an indefinite period.

ACTION PLAN

1. More support to the clinical teams in the reporting of an adverse incident and the application of the designation of a SUI, to ensure a more timely reporting of events in the future.
2. Out of Hours Clinical Managers will be encouraged to report deaths at Gosport War Memorial Hospital to the Senior Manager on Call who may then discuss the scenario with the Director on call.