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7 August 2017

[redacted]

By email
[redacted]

Dear [redacted]

Request under the Freedom of Information Act 2000 (the "FOI Act")

I refer to your email of **07 July 2017** in which you requested information under the FOI Act from NHS Improvement. Since 1 April 2016, the Patient Safety functions under section 13R of the NHS Act 2006 have been exercised by the NHS Trust Development Authority (NHS TDA). The NHS TDA is now part of the integrated organisation known as NHS Improvement.

Your request

You made the following request:

"How many incidents were categorised as death incidents in England under NRLS for the period 1.1.16 to 31.12.16 under the incident types (i) medical device/equipment, and (ii) access, admission, transfer, discharge?

For each of these incidents please provide me with a summary of what took place. The level of detail that I would require you to provide would be similar to that provided in a previous FoI response (Ref: SDR-128420)"

Decision

NHS Improvement holds the information that you have requested.

NHS Improvement has decided to withhold some of the information that it holds on the basis of the applicability of the exemptions in section 40 and 41 as explained in below.

The information we hold is from the National Reporting and Learning System (NRLS). By way of background, some information about the NRLS may be helpful. The primary purpose of the NRLS is to enable learning from patient safety incidents occurring in the NHS. The NRLS was established in late 2003 as a largely voluntary scheme for reporting patient safety

incidents, and therefore it does not provide the definitive number of patient safety incidents occurring in the NHS.

All NHS organisations in England and Wales have been able to report to the system since 2005. In April 2010, it became mandatory for NHS organisations to report all patient safety incidents which result in severe harm or death. All patient safety incident reports submitted to the NRLS categorised as resulting in severe harm or death are individually reviewed by clinicians to make sure that we learn as much as we can from these incidents, and, if appropriate, take action at a national level.

The NRLS is a dynamic reporting system, and the number of incidents reported as occurring at any point in time may increase as more incidents are reported. Experience in other industries has shown that as an organisation's reporting culture matures, staff become more likely to report incidents. Therefore, an increase in incident reporting should not be taken as an indication of worsening of patient safety, but rather as an increasing level of awareness of safety issues amongst healthcare professionals and a more open and transparent culture across the organisation.

In total 16 patient safety incidents were reported to the NRLS, where the incident was categorised as 'medical device/equipment' and the outcome was reported as death by the original reporter; and occurring between 1st January 2016 and 31st December 2016 (based on the date the incident was reported to have occurred) and exported to the NRLS on or before 17th July 2017.

In the same time period for the category 'access, admission, transfer, discharge' there were 137 incidents reported to the NRLS as death by the original reporter.

Table 1. Breakdown of the 153 incidents categorised as 'medical device/equipment', and 'access, admission, transfer, discharge' where outcome was reported as death.

Year	Incident category		Total Incidents
	medical device/equipment	access, admission, transfer, discharge	
2016	16	137	153

In response to part 2 of your request, Annex 1 below provides a summary of the 153 patient safety incidents reported as occurring between 1st January 2016 and 31st December 2016.

Section 40 – personal information

NHS Improvement considers that some information is exempt from disclosure under section 40(2) of the FOI Act on the grounds that it amounts to personal data and the first condition under section 40(3)(a)(i) is satisfied, namely, that disclosure would amount to a breach of the first data protection principle (personal data should be processed fairly and lawfully) as the individuals concerned would have a reasonable expectation that their information would not be disclosed into the public domain.

Section 40 is an absolute exemption and consideration of the public interest in disclosure is not required.

Section 41 – information provided in confidence

NHS Improvement considers that some of the withheld information is exempt under section 41 of the FOI Act on the basis that it was obtained by NHS Improvement from a third party, disclosure of which would give rise to an actionable breach of confidence.

Section 41 is an absolute exemption and does not require the application of the public interest test.

Review rights

If you consider that your request for information has not been properly handled or if you are otherwise dissatisfied with the outcome of your request, you can try to resolve this informally with the person who dealt with your request. If you remain dissatisfied, you may seek an internal review within NHS Improvement of the issue or the decision. A senior member of NHS Improvement's staff, who has not previously been involved with your request, will undertake that review.

If you are dissatisfied with the outcome of any internal review, you may complain to the Information Commissioner for a decision on whether your request for information has been dealt with in accordance with the FOI Act.

A request for an internal review should be submitted in writing to FOI Request Reviews, NHS Improvement, Wellington House, 133-155 Waterloo Road, London SE1 8UG or by email to nhsi.foi@nhs.net.

Publication

Please note that this letter and the attached information will shortly be published on our website. This is because information disclosed in accordance with the FOI Act is disclosed to the public at large. We will, of course, remove your personal information (e.g. your name and contact details) from the version of the letter published on our website to protect your personal information from general disclosure.

Yours sincerely,

NHS Improvement

Annex 1

	IN05 Incident Category - Lvl2	IN07 Description of what happened
1.	Medical device / equipment	I was working on response car [number] and deployed to 999 call for male SOB . The patient was known COPD and was having severe difficulty in breathing . The patient was given nebuliser . A double technician crew [number] also arrived on scene . I travelled with the patient and a pre alert was given to [name] Hospital . Whilst en route to hospital the patient breathing started to deteriorate . I took the bag and mask from response bag and found that it was a paediatric bag and mask . I asked [initials] to pull over so we could get a spare adult bag and mask from the cupboard below the stretcher . We could not locate a spare adult bad and mask in the usual spares cupboard . I then had use the paediatric bag and mask to assist ventilations for approximately 4 minutes until we arrived at A / E. On arrival at A / E the awaiting nurse provided me with an adult bag and mask . The patient was taken into resus . After transfer the cupboards to ambulance where checked again and a spare adult bag and mask was found in a different cupboard . .
2.	Access, admission, transfer, discharge (including missing patient)	Excessive delay - 37 min response time for cardiac arrest , p / t deceased on scene with the crew .
3.	Access, admission, transfer, discharge (including missing patient)	Patient inpatient on [name] ward with alcoholic liver disease - absconded from ward and missing patient document completed including police contact (last seen on ward at [time]) - log [number] . Found by passer by in NHS car park at [time] in cardiac arrest . Patient RIP . .
4.	Access, admission, transfer, discharge (including missing patient)	written in retrospect patient admitted with infected pyoderma gangeriosm , patient had cardiac arrest and died . .

5.	Access, admission, transfer, discharge (including missing patient)	patient developed acute gi bleed , unable to stop bleeding so required embolization . Transfer to ITU [initials] agreed . HDU ambulance requested at approx 17.30 from [initials] medical , however this failed to arrive in timely manner (arrived after 21.00) and patient became unstable to transfer . Patient arrested at 18.30 in ITU due to hypotension , ROSC taken to theatre however bleeding unable to be stopped and patient died at 23.30 . .
6.	Access, admission, transfer, discharge (including missing patient)	JOB [number]Initial code [number] 22:39 , triaged by [emergency service] and upgraded to R2 22:47 as known AAA and severe back and abdominal pain . Crew at allocated and mobile 22:57 and at scene 23:24 . 23:35 crew advised patient deceased and asked for Police to attend . No nearer resource and [place] unable to assist . .
7.	Access, admission, transfer, discharge (including missing patient)	Patient admitted to Ward [number] [date] with diarrhoea and dehydration secondary to Radiotherapy Transferred to ambulatory assess [place] unit [date] at night as for discharge Discharged home [date] at 11.30 Returned to A&E with possible sepsis / necrotising facitis on [date] at 17:29 Patient died [date] at 08.30 . .
8.	Access, admission, transfer, discharge (including missing patient)	Patient was seen on the Ambulatory Care Unit (part of the acute medical service) . He was seen by myself who felt him to have gastroenteritis , for which treatment was given and he was discharged home . He represented the following morning ([date]) in extremis and was found to have an extensive haemorrhagic stroke . . This was unexpected and unanticipated by myself , and due to the severity of later presentation should be considered for thorough investigation . . .
9.	Access, admission, transfer, discharge (including missing patient)	I have been informed by the Police that a patient known to the Trust has died [[Number]] . I was intending to undertake a joint visit with the PCSO concerned before I was notified of the death [see progress notes] . There is no suggestion of untoward event or Coroner involvement , and it is believed that the death was as a result of natural causes as the patient [aged 70] was in poor overall health . . I am writing to patient GP , requesting additional information about the death , and will also speak to housing support workers if this is necessary . Managers at [place] have been informed , and requested Datix completed . .

10.	Access, admission, transfer, discharge (including missing patient)	I was working in Ward [name] day assessment on Friday [date] , registrar had accepted a patient from GP ?sepsis , but attended A&E via ambulance . Nurse called to handover the patient and I was informed had 3 day history of fever and lethargy but is tolerating diet and fluids awake and alert , pews score 2 for tachycardia and family concern , but BP and otherwise stable . I informed nurse that as she attended via ambulance although patient was accepted by paediatrics , that will still need to reviewed by A&E doctor and that with tachycardia of 176 that she will needed to be considered for sepsis 6 pathway . I received another call regarding the patient after child reviewed by doctor , and was informed that impression was tonsillitis and slight dehydrated hence tachycardia , so plan was for oral fluid challenge which had been commenced and for paeds review as had been accepted . No urine sample as not passed urine in department yet but has had some loose stools otherwise no change . Registrar verbally informed and based on information given was happy for child to attend ward as had already accepted from GP . Cubicle prepared for patient due to loose stools . When patient arrived on ward looked very unwell , pale / yellow , red blotching rash to cheeks of face , tracheal tug and moderate work of breathing , monitoring applied immediately , tachapnoeic , pews=4 [Information withheld under section 40 of the Act] . Spoke with nurse from A&E and highlighted that child looked very unwell and that this was not communicated in the handover just pews 2 for family concern and tachycardia , nurse said doctor said child was safe for transfer and I then asked did she think the child was to transfer which she replied that the child did not look this unwell in A&E , however on reviewing the A&E documentation that last set of observations recorded , the pews score documented was 3 although was tachycardic , tachapnoeic , moderate work of breathing identified and family concern , however this was not communicated to myself or ward . Rest of handover taken . Nurse practitioner located and attended immediately and then registrar to start treatment . .
11.	Access, admission, transfer, discharge (including missing patient)	Informed by nursing team on [name] ward that informal patient , recently discharged in absence after going AWOL , had been discovered deceased . There are suspicious circumstances around his death as he was found to have trauma to his head. A post mortem examination revealed [initials] died from multiple injuries and had suffered serious burns . ' [Information withheld under section 40 of the Act] . '

12.	Access, admission, transfer, discharge (including missing patient)	At 21.22 a 999 call was received from a member of the public walking past patients home . Caller states he heard a male shouting for help from inside the home but did not approach the address . The call was coded as a G2 and the EOC informed the police who arrived on scene at 23.13 and called in a further call . This call was coded R1 as a cardiac arrest . [trust] allocated a resource at 23.15 but on arrival the patient was deceased . .
13.	Access, admission, transfer, discharge (including missing patient)	Job nr [number]- Job came in as pre - alert R1 - recoded to R2 then back to R1 as pt had arrested during interrogation . Pt is now deceased . . Overall response time of 13 minutes . .
14.	Access, admission, transfer, discharge (including missing patient)	Call has come in for R1 cardiac arrest - response time was 15.02 . Pt is deceased .
15.	Access, admission, transfer, discharge (including missing patient)	despatched to call [number], advised en route that patient in cardiac arrest in the street , i asked what backup was available , advised [call sign] further update requested advised trying other [place] for crew . waited approx 30 minutes on scene for back up . .
16.	Access, admission, transfer, discharge (including missing patient)	Call came through on 999 for a patient that had fallen and sustained an eye injury - traiged to non ambulance disposition which the patient refused and call went for a clinical call back - there was a delay of 45 minutes for a call back from the clinical desk and the patient didnt answer . The clincian tried a number of times to call back and phoned round hospitals but patient had not self - presented . The call was then upgraded 1 hour and 21 minutes after the orginal call ended . Crew arrived on scene at 20:34 . The Fire Brigade were called to assist with access and on entering the property the was found deceased (dispatcher informed at approx 21:16 - 42 minutes after booking on scene) . If the policy of upgrading a clinicain immediate call back to a Cat C 30 after 20 minutes was adheard to then this may have been prevented . .
17.	Access, admission, transfer, discharge (including missing patient)	Patient brought to A&E by ambulance in full cardiac arrest , patient found at home following a house fire . Patient had been discharged from [place] by ambulance today at 15:20 . [Information withheld under section 41 of the Act]

18.	Access, admission, transfer, discharge (including missing patient)	Resident was last seen sleeping in his room and around 14.30 a support worker reported to the nurse that resident wasnt responding . At 15.45 nurse recorded that she called the GP surgery requesting an urgent home visit and the receptionist advised her to send a fax which was sent at 16.30 . The nurse received a call from the surgery at 17.00hrs and was informed that the GP advised to call for an ambulance . At 17.05 an ambulance was summoned , while waiting for the paramedics to arrive , the emergency service called to inform the nurse that the ambulance will come soon and advised the nurse if patient becomes worse to call them back . Resident was later escorted to hospital at 20.15 .
19.	Access, admission, transfer, discharge (including missing patient)	72 F admitted under physicians [date] with 5-6 / 52 history of diarhhoea . Previously well , good performance status . Seen by surgical cons oncall [date] post take morning round . Clinically dry , tender both iliac fossa . High CRP . Likely diagnosis of colitis ? Urgent CT requested . On - call SHO ATSP ~ midday due to episode of hypotension , fluid challenge given with improvement in BP . Abdo signs , more tender RIF and LIF . No signs of generalised peritonitis . CT 14.30 - free air and fluid note . Pt consent - for laparotomy . CEPOD theatre , laparotomy in progress . Discussions ~ 15.00hrs to open second theatre . No anaesthetist available . On - call anaesthetist occupied with ongoing emergency laparotomy . Situation escalated to relevant CD . Unable to provide any additional anaesthetic support . Further deterioration on ward 17.30 - 18.00hrs , fluid resus given , ITU reg present . D / W ITU cons + staff to transfer to ITU for support . Taken to anaesthetic room CEPOD theatre , ~20.00hrs . Pt on table 22.00hrs . Surgery end 12.30 ITU post - op . Died [date] . Delay in getting to theatre . Preventable death . .
20.	Access, admission, transfer, discharge (including missing patient)	This patient was brought to [place] ED post chest stabbing [day] early afternoon by the [emergency service] team . He was at the time clinically stable . He deteriorated with recurrent pericardial tamponade which was repeatedly drained . He was blue light transferred to [place] CTC with the ED consultant in attendance but arrested 2 minutes from the CTC and has since died . The [emergency service] team should have taken a chest stabbing to [place] not a trauma receiving unit with no cardiothoracics on site .
21.	Access, admission, transfer, discharge (including missing patient)	[Information withheld under sections 40 and 41 of the Act]

22.	Medical device / equipment	Emergency call raised within the ward at 22:15 , MET call put out by HCA on ward . On arrival patient making no respiratory effort and unable to feel pulse , DNAR form located within patients notes , when medical team arrived no input needed , patient passed away . Other staff members present throughout same and patients named nurse (see statements) started to remove O2 . Difficulty in turning o2 off via the connection site by x 2 staff members (see statements) and a leak identified within oxygen connection system . No O2 going through the oxygen mask upon further examination . Above escalated accordingly . Equipment bagged and kept . .
23.	Access, admission, transfer, discharge (including missing patient)	Patient transferred from [name] Care unit at midnight to [ward] due to capacity issues and [place] needing to take a patient from theatre . [ward] had to go one up and moved the most suitable patient they had into this bed so they could take the patient from [place] . The patient was transferred over with an EWS of 3 . By the time he arrived onto [ward] an initial set of observations was completed and he scored an EWS of 9 . [ward] were already one Registered nurse short on the night shift . The patient arrested shortly after and the team were called to attend . Resuscitation was successful however 4 hours later the patient passed away . A DNAR form had been completed after the first arrest . .
24.	Access, admission, transfer, discharge (including missing patient)	baby found with mim pale and blue to extremities . not breathing . heart rate less than thirty .

25.	Access, admission, transfer, discharge (including missing patient)	Patient (redacted) seen at 0739 today by [number] [initials] (redacted) and [number] [initials] (redacted) . C / O 3 day history of shortness of breath . No chest pain . No signs of bacterial infection / sepsis . Diagnosed with ?viral LRTI . Given course of oral prednisolone and self care advice (fluids and paracetamol)and discharged on scene by [initials] with worsening care advise . All parties happy with this plan . Patient had no significant prev history or co - morbidities . He was left at home in good spirits. 1 hour after discharge - 2nd call to address . Patient now unconscious and gasping for breath . [number] dispatched . On arrival patient was in cardiac arrest with no obvious cause . After 40 minutes of ALS the patient had not improved and , after a conversation with the CCP desk , ROLE was carried out . This IR1 is being completed on the advice of [initials] (redacted) . All paperwork pertaining to the incident (s) is being held by [initials] (redacted) at [place] . [initials] (redacted) to complete a " recollection of events " . .
26.	Access, admission, transfer, discharge (including missing patient)	Unexpected neonatal admission resulting in neonatal death . . Baby reported by mother to be mottled in colour whilst skin to skin , neonatal resus [number] put out with full attendance . Baby was breathing but colour dusky , transfer to NNU . Coarctation of aorta suspected and transfer to [hospital] with parents following , baby died on arrival at [hospital] . RIP . .
27.	Medical device / equipment	I checked Pt remote device transmission on the [name] system on [date] at 17:00 . I noticed that his battery had tripped ERI (Reached [date]) . I then looked into his previous transmissions and noticed that his Battery had 2.1yrs longevity with 45% remaining to ERI on [date] . The following transmission on the [date] (Initially reviewed by [initials].) showed he had 8 months longevity with 14% remaining to ERI . The lead parameters were all stable . No therapies were delivered and no outputs were altered within this time period . Discussed findings with [initials] . and we decided to take the case to Dr [initial]. the following morning . .
28.	Access, admission, transfer, discharge (including missing patient)	Call received at [time] on [date] requesting an ambulance for a female that had been found on the floor , outside , with her leg under the gate . Call coded [number] G2 . Ambulance allocated [time] and arrived on scene at [time] , response time 40 mins . [number]yr old female taken to [name] hospital on a red standby Peri Arrest . Call received from police some time later for a data protection request advising that the patient passed away in hospital . . Concerns raised by Supervisor regarding the coding of the incident . It is possible that the incorrect coding was generated . Had this coded as a Red response there was an RRV available with

		an eta of 5 mins showing on the RESG . .
29.	Access, admission, transfer, discharge (including missing patient)	[number]: At [time] , [place] Police called regarding a male stabbed in [place] we attended as an R2 and arrived at [time] . A search of the street found no patient and the crew cleared at [time] – [number]: At [time] , a 999 call was received to a p
30.	Access, admission, transfer, discharge (including missing patient)	[number]yr old gentleman . Admitted under general surgery [date] with gallstone pancreatitis and discharged after 7 days . Had outpatient review with surgeon [date] and placed on waiting list for URGENT laparoscopic cholecystectomy . . Patient admitted to [hospital] [date] with acute gallstone pancreatitis and became significantly worse within 2 days requiring admission to ITU where despite full intervention for multiorgan failure he died on [date] . . [Information withheld under sections 40 of the Act]
31.	Access, admission, transfer, discharge (including missing patient)	Patient was admitted to hospital with " ? aspiration pneumonia " (taken from [emergency service]) prior to SLT community assessment . When rang patient to arrange initial assessment patient was an inpatient in [hospital] Hospital .
32.	Access, admission, transfer, discharge (including missing patient)	Patient died of advanced dementia and cerebrovascular disease whilst on SLT waiting list .
33.	Access, admission, transfer, discharge (including missing patient)	Patient deteriorated whilst at nursing home , developed aspiration pneumonia whilst an inpatient and subsequently died . All occurred whilst on SLT waiting list . .

34.	Access, admission, transfer, discharge (including missing patient)	Patient was admitted to [place] Hospital on [date] whilst on SLT waitlist . Subsequently died in [place] . Unable to access [emergency service] hospital records for reason of admission , nursing home report " was related to his chest " . .
35.	Access, admission, transfer, discharge (including missing patient)	Patient died whilst on SLT waiting list . .
36.	Access, admission, transfer, discharge (including missing patient)	[initials] was reported as missing by the carers who go to see her . They were unable to get access to [initials] house Saturday . When there was no answer on Sunday they reported her as a missing person . Daughter has been to the property and it appears [initials] has not got her wallet , bus pass or medication with her . .
37.	Access, admission, transfer, discharge (including missing patient)	A patient who was under the care of [name] Hospital , suffered a mycocardial infarction on the [date] and was assessed at the [name] Hospital and discharged within a few hours . The patient experienced further chest pain on the [date] and was re - admitted to [name] Hospital and discharged back to [name] on the same day . [name] Hospital liased with [place] on the [date] and it was agreed that the patient would be admitted to [name] Hospital . This happened but the patient was discharged back to [name] Hospital at 0300 and arrested and died two hours later . .
38.	Access, admission, transfer, discharge (including missing patient)	I was called to see patient by medical registra as deteriorating in RESUS with oxygen saturations of 86% on 15L O2 and Atrial Flutter with Heart Rate of 140 , I was told patient needed CPAP ventilation . On route to RESUS (20minutes later as I discussed patient with ITU team before attending as felt this patient may need ITU support from what had been handed over) the patient was already in the corridor outside A&E on route to [unit] with oxygen saturations 82% and a respiratory rate of 40 , working hard but ALERT . I felt this was an unsafe transfer and the patient should have remaind in RESUS . .

39.	Access, admission, transfer, discharge (including missing patient)	This patient was picked up by [emergency service] just before 6:00 PM on the day of presentation . His second set of vitals were done by crew at 6:30 PM . But he did not book in until 11:54 PM when he was streamed to [hospital] . He waited a further 3 hours in [hospitals] and was sent to [place] at 2:45 AM the next day at which point on initial inspection he was severely mottled and appeared peri - mortem . .
40.	Access, admission, transfer, discharge (including missing patient)	Patient admitted to [name] ward from acute trust at around 3 pm . Found on bed not breathing at 1930 . Patient certified dead at 2000 . Patient died in less than 24 hours on admission . .
41.	Access, admission, transfer, discharge (including missing patient)	[Information withheld under sections 40 and 41 of the Act]
42.	Access, admission, transfer, discharge (including missing patient)	Received a call from vascular surgeon in [hospital] on [date] at 06:25 concerning a patient that was transfer from SRU (MR [initials] with leaking tripple A) . he said pt die on arrival and shouldn't have if pt was transfer as soon as possible . He said he ask for transfer at 02:10 and did not arrived till 04:30 .
43.	Medical device / equipment	In attendance at cardiac arrest and applied the LUCAS to maintain compressions . On attaching the Lucas , the unit was switched on and the suction cup moved down to chest , and then the 30 / 2 button pressed - on doing this there was a load buzzer and the red triangle alighted . I then switched everything off and then retried in the same manner , but the same thing happened again . The unit was then removed and we resorted to manual CPR . The patient had been down a while before we arrived on scene , and the time was minimal taken to interrupt CPR , so I believe the effect to the patient was minimal . The patient has now passed away , as we were unable to maintain the ROSC x 2 . .

44.	Access, admission, transfer, discharge (including missing patient)	The patient in question came from an acute hospital specialised in wound care . the patient came to us in a distressed stae . All her inner thighes were escoriated , red and ulcerated . This lady had a high thigh amputation and had a large open wound where the surgical scar had de - hissed , of which we were not aware about until arrival through a written copy of a wound dressing regime . We were under the impression the stump was dry . There was a noted grade 4 presure wound to left heel , of which was dressed twice weekly before admission to the acute hosptal by the district nurse team . There was also a moisture wound to sacral area . .
45.	Access, admission, transfer, discharge (including missing patient)	Mother attended with possible PVB , possible SROM . Upon commencement of CTG , FH 102bpm . Immediate transfer to Labour Ward at 06:35 . 06:48 Transferred to theatre 06:58 Baby delivered . Born in poor condition requiring CPR and intubation .
46.	Medical device / equipment	Mr [initial] was in ICU bed [number] . He had a tracheostomy in situ and was being put on to High Flow CPAP ventialtion . The tubing curicut was incorrectly set up by the staff nurse at the bed side . When connected Mr [initial] was unable to breath out . His lungs became hyperinflated which caused a cardic arrest . The crash team were called , but he did not survive the arrest . .
47.	Access, admission, transfer, discharge (including missing patient)	Patient found collapsed in chair by staff nurse completing a medication round . By bed in chair in room [number] bed 3 . Found to be unrousable . .

48.	Access, admission, transfer, discharge (including missing patient)	The patient attended [name] ED via [emergency service] with a pre alert stating severe chest pain , haemodynamic instability and likely AMI . The ambulance crew had spoken directly with [hospital] CCU but they had not accepted the patient and she was therefore brought to [name] ED . On arrival the patient was in cardiogenic shock with an ECG , depite a paced rhythm , showing marked ST segment elevation in the inferior leads with recipricol changes . The patient was known to have CAD and previous PCI . Fllowing a 60 minute discussion with [hospital] cardiology team , including multiple phone calls to CCU expressing the urgency whith which a decision was needed due to persistant cardiogenic shock , an ultimate decision was made to accept the patient and transfer them to Cardiology at [hospital] . Unfrotunatley within 5 minutes of the decision being made the patient suffered a cardiac arrest . She died in the department . Please note this incident report forms part of multiple indicent reports and statements from different sources within ED and [emergency service] . .
49.	Access, admission, transfer, discharge (including missing patient)	Gentleman aged [number] attended AED at midnight . Following review he was discharged home at [time] hours . He was found dead at home 30 hours later ; it is thought that he had been dead for approximately 24 hours . An inquest has been opened and adjourned pending investigation . The cause of death following post mortem is PE and DVT . .
50.	Access, admission, transfer, discharge (including missing patient)	[age] female . Multiple co - morbidity including cardiomyopathy and recent DVT / PE . Admitted with abdominal pain . CT diagnosed rectus sheath haematoma . Patient stable then deteriorated . Repeat CT angiogram [reported at [time]] hrs showed significant extension of haematoma with active bleed . Decision for interventional radiology [embolisation] at [hospital] . Patient stabilised at [hospital] . Transferred to [hospital] but unfortunately died shortly after admission to [hospital] . .
51.	Access, admission, transfer, discharge (including missing patient)	at approx 19:00 the patient was pickedup from [name] ward by [emergency service] for transfer to stroke unit at [hospital] . The medical buff notes from [hospital] accompanied the patient by mistake . The patient was certified as deceased at [hospital] ED . There was a community DNAR in place prior to transfer . .
52.	Medical device / equipment	Elective operation ([date]) - laparoscopic bowel resection . Next day patient moribund , delay in theatre (many factors previous Ulysses [number]) laparotomy and anastamosis incomplete . Surgeon said in theatre " the staple device must have failed " . Septic peritonitis and death despite resuscitation and ITU post op . .

53.	Access, admission, transfer, discharge (including missing patient)	20.00 : Site manager called to " give a name " . The name was given so as the pt age and diag , when it was asked for more information about the pt , the site manager answer that she " didn't know " . 23.45 : Received pt with NEW of 11 from A+E , I told the nurse that we couldn't receive a pt with that NEW and ther was no SBAR completed in A+E but the nurse that the doctores aware of it and they wanted the pt in [name] ward and they way to r / v the pt . 00.05 : A+E nurse finiched his handover and the doctores haven't arrived , obs were done and pt had NEW of 10 so [emergency service] was colled and surgical team informed . 00.10 : MET and surgical team arrived and we follow the instructions . Was asked if pt could be transfered to ITU and the asnwer was no . .
54.	Access, admission, transfer, discharge (including missing patient)	Primigravida Spontaneous onset at 39+3 week with clear liquor . Suspicious fetal heart trace Forceps 2 pulls with an episiotomy . Apgar 4@14@5 ApH 7.27 BE-6.7 VpH 7.29 BE-7.9 Weight 3140gm Baby required intubation and transfer to NNU . On chest XRay ?enlarged heart . Transferred to regional unit .
55.	Access, admission, transfer, discharge (including missing patient)	Trauma patient . Trauma call 0300 . Discussed and accepted by MTC at [hospital] . Patient transferred at 0715 . Unnecessary and unsafe transfer : patient died . .
56.	Access, admission, transfer, discharge (including missing patient)	Inpatient death . Patient collapsed at time of discharge . Relative in attendance . .
57.	Access, admission, transfer, discharge (including missing patient)	57 M transferred from AMU at [hospital] after presenting with chest pain and dynamic ECG changes . Known CKD on PD QDS . On PTWR at [hospital] by Dr [initial] plan for admission under Cardiology at [hospital] with side room for PD . Discussed with Renal Team at [hospital] and transfer agreed . Prior to leaving [hospital] respiratory deterioration can be seen in nursing obs . En route deteriorated further with Ambulance pre - alerting ED . Respiratory and then full cardiorespiratory arrest within 1-2 minutes of arrival . CPR discontinued , no reversible causes found . .

58.	Access, admission, transfer, discharge (including missing patient)	[initials] requested for his unescorted section [number] leave (45 minutes)to the hospital grounds and left the ward at 09:25 . [initials] was due to return by 10:10 , however this was highlighted during the security checks at 10:30 . Hence , AWOL procedure was implemented . .
59.	Medical device / equipment	SN and a NHSP CSW was attending to patient on 100% 30L Oxygen 10cm PEEP when oxygen tubing became disconected from humidifier . The SN and CSW had not noticed this . The patient suffered a respiratory arrest and later died .
60.	Access, admission, transfer, discharge (including missing patient)	Patient was transfered from [name] Hospital to [hospital] for an interventional radiology procedure . He was not accepted by the medical team and they were unaware that he was being admitted . When he arrived he rapidly deteriorated and was transfered to medical HDU . On HDU he deteriorated further and eventually died the next day . . The patient should not have been accepted by radiology without letting the medical team know . They did not have an appropirate handover of care or information about the patient . .
61.	Access, admission, transfer, discharge (including missing patient)	stroke Patient brought in as Red call , seen on arrival by stroke team . no beds in resus , no beds on stroke unit . moved to ward [number] at 23:55 at high risk of malignant syndrome , placed on Level one pathway . The Patient died [date] .
62.	Access, admission, transfer, discharge (including missing patient)	Dr informed me yesterday that he was concerned re a pt under his care who was discharged over the [bank holiday] period from [hospital] . Dr had expected the pt to remain in hospital pending a CABG and ? endarterectomy at [place] . The pt , we are informed subsequently died at home . Clearly we need to understand the circumstances around the discharge etc and one of the matrons will undertake a full investigation commencing today . On review of the notes and on initial review it appears that the vascular surgeon from [place] has indicated that a discharge was appropriate (thurs pm) and this appears to be confirmed by the evening ward doctor who notes the visit from the vascular surgeon and states that [place] cardiothoracic team have informed C[number] that the pt can have his CABG as an OP . The pt was discharged the next day .) .

63.	Access, admission, transfer, discharge (including missing patient)	I went to visit this gentleman to be informed that he had been sent home from [place] the day before at 1pm and had been readmitted at 4am the following morning vomitting blood .[Information withheld under section 40 of the Act]. .
64.	Access, admission, transfer, discharge (including missing patient)	at 1613 [date] call came in from above address coded a Red 1 , [number] [number] cleared eta 3 mins but showed out of meal break window , on inspection some 20 minutes later it shows that the crew had signed on the wrong shift pattern and was not out of meal window and should have responded to the Red 1 call . Patient deceased on arrival of crew [number] a delay of 13 mins if [number] had been allocated . .
65.	Medical device / equipment	Patient attended lab [number] for elective transcatheter aortic valve implantation . The procedure was complicated by embolisation of the TAVI valve (Corevalve) superiorly after it was released . The valve was snared and a new Corevalve was deployed . Blood pressure dropped acutely and it became apparent that a dissection of the aorta with associated perforation occurred . The second valve was rapidly deployed and surgical help asked for urgently . .
66.	Access, admission, transfer, discharge (including missing patient)	patient admitted with gi bleed and found to have incidental findings of AAA , was seen by vascular surgeons from [place] who requested patient be transfered to [hospital] for surgery . .
67.	Access, admission, transfer, discharge (including missing patient)	Inappropriate transfer to ward [number] . Patient needed ward [number] as documented in admission notes . Pt was on CPAP at home however this was not brought in by family at time of admission . .
68.	Access, admission, transfer, discharge (including missing patient)	Case reviewed at Stillbirth Review Group on [date] . [number] year old 26 / 40 pregnant , seen at Day Obstetric Unit feeling unwell , breathless with abdominal pain . Observations outside of satisfactory range , CTG not met criteria , raised lactate . Discharged home . Referred in to day unit by GP 3 days later as remained unwell , no fetal movements and unable to locate FH . Intra uterine death confimed in day unit . .

69.	Access, admission, transfer, discharge (including missing patient)	Patient discharged home [date] , on [date] patient was found unresponsive on the kitchen floor . Family were unaware that patient had been discharged home . .
70.	Access, admission, transfer, discharge (including missing patient)	PP referral made for patient with exacerbation of COPD by C512 . [number] phoned patient as had been able to get PP to attend in timeframe . Delayed PP attendance until following morning . Patient was found deceased in chair by carers in the morning . .
71.	Access, admission, transfer, discharge (including missing patient)	This incident has effectively occcurred off site but I have no option for recording that . patient attended ED at 18.58 with a history of recurrent collapse . he was referred to the medical team with Type 1 respiratoy failur , possible arryhthmia and transient loss of consciousness . The medical team doscharged the patient home at midnight . the patient arrested and died on the journey home with[Information withheld under section 40 of the Act]. .
72.	Access, admission, transfer, discharge (including missing patient)	SUMMARY OF ISSUES : 1) Patient prescribed triple anticoagulation subsequently had significant haemorrhage leading to probable brain death . 2) Previously stable patient had NEWS 6 on ward as ambulance arrived . SHO decision to continue with transfer of patient to tertiary hospital instead of calling for help on ward . 3) Ambulance crew contained two technicians and no paramedics and therefore declined to convey patient , having already accepted handover on ward and taking patient to ambulance . 4) PACS failure to transfer images to [place] leading to delay in transfer . Patient admitted on [date] with vomiting and confusion . Raised inflammatory markers on admission hence treated with antibiotics . On [date] , whilst inpatient on [hospital] (Ward [number]) noted to be more drowsy . On the ward round , SHO questioned whether it was ok for the patient to be on aspirin , clopidogrel , and dalteparin together . Assured by consultant that this was ok . . In view of drowsiness , CT head was requested . Patient remained stable on ward throughout day . Went to scan mid - afternoon . Report received approx 4-5pm (apologies , no notes available to me at time of writing this to clarify exact timing of events) stating that patient had a bilateral intraventricular bleed . I (SHO) phoned the [hospital] consultant to inform her , and then called the neurosurgical registrar at [initials] , who accepted the referral for transfer . Time critical ambulance called , which arrived approx 10mins later (approx 1850) . On arrival , nurse informed SHO that NEWS was now 6 as BP increased , HR increased , AVPU decreased . SHO decision to continue with transfer to [place] . Obs

		handed over to ambulance crew - they accepted patient for transfer . Attempted to phone [hospital] consultant to inform them - unable to contact via switchboard . Crew returned to ward shortly after to say that obs were same as what they had been handed over and that they were unhappy to transfer patient without paramedic or medical escort on board . SHO called anaes on - call to request medical escort - informed that anaes on - call was not transfer - qualified , but would find colleague to help . ITU consultant and anaes on - call came to A&E and with SHO went out to ambulance in car park to assess patient . HR now ~200 , BP ~180 / 150 , GCS decreasing . Attempts made to stabilise patient in ambulance with fluids and electrolytes . Medical on - call team informed of situation . Decision made by ITU Cons to move patient back into hospital . ED Sister informed , and Resus cubicle made available . Patient moved into Resus . GCS now 3 . Neurosurgical team at [place] informed by phone of deterioration , advised stabilise and re - scan . Patient intubated & cardioverted in ED . Second CT scan obtained showing further haemorrhage into ventricles . Initially unable to transfer images to [place] due to the images being ' quarantined' by computer (new CT scanner , already had 1 CT head on PACS that day for this patient , issue with not issuing new attendance number for second scan ?) . Neurosurgical team informed , declined to discuss patient without being able to see images . Told us to send images by CD in taxi to [place], or fix PACS to send electronically . . At this point (approx 9pm) I (SHO) left , as already 3 hours beyond end of shift , with patient in care of ITU / Anaes & ED . . Following day ([date]) , informed that patient had eventually been transferred to [place] . I phoned Neuro ITU in [place] to be informed that patient had been to theatre overnight for extraventricular drain , but that intracranial pressures were very high / unstable and neurosurgical team were likely to carry out brainstem testing that day to confirm brain death . .
73.	Access, admission, transfer, discharge (including missing patient)	Unexpected death - patient given sensitising chemotherapy (Cisplatin) [date] then consequent radiotherapy . Consequently developed infection and neutropenic sepsis and multi organ failure . .

74.	Access, admission, transfer, discharge (including missing patient)	Baby born by Category 1 Caesarean Section for fetal bradycardia , susbesquently admitted to the neonatal unit . . Background : [Information withheld under section 40 of the Act]. The CTG normalised on labour ward , then a deceleration was heard following fetal movement . Midwife was unable to then pick up the fetal heart abdominally , help was summoned , a repeat vaginal examination showed the cervix was closed and a fetal bradycardia was confirmed on ultrasound . Code Red initiated , baby was born by GA section 11 minutes following the decision to deliver . Baby was born pale , floppy and with no heart rate or respiratory effort . .
75.	Access, admission, transfer, discharge (including missing patient)	Service user was found dead in some undergrowth by a member of the public , drugs paraphernalia were found close by . Service user was assessed in the new patient screening clinic seven weeks earlier and referred to CMHT for CPA assessment and consultant psychiatrist appointment . Service user agreed to continue to engage with drug and alcohol services .
76.	Access, admission, transfer, discharge (including missing patient)	This patient had hypertrophic cardiomyopathy . He had NSVT on a Holter performed in [date] . With his other clinical features this placed him in a high risk category for sudden death . His sudden death risk was not assessed or documented until a clinic appointment in [date] . At that time he was listed for a cardiomyopathy MDT discussion to confirm the need for ICD (and also to discuss other issues including genetcis , anticoagulation , and management of outflow tract obstruction) . Sadly , he suffered sudden death in the intervening period . .
77.	Access, admission, transfer, discharge (including missing patient)	Patient was reported missing from the ward to the police . After reporting the incident , the police rang the ward back and advised that they had located a person at the bottom of a bridge who they believed was the missing patient based on description given . The police later confirmed that the person was the patient and also confirmed he had died . .

78.	Access, admission, transfer, discharge (including missing patient)	Following taking a set of vital observations which were oxygen saturation 83% , respiration rate 32 , unable to gain a blood pressure reading , pulse was 77 and temperature was 37 degrees and reading the TEP form which showed that the patient was suitable for hospital addmission,999 was called and an emergency ambulance was requested with all of the information about the patients condition being passed to the ambulance call handler . Approximately 25 minutes after the ambulance was initially called I called back to say that the patient was deteriorating and was struggling to breathe . The ambulance finally arrived approximately 40-45 minutes after the first call . Patient subsequently died in the emergency department of [place] Hospital . .
79.	Access, admission, transfer, discharge (including missing patient)	Pt BIBA on [date] following collapse , treated for postural hypotension and discharged home on the same day . [Information withheld under section 40 of the Act] had been found dead at home this morning . .
80.	Access, admission, transfer, discharge (including missing patient)	It was reported by another member of staff who had just finished the late shift that they saw a patient who like a patient nursed on [place] walking by the [name] Park . Staff went on to look in all the rooms and all the areas of the ward and could not find him . All the fire exits and doors were locked . By then it was observed that Patient A was missing on the ward . .
81.	Access, admission, transfer, discharge (including missing patient)	A 2222 Cardiac arrest call was made to a patient who deteriorated in the depart into cardiac arrest . NEWS prior to arrest were 12 . . ALS protocol for the non - shockable arrest was followed . Reversible causes considered and ruled out . Unfortunately , the resuscitation attempt was unsuccessful . .
82.	Access, admission, transfer, discharge (including missing patient)	Baby delivered at 1150 required prolonged resuscitation , paed consultant called Baby admitted to nnu , ventilated and requiring transfer for cooling .

83.	Access, admission, transfer, discharge (including missing patient)	[Information withheld under section 40 of the Act]. [name] medical centre called surgery to say that he wasnt there .. [Information withheld under section 40 of the Act] Reception received a call from ward sister on ward at community hospital who said he had died on route to hospital and was taken straight to the mortuary [Information withheld under section 40 of the Act]. .
84.	Access, admission, transfer, discharge (including missing patient)	Patient attended ED with signs of sepsis . Patient unwell with NEWS of 3 , undergoing treatment from GP for LRTI and dip positive catheter urine from SPC . Tried to refer patient to medical team but AMU Consultant refused referral as patient had SPC and needed changing . Advised I was happy to refer to surgeons for them to arrange an SPC change but the acute problem was sepsis from either chest or urine source and the medical team should be the ones to look after that . AMU consultant refused referral without seeing patient . I referred to the surgical registrar who saw the patient and felt they were septic too but had no choice but to admit under surgeons .
85.	Access, admission, transfer, discharge (including missing patient)	Two month old baby found unresponsive in bed next to mother . 999 call made . No CPR performed prior to the paramedic arrival . Upon arrival the baby did not have any cardiac output , the baby was cyanosed with increased tone and levidica was present . CPR initiated but unsuccessful at home [Information withheld under section 40 of the Act] .
86.	Access, admission, transfer, discharge (including missing patient)	I am reporting this unexpected death in retrospect using the documentation available but I was not actually on shift the weekend that this occurred . .
87.	Access, admission, transfer, discharge (including missing patient)	Admitted to ED [date] at 21:48 . Very unwell and hypothermic . Seen by FY2 . Confused and hypothermic - unclear if a blood gas was taken . No screen for sepsis , no senior review evident except to insert cannula . No IV antibiotics . Seen by Med CMT - lactate 15 . No senior review , no IV antibiotics . . Seen by Consultant at 08:20 - no repeat of lactate , no IV antibiotics . . Continued to deteriorate. I am aware this patient may have been bedded in the ambulance triage area despite having a lactate of 15 . . Arrived on MAU very unwell . . Identified as needing HDU level care at 16:10 - no beds . . Cardiac arrest at approx 19:00 . . ROSC then transferred to ITU . . I think this case may require a RCA or SUI investigation . .

88.	Access, admission, transfer, discharge (including missing patient)	At around 05.45 hour , staff approached the patient to do his fasting blood sugar level . He was covered in vomit on pillows and every where on the bed . When staff called him he did not respond , he was breathing . Staff immediately called for help , he was not responding . He was assisted to be cleaned up , but he was not weight bearing . . Duty doctor was called but he was unable to be contacted . DSN was contacted immediately to contact the doctor as this was an emergency . DSN tried to contact the duty doctor but he was unable to reach him . Staff already called the ambulance who were on their way , and has alerted the DSN . Ambulance crew arrived at about 7.15 hours and the pat was transferred to the [name] Hospital accompanied by a member of staff . . Vital signs monitored prior to calling the ambulance : BP:126 / 68 mg , Pulse : 89 bpm , Sats : 96% and Fasting BM was 14.3 mmols .
89.	Access, admission, transfer, discharge (including missing patient)	SSN (1) on bleep 500 came on the Ward and advised me that a patient on A+E need to come up to us directly as she was receiving BIPAP therapy . At that moment I had a female bed inside the bay and a SDR available so I asked SSN (1) to find out what was more appropriated for the patient . He made a phone call to A+E and spook with SN regarding any confusion , expecting death . . . in the end of the call he told me that she would be better in the bay just to monitor as she was on BIPAP . Around 21:00 I received (2)on [name] Ward . Patient was extremely agitated and trying to get out of bed and not on BIPAP . Informed by SN (3)on A+E that patient only tolerated BIPAP over 2 minutes and was taking it off . Patient also overload , it sounded like if patient was drowning in her own flam informed that had 2 doses of IV furosemide but no catheter in place as patient refusing . After handover I went to the patient that was with HCA (4)and (5) . She looks like she was getting worse and losing her strength . While HCA (4) and (5)went to get a Hi Low bed due to patient been a very high falls risk , I started to do some suction what was difficult due to the fact of the secretions been so thick . Patient dropped her respiratory rate very quickly and by the time that HCA came back she was nearly death , which didnt take more than 10 minutes . 15NRB mask applied but patient not responding . [Information withheld under section 40 of the Act]. Doctor (8) that was looking after patient on Ressus came to see her and told me that was expecting this already + confirmed that patient didn't tolerated the BIPAP . This transfer to [name] Ward hasn't been appropriated as patient not on BIPAP and Medical Team expecting her not to resist very further + patient very distressed . .

90.	Access, admission, transfer, discharge (including missing patient)	Attended cardiac arrest call at 02:58 . on arrival no output , unrecordable BM , severe metabolic lactate acidosis on ABGS . NB ; BM at 21:33 was 25.8 known diabetic patient . Although there is another BM recording entered on the BM chart " under extra reading " 15.3 mmols but this is likely falsified (separated incident completed [number]) likely patient had a high BM for hours . .
91.	Access, admission, transfer, discharge (including missing patient)	At 17:33hrs on above date EOC received 999 call to a 57yo Female with severe breathing problems coded 6E1..conscious but not breathing....this turned out to be a cardiac arrest . At 17:35hrs I was told to proceed to [place] ambulance station to book my 20 minute refreshment break . I was only allocated to the call at 17:54hrs and mobilised at 17:55hrs . . . . . I was told en route that it was a cardiac arrest with AED on scene and that I had no back up whatsoever [Information withheld under section 40 of the Act]. My initial assessment of the patient was that she was cyanosed to the extreme , her pupils were " fixed " and dialated , her airway was full of vomit and she was asystolic on the ECG . I arrived at the decision that the female was sadly deceased . [Information withheld under section 40 of the Act] I feel that this patient would have greatly benifited from early [emergency service] intervention and that we as [emergency service] have badly let the patient and the loving relatives down greatly. I feel that my 20 minute mealbreak took presidence over a patient who was potentially salvageable Repercussions from the family are inevitable....and I ask the question which I want answered asap . . . why are meal breaks put before patients lives ? .
92.	Access, admission, transfer, discharge (including missing patient)	Transferred Patient from A&E Trolleys to AMU @ 19:30PM . MED ACCEPT , A / W MEDICS REVIEW , RECENT D / C FROM W26 YESTERDAY MEWS OF 0 , BEFORE TRANSFER . Pt mobilised off the trolley with help of the carer and myself , (pt on section 2 from [place] , known learning difficulties . HCA from AMU , took over so I could handover to the Nurse ; turned around Patient had fell back on the bed , no head injury Unresponsive , no documented hx of epilepsy on notes . Pt then went into a cardiac arrest , met call / cardiac arrest call put out ; gave as much information to medics attending stated he was an medical acceptance with a blocked catheter , hense no ECG done in A&e , BLOOD AND CANNULA DONE . Explained to the AMU staff that patient was fine on transfer and spoke to carer whilst being transferred stating he didn't want to be in hospital . Left the ward @ 20 : 00pm , pt had output , being tubed on AMU Carers notified family when on AMU , ? advised for them to come in . Spoke to Sister on Ward , again stating pt was fine on transfer . .

93.	Access, admission, transfer, discharge (including missing patient)	Patient was in a rehabilitation bed at [place] and was admitted to hospital due to being found unresponsive , the ED Doctor contacted [place] staff and told them the patient was well enough to be discharged back to them . When the patient arrived back to [place] she was unresponsive , she was transported immediately back to hospitla to the ED . The patient passed away later that day . .
94.	Access, admission, transfer, discharge (including missing patient)	Unexpected transfer of patient from ward [number] to ward [number] . Patient had been on ward [number] for 5 days awaiting ARM . SROM [date] 11.30 . Maternal sepsis . Sepsis 6 followed . Patient transferred to theatre for fetal compromise . Cat 1 section under GA . Baby transferred to NICU following delivery . FH &lt 60 by 4 minutes . Full neonatal resus intubated by 1 minute . Needed cardiac compressions until 10 minutes of age . Adrenalin not required . 30mls / kg bolus IV 0.9% saline.1 X Bicarb and Dextrose bolus . IV Abx given within first 15mins of life . . FH above 100bpm at 10 minutes . Baby ventilated cooled and transferred to NICU . .
95.	Access, admission, transfer, discharge (including missing patient)	requested visit post hospital discharge to redress legs patient discharged as REHAB patient with no DNAR and no clear arrangement for follow up REHAB intervention state family - unsure if this is correct as unable to located any discharging documentation . on arrival patient had been stuck in chair for 24 hours post discharge as unable to mobilize due to difficulty mobilizing patient declined carers trying to assit to put to bed compression bandaging on right leg and only k - soft and k - plus with no k - lite and this is wrong leg bandaging to left leg k - soft and k - lite and no compression - this is the leg that compression required family distressed as not coping .
96.	Access, admission, transfer, discharge (including missing patient)	Received patient from ambulance crew - pre alerted as ? PE . ECG was seen by doctor in charge and patient was having an MI . Crew was questioned why they did not take the patient to [place] and the paramedic stated he thought it was a PE and left . Doctor[Staff Name 1] discussed with [place] and advied to book a blue light ambulance to transfer the patient to [place] . Patient then deteriorated , ITU were called and patient later had a cardiac arrest and died . .
97.	Access, admission, transfer, discharge (including missing patient)	Unexpected precipitate birth of 26 week baby on adult ITU . Thought to be still born . Resuscitated and admitted to neonatal unit . .

98.	Access, admission, transfer, discharge (including missing patient)	Patient arrived by Ambulance to A&E Department . Unaware of pregnancy , felt to be term size on palpation . Seen in Labour Ward Triage : diagnosed IUFD and placental abruption . Blood pressure raised - treated with oral anti - hypertensive therapy x 2 . ARM performed and progressed to NVD male infant . At birth , cord noted twice around the baby neck and presence of large retro placental clot . The ambulance record indicates the patient reported : had pv bleed and abdominal pain last few weeks and had been seen by her GP the previous week , but there is no evidence to indicate the GP referred the patient for further review or management . .
99.	Access, admission, transfer, discharge (including missing patient)	Patient recieved news that the [Information withheld under section 40 of the Act]. [Patient Name] then left the ward in a panic against medical advice . She has a cannula in situ . .
100	Medical device / equipment	patient underwent intramedullary nailing with lateral femoral nail on [date] . locking bolts for nail missed the nail via the jig . this rendered the nail unstable . patient leg deformed on weight bearing post operatively . the patient had to undergo revision of the nailing on [date] . the patient has now died previously , an incident form has been completed detailing the problems with this particular device , highlighting that this jig had resulted in the same problem several times with different surgeons . it was proposed on this form that this nailing system should be taken out of service . a similar issue has been found at the children hospital who use the same system . despite this , the nailing system remained in service and the same problem has occurred again . .
101	Access, admission, transfer, discharge (including missing patient)	Low risk primip T+6 attended [place] for assessment at 0230 as contracting . History of reduced FM elicited and CTG commenced 0320 . CTG abnormal and transferred to labour ward . Arrived labour ward 0502 . Review by senior MW and Obstetric SR 0506 . Decision Category 1 0509 . Into theatre 0510 . GA start 0518 . Delivery 0526 of female infant in poor condition and resuscitation commenced by neonatal team . Cord gases art pH 6.68 BXS -30 , venous pH 7.03 BXS -17 Remains in poor condition on NNU undergoing therapeutic cooling . .
102	Medical device / equipment	Patient underwent a cemented hip hemiarthroplasty for fractured hip . During surgery , 2-3 minutes after cementing , she developed a low blood pressure and became unrespinsive . Surgery was completed . patient started dropping her breathing and cardiac output . A DNAR order was in place . Declared dead at 13:22 . .

103	Access, admission, transfer, discharge (including missing patient)	[number] year old man diagnosed with coronary artery disease based on angiogram , CTCA and CMR . These test were carried out starting in [month] this year by [name] Hospital cardiology team . Referral to cardiothoracic surgeons was done in [month] after the invasive angiogram . Invasive revealed significant RCA lesion and retrograde filling of LCA from RCA . As unable to cannulate LCA a referral for CTCA was done and also to CT surgeons at the same time . However , he never got to see a surgeon , there is no evidence of him being referred to [hospital] (there is evidence that [hospital] have referred him based on a typed referral letter) . Before he was seen by CT team he suffered a cardiac arrest in the community and brought in by ambulance via DAMI pathway to . Angiogram following arrest on autopulse revealed same information as before . He suffered further cardiac arrest and attempts to revive him were unsuccessful . Case discussed with coronor and death certificate was issued . .
104	Medical device / equipment	The patient suffered a cardiac arrest a few hours after having a chest drain inserted for treatment of a hydropneumothorax . During the arrest I felt it necessary to insert another chest drain to try to relieve a presumed tension pneumothorax or haemothorax . There was no equipment available on the renal unit to insert a chest drain , nor equipment to perform a pericardiocentesis as cardiac tamponade was another possible cause for the arrest . We tried needle decompression twice , but the patient died . . .
105	Access, admission, transfer, discharge (including missing patient)	unexpected admission to SCBU .
106	Access, admission, transfer, discharge (including missing patient)	patient left the ward to have coffee and cigarette . Found collapsed and in cardiac arrest in toilet on ground floor . resuscitation unsuccessful and patient died . .
107	Access, admission, transfer, discharge (including missing patient)	Declared as a Serious Incident on StEIS on [date] Patient had been taken to [name] Hospital voluntarily under Section 2 MHA by [emergency service] following a call to police and [emergency service] during the morning of [date] at approximately [time]hrs . He had been assessed at the hospital and had subsequently run away from the hospital becoming a high risk missing person . Note from manager - History from mum , NIC and security are that a female member of staff from the mental health team agreed that patient

		could go to [place] whilst under section . .
108	Medical device / equipment	During the 2am rounds on night shift a patient was found on the floor in the cubicle unresponsive , cyanosed and not breathing . The LVAD was unplugged from all power source . LVAD did not sound an alarm . .
109	Access, admission, transfer, discharge (including missing patient)	Patient requiring ICU bed , acutely unwell with respiratory failure . Being cared for in an inappropriate clinical area (CCU) since late Sunday [date] . Delay in admission to ICU as no bed available , Site not happy to consent to transfer of surgical patient to CCU in exchange for this patient at 12:00 , insisting that we wait for maternity bed to transfer out another patient . Maternity at the current time were unsure as to how long a bed availability would be . .
110	Access, admission, transfer, discharge (including missing patient)	Cardiac arrest - 43 year old patient went in to cardiac arrest and died after 40 minutes of ALS algorithm CPR . - Patient had three potentially reversible causes identified : (1) - hypoxia from aspiration (2) - hypoglycaemic (3) - K 1.6 on arrest ABG - Patient had no formal potassium checked during admission as it had haemolysed . Given 2 litres of plasmalyte and 2 litres saline without potassium during the two days prior to arrest whilst in hospital . Potassium was 2.7 on the admission ABG and patient continued to vomit whilst in hospital with no recheck of U&Es . - Patient not seen on the day of arrest and transferred from AAU to G[number] without any of the doctors on G[number] being aware of the patients transfer and that he hadn't been seen by a doctor that day . - On transfer to G[number] no consultant was allocated to the patient and it was unclear whos care he was under to make decisions about levels of escalation . - Patient transferred on a ' reverse boarding ' scheme as per managemental decisions . Nursing staff on G[number] decided to transfer him to a cubicle just before he arrested but the plan was for him to be on the corridor or an extra patient in a bay . - The defib machine had no clear instructions on how to override the automatic setting and put on to manual to enable ALS alorgithm to be fully followed and reduce gaps between shocks and CPR being restarted . None of the team - cardiac arrest team , ICU nurses , ward nurses or ward doctors knew how to do this and so it was left on automated setting . .

111	Access, admission, transfer, discharge (including missing patient)	Admitted with urosepsis on [date] , discharged on [date] on oral antibiotics . Vomiting at home . Seen by paramedics and on call GP . Further deterioration led to ambulance bringing her back in on [date] at approx . 13:00 . Significant concern as hypoglycaemic and purple feet . Difficult IV access . Escalated to ITU at 16:30 when found to have lactate 14 . Died despite maximal resuscitation at 01:15 [date] . Concern about discharge from hospital and missed opportunities to escalate earlier and that this could be an avoidable death . .
112	Medical device / equipment	Patient sent home from [ward] on [date] without his home oxygen prescription updated . . Patient identified as Recovery Uncertain . Estimated prognosis is months . Rationale for estimated prognosis - End stage COPD on 15L home O2 Left pneumonectomy in [year] . Family / significant others understanding of condition and prognosis – [Information withheld under section 40 of the Act] Patient agrees with the explanation ands understands . Recommendations for Community - Ward based care . Preferred place of care - Home . Out of hours form sent to GP Out of Hours . No funding agreed . . Patient was sent home with wards NRB mask and tubing : Patient using incorrect tubing (standard 2.1 mt for a prescription of 15 L / M) . The patient was discharged from hospital and sent home with a NRB mask connected via 2.1 mt standard tubing (which will only supply up to 4 L / M) and told not to use any other masks or cannulaes , when he connected the mask to the concentrators (2 x HF Nidek) the flow dropped below 12 L / M and could not be adjusted to the correct prescription . When [place] engineer saw the tubing and explained what the problem was , I replaced the incorrect tubing with the correct one (5 mm installation tubing) and the flow went up to the correct level . I also explained to the patient that the prescription we have for him is for 10 to 15 L / M via a 40% mask and a 1600HF cannulae and asked him to contact the prescriber and ask for the new hoof , with the change of mask , to be sent to [place]. . Once [place] engineer changed the tubing back to [place] tubing the machines 02 levels immediately corrected and patients symptoms also improved . However subsequently the patient died following this incident . .
113	Access, admission, transfer, discharge (including missing patient)	Patient had an EMR . A perforation was recognised and treated endoscopically . Patient was not admitted and discharged following review and that the patient was well . Readmitted two days later under surgeons but discharged . Patient readmitted 12 days later to [hospital] , transferred to [place] and died . .

114	Access, admission, transfer, discharge (including missing patient)	Incident raised by [place] CCG who have asked that this be raised as a SUI and RCA undertaken . . GP referred patient by email to HF email address and received a read receipt . There is no record of the referral being received at this email address on [date] . .
115	Access, admission, transfer, discharge (including missing patient)	Patient initially referred with acute subdural haematoma and GCS14 . Referring hospital advised to observe patient , repeat a CT at an interval and that we would admit the patient to the [hospital] once the acute haematoma had become liquid and could be drained with burr holes . (Referring team also asked to contact us if the patient deteriorated before then) . . After various phone calls I made the decision to admit the patient on [date] . I had several conversations with on call registrars about this subsequently and understood that the patient remained on our TCI list . On [date] I understood that she was due to be transferred over the weekend . . I was phoned in the morning of [date] to say that the patient had deteriorated to a GCS of 7 and was being intubated for transfer . I was phoned again later that day to say that the patient had died , approximately 20 minutes after arriving in our Emergency Department . .
116	Access, admission, transfer, discharge (including missing patient)	Patient death . .
117	Access, admission, transfer, discharge (including missing patient)	Patient with twin pregnancy , under care of Fetal Medicene Unit due to anti - d and anti - c antibodies , admitted to [hospital][date] for intrauterine blood transfusion of both twins . Unable to obtain adequate fetal monitoring post procedure and prior to discharge . Care continued by [hospital] - when attended at 34 + weeks (6 days later) 1 twin was sadly fetal death in utero and second twin required exchange transfusion . .
118	Access, admission, transfer, discharge (including missing patient)	Patient presented with abdominal pain and collapse , low BP , 8cm AAA on FAST Scan . Delay in transfer to [place] as the Vascular Team ([hospital]) requested for CT Angiogram . before transfer . Patient sadly died en - route to [hospital] in the ambulance . .

119	Access, admission, transfer, discharge (including missing patient)	Contacted by Ward manager of EAU [number] at 23:00hrs to advise that a patient who had been discharged by the surgical team had been registered as missing by Family with [place] Police . Had not returned home 2 hours after discharge from hospital .. [Information withheld under section 40 of the Act]. At approximately midnight phone call received in ED from Duty Officer for [hospital] to advise that they had a deceased Male that had been found at [place] . They wished to transfer the male to ED / mortuary direct . Police present at scene and Family en route to ED . Overnight Mortuary Technician contacted . All parties met at ED . [Information withheld under section 40 of the Act].. Patient identification confirmed as the patient discharged from EAU [number] . [Information withheld under section 40 of the Act]. Paperwork completed by the Police and body taken to the Mortuary with Police , [hospital] and Mortuary technician present . EAU [number] informed and requested to secure notes in the Ward managers office . On call Duty Manager informed in the morning . .
120	Access, admission, transfer, discharge (including missing patient)	Patient attended the AED on [date] requesting diazepam to help her sleep due to chronic back pain . She was discharged home . . Patient returned to the department on the [date] with increased pain and also giving a history of significant weight loss . On arrival the patient looked pale and gaunt and had a NEWS of 8 . Her pain score was documented as severe . She was given codeine for pain relief as she had already been administered paracetamol by the Ambulance crew . After an hour her NEWS has increased to 10 . Seen by registrar who felt symptoms were drug related . Patient had been diagnosed earlier with UTI but had not taken antibiotics . Urine checked in department and was positive . Patient was reviewed at 1pm and 2.25pm by registrar who documented obs had improved following fluid challenge and discharged her 2.30pm . . Patient returned to department at 16.16 following a collapse and was unresponsive . After review in the department by anaesthetics this patient was taken direct to the operating theatre and then to ICU . .

121	Access, admission, transfer, discharge (including missing patient)	The patient attended ED with increased breathlessness and ankle swelling over the previous 2-4 days . This occured on the background of advanced COPD and she was approaching the end of her life . She was assessed by an ST[number] doctor who determined her to be clinically stable with panic episodes . As the Consultant on call I was informed of her review and the stability of all her investigations including blood gases as well as the clincal plan . Her blood gas on retrospective review showed a deterioration that should have prompted recognition of a less stable clincal state . It was appropriate not to instigate NIV at that juncture but it would have been appropriate to admit the patient if she wished for further observations . Increase of her anxiolytic (lorazepam)medication and discharge was unlikely to be the right course of action . The patient returned home and spent the night distressed with breathlessness .[Information withheld under section 40 of the Act], by which time she did not wish readmission . Her GP phoned me on [date]and we discussed the case . I have been trying to contact the family to apologise and inform them of the incident investigation and did so this morning . .
122	Access, admission, transfer, discharge (including missing patient)	Patient transferred to [name] Ward from [name] Ward , [name] Hospital . Bed co - ordinator reports she was informed that patient had been medically stable for 72 hours and that all blood were within normal limits , she was also informed that NEWS was 0 . Patient arrived on the ward at 16:00 hrs , was admitted by ward staff and doctor . 17:00hrs NEWS score 0 and blood sugars were within normal limits but patient declined to have insulin stating she had not eaten and it was too late to be administered . Patient was to have PEG feed administered overnight and this was commenced at 19:20hours as per regime . On hourly checking overnight patient was found unresponsive at 04 ; 00hrs . .
123	Access, admission, transfer, discharge (including missing patient)	CrCU Full with no empty beds . Critically ill patient in ED requiring urgent dialysis on the unit . Delayed discharge in Bed [number] (had been delayed approx 5 days)had bed identified for her on Ward [number] that ED patient was going to be admitted into . Patient about to leave for Ward [number] when we received phone call saying that the bed had been given away as there was a patient breaching in ED . This led to a significant delay in admitting the critically ill patient from ED . . Patient deteriorated quickly on arrival and died before dialysis could be commenced .

124	Access, admission, transfer, discharge (including missing patient)	[Information withheld under sections 40 and 41 of the Act].
125	Medical device / equipment	Patient with hypoplastic left heart and bronchiolitis . Deteriorated on HDU requiring CPR and resuscitation which followed a CPAP malfunction . Patient recovered following resuscitation Transferred to theatre and intubated on the advice of [hospital] team but subsequently died .
126	Access, admission, transfer, discharge (including missing patient)	Patient with diagnosis of terminal cancer seen as collapse and head injury . Found to be in fast AF (known AF) High NEWS on arrival = 5 with tachycardia and low blood pressure . Patient seen and treated for head injury . Doctor seeing did treat for fast AF also but no apparent response looking at recorded observation which got worse NEWS=6 . Despite this patient discharged home - possibly self discharged according to later notes ? . Patient had OOH respiratory and then cardiac arrest at home approximately 2 hours later and was brought back to ED and died . .
127	Access, admission, transfer, discharge (including missing patient)	Patient transferred to resus following a AAA scan in majors that identified an enlarged aorta . Patient was escalated to the Surgical Reg and taken for a ct angio . The surgical Reg was on scene before the CT was reported . A 6.8 cm leaking AAA was confirmed on CT report . The surgical Reg contacted [place] and was accepted for immediate transfer . At 0120 hrs a blue light nil delay crew was called at the request of the Surg Reg for immediate transfer to [place] . (on call for vascular surgery) . At 0152 hrs the crew arrived to transfer the patient . At 0230 the crew reappeared at the resus doors with concerns that the patient had deteriorated in the back of their ambulance . They requested a temporary dnar form for the transfer . I tannoyed for an ED doctor to assist . ST[number] [Staff Name 1] and trainee ACP [Staff Name 2] and the nurse in charge [Staff Name 3] attended to the patient in the back of the ambulance , asked for the patient to be returned to resus and alerted 3333 for a peri arrest and to get surgical reg assistance . At 02.50 pt in cardiac arrest ALS protocol commenced . Pt death was confirmed at 03.20 .

128	Access, admission, transfer, discharge (including missing patient)	[Information withheld under sections 40 and 41 of the Act]
129	Access, admission, transfer, discharge (including missing patient)	I (critical care outreach practitioner) was called to see a patient on AMU at 06.30 this morning that had been transfered to AMU from the emergency department with a MEWs score of 8 , the patient had an unrecordable blood pressure on my arrival and i had noticed since admission to the E. D around midnight the patients blood pressure had been significantly low according to the observation chart . The patient had intravenous fluid resuscitation with no effect on her blood pressure but appeared to exacerbate her known congestive cardiac failure . The Arterial blood gas taken , had been misplaced and no values were in the notes however the notes stated the patient was retaining carbon dioxide . The patient had been in the emergency department for 6 hours without having an intensive care review and transfered with an unstable blood pressure . .
130	Access, admission, transfer, discharge (including missing patient)	Service user brother call weekend duty team to inform of death of service user in the early hours of the morning . Cause of death reported to be cardiac arrest . .
131	Access, admission, transfer, discharge (including missing patient)	Patient attended AED with presenting complaint of " abdo pain 1 / 7 sharp in nature D & V " . Patient unexpected death at home shortly after discharge . .
132	Access, admission, transfer, discharge (including missing patient)	[number] year old male presented to [hospital] Ed private transport at 10:16 on the [date] Triage 10:51 - Assaulted around 03:00-04:00 with head injury and laceration above right eye Reviewed by Doctor Impression : Facial / head injuries does not meet CT head criteria Plan : Steri - strip to right eyebrow Head injury advice given Discharged 13:20 At home patient developed right sided weakness ,

		blind in left eye and was taken to [place] ED at 21:07 , neurosurgery and sadly died on the [date] after not recovering . .
133	Access, admission, transfer, discharge (including missing patient)	patient with critical aortic stenosis was admitted from clinical and worked up for valve repair. Sudden deterioration on [name] to cardiogenic shock and referral to CCU. CCU lacked capacity but asked medical consultant to refer to CTC CCU (this is a deviation from policy. Patient arrested and died (8 hours after deterioration)before being transferred due to multiple referrals and lack of capacity.
134	Access, admission, transfer, discharge (including missing patient)	Concerns raised from patient family regarding treatment provided in ED and ACU , and patient unexpected death . Patient attended with shortness of breath and chest pain and issues noted by family regarding timeliness of treatment and decisions regarding discharge . He had a cardiac arrest on ACU and subsequently died . Concerns also raised via the coroner when requesting medical report for inquest . .
135	Access, admission, transfer, discharge (including missing patient)	This is a retrospective incident notification for a possible unexpected death . The patient died within 24 hours of a A&E ([hospital]) to A&E ([hospital]) transfer . .
136	Access, admission, transfer, discharge (including missing patient)	Patient on IPWL for an orthopaedic procedure , waited 95 weeks . Bookings team attempted to contact patient with appointment date and during this process confirmed via the NHS Spine that this patient has died . .
137	Access, admission, transfer, discharge (including missing patient)	P1 was reported as a missing person at 17:00 this evening by their mother . P1 has recently been low in mood and had been away from home since 5am this morning . [Information withheld under section 40 of the Act].

138	Access, admission, transfer, discharge (including missing patient)	I was the nurse in charge of High Dependency Unit (HDU) on the night of the [date] . There was no NSTEAC / runner in HDU as one of the agency nurses did not attend HDU for the nightshift . The on call cardiology registrar [number] notified me about a patient that had been referred to him by the registrar in [place] Accident and Emergency (A&E) at approximately 02:10am . The information that the registrar provided was that the patient was a female with a STEMI . This is the only information that the registrar provided . Upon further questioning regarding the patients name , date of birth , past medical history and current clinical stability he was unable to provide further information . I informed the registrar that in order to accept this patient I need more information and that there was no other nurse apart from me able to take care of this patient . At this point I asked if the patient is going straight to the catheter lab or if she would come directly to HDU . His reply was it depends if the catheter lab team was present on the patients arrival , he then confirmed that he had already called the on call catheter lab team . At this point I made it clear to the registrar that I needed more information . At no point did the registrar ([number]) contact the on call HDU consultant . .
139	Access, admission, transfer, discharge (including missing patient)	Possible hospital associated venous thrombosis . .
140	Access, admission, transfer, discharge (including missing patient)	Cardiorespiratory arrest and later death following vomit / regurgitation after Hartmanns for perforated colon [date] . Consultant ward round [date] record in notes says " Soft diet . If vomits - NBM + NGT " . Nursing record in 7 day care plan for [date] says : ...patient feeling sick . . . . Antiemetics giveniv . . . . [date] 02:25 Record says " patients vomitting earlier , so assisted to sit up . Unable to vomit more and became very ?lethargic ? when trying to check obs so crash bell pulled and started CPR . . . . . Fluid balance sheet indicated patient vomited " 55 + 310 " . Issues : 1 . Patient was " vomitting earlier " . So should (?) have had an NG placed based on plan at consultant ward round . That likely would have prevented the aspiration / arrest 2 . Could impaired gastric emptying have been picked up at that ward round earlier in the day ? 3 . Should patient have had an NG tube from time of her emergency operation [date] ? .

141	Access, admission, transfer, discharge (including missing patient)	Complaint from patient brother that there was delay in an ambulance attending the patient and when the crew arrived they were unable to gain access which required the assistance of the police (who had received the original 999 call) . .
142	Medical device / equipment	[[date] 13:37:29 the reporter] Unexpected death .
143	Access, admission, transfer, discharge (including missing patient)	Referral recieved from [name]Hospital Liasion team regarding male Patient [initials] who was subject to Section 4 MHA . Staff Nurse felt this was inappropiate due to reports that [initials] was vomitting , (" unable to keep anything down ") . Due to historic information / being well known to the ward , Staff Nurse questioned possiblity of alcohol withdrawals or hidden overdose . However informed that Patient [initials] was ' Medically fit " . After further exploration with [hospital] Consultant it was established that [initials] had actually refused any physical observations . Telephone call recieved around 23:30 reporting that Male Patient [initials] had passed away following a heart attack , 45 minutes prior to commencing transfer to [name] Ward . .
144	Access, admission, transfer, discharge (including missing patient)	referral made to service by GP to SPE at approximately 930 am fro [hospital] to visit a patient who has slight shortness of breath , and back pain . call was initially acknowledged by [hospital] - [Information withheld under section 40 of the Act] contacted the GP who called [hospital] again and was advised that a visit was allocated but unable to give a timeframe as the service was exceptionally busy . the call was handed to the [hospital] Gp at 1830 for a home visit and re triage - unfortunalty the doctor arrived at 1030pm and the patient had collapsed and LAS taken to hospital where unfortunalty she died . .
145	Access, admission, transfer, discharge (including missing patient)	Patient admitted [date] to ED at 17:46 hours following a fall 5 days ago with increasing pain since . CT thorax performed which showed multiple left chest rib fractures , small effusion which could be haemothorax and inflammatory changes on left lung . Also in urinary retention and catheterised . . Patient transferred to the surgical assessment unit under the care of Urology and General Surgery 23:43 [date] . During the night shift seen by Dr [initial] (urology SHO) due to low blood sugar readings and then by Dr [initial] , Medical SPR advised stop codeine , IV antibiotics , Arterial blood gas , stop nephrotoxic medications , stopping anticoagulation and to give IV fluids with dextrose to counter insulin accumulation due to impaired renal function (Acute Kidney Injury stage 1) . . Patient seen by surgical WR at 09:12 [date] (Mr [initial]) who noted problem list :

		flail chest , acute kidney injury , drowsy . Plan was to follow previous medical plan . Seen by [doctor] (Urology Consultant - time not documented) [date] . Issues : 1 . Flail chest & Community acquired pneumonia , acute urinary retention resolved . Plan was to re - discuss with medical team regarding drowsiness . 14:00 seen by surgical FY[number] (Dr [initial]) who was asked to perform Arterial blood gas by urology Dr. This showed metabolic acidosis . Not producing urine , reduced saturations . Concern re : declining conscious level , metabolic acidosis , unwell patient who needs senior review , Acute Kidney injury now stage 2 . CT brain requested after discussing with urology consultant . Seen by Dr [initial] Senior clinical fellow carrying on - call medical registrar bleep time not entered , seen [date] . Noted improvement in arterial blood gas tension , metabolic acidosis persisted . Plan was for IV fluids , reduce oxygen proportional to need , CT head (performed , no evidence of bleed) reduce insulin dose in keeping with worsened renal function and requested Ultrasound kidneys . Seen [date] by urology SPR (nil documented) plan was for transfer of care to medicine . This was discussed with night SPR for medicine who was asked to review and discuss not for resuscitation with next of kin . Handed over to day SPR for medicine (Dr [initial]) who reviewed patient 11:11am on [date] . Noted poor urine output , worsening renal function (now acute kidney injury stage 3) , persisting metabolic acidosis . Diagnosed uraemic encephalitis , acute kidney injury and delirium due to community acquired pneumonia or urosepsis . USS kidneys showed no obstruction and cases discussed with urology SPR who advised medicine to take over care as no acute urological problem . IV fluids and antibiotics continued and fluid rate increased by Dr [initial]. . Seen by surgical registrar (name not legible) discussed with medical registrar re : take over of care . Discussed with on - call consultant in acute medicine (Dr [initials]) re : good prior baseline function , reversible pathology escalate to critical care ? Seen by Dr [Staff Name] 16:15 [date] . Diagnoses : recent severe trauma , AKI secondary to injury , reduced oral intake , usual medications with nephrotoxic effects and development of pneumonia following injury . Active urgent problem was deteriorating renal function and worsening infection presumed to be left basal pneumonia . Despite IV fluids not improving BP low and little urine output . Dr [initial] contacted critical care regarding review to escalate care to ITU for vasopressors and haemofiltration . Seen by ICU SPR 17:00 [date] and Dr [initial] ITU Consultant at 17:15 . Decision was made and discussed with family that Mr [Patient Name] would require full ITU care at this point likely to also include intubation and ventilation , and that the chances of survival were low . It was decided that this was not a treatment option . The patient continued to deteriorate and was reviewed in the night of [date] by the surgical doctor on call who prescribed symptom relief

		medication . . He sadly died 14:30 [date] .
146	Access, admission, transfer, discharge (including missing patient)	Patient appeared unwell but responsive . .
147	Access, admission, transfer, discharge (including missing patient)	Patient admitted to AMU via A&E , brought in by ambulance with h / o witnessed seizure . Unable to communicate in English (Lithuanian)History taken using language line . CT head showed Right fronto - parietal subdural haematoma and discussed with Neurosurgeons at QMC , advised neuro - obs for 48hrs . 24hrs later developed respiratory and circulatory failure , repeat CT showed extensive bleed in the same area and raised intracranial pressure . Neurosurgery at QMC contacted and ICU team advised not for intervention as patient has coned and subsequently patient died on the Intensive care unit on [date] at 11.45 . .
148	Access, admission, transfer, discharge (including missing patient)	This Datix is being submitted retrospectively and has already been investigated as a Serious Clinical Incident ([date and number]) . Complaint [number] . This patient was under the care of the Hepatology Team . Being seen in [date] and a further appointment was requested for 8 - 12 weeks this appointment was never made . The patient gradually deteriorated and was admitted to hospital where it was decided a liver transplant would be required . This patient sadly died in [date] . .
149	Medical device / equipment	Following a planned surgical tracheotomy the patient was transferred to NCCU . Shortly after arrival on NCCU the tracheotomy tube became displaced and a fibre optic examination , and subsequent CT , demonstrated a defect in the tracheal wall . . The patient was intubated orally without compromise of oxygenation . Later the patient was transferred to [place] where she subsequently died . . Detailed reports have been provided to [Staff Name 1] and [Staff Name 2] . . This report is being submitted now after it became apparent that one had not been completed at the time . Following review of the notes and preparation of a report for the Coroner I am submitted a QSiS to allow the investigation to be conducted within the usual Trust processes . .

150	Access, admission, transfer, discharge (including missing patient)	service users daughter contacted [organisation] to inform staff member that the service user had passed away , staff member contacted daughter [date] who gave information that the service user had taken their life by hanging on the [date] .
151	Access, admission, transfer, discharge (including missing patient)	Service user found deceased at [place] . Suspected Overdose . Information received from Coroners on [date] . .
152	Access, admission, transfer, discharge (including missing patient)	The service user was found dead in their bedroom [Information withheld under section 40 of the Act]. A [organisation] staff member was informed [Information withheld under section 40 of the Act] when she rang to offer the service user a CPA Review for [date] . .
153	Access, admission, transfer, discharge (including missing patient)	Service user found dead in her home . Medication (pill capsules and blister packs of co - codamol , codeine , clonazepam and midazolam oral syringe)[Information withheld under section 40 of the Act]. .