Inquest highlights missed chances to save patient

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NEGLECT contributed to the death of a patient, a coroner has ruled.

Dr Elizabeth Didcock, assistant coroner for Nottinghamshire, said there were missed opportunities to save Marie Henson's life.

The inquest was told Mrs Henson, of Upton, went to Newark Hospital's urgent care centre on February 3, 2019, with a urinary tract infection.

The coroner said there was evidence of diabetes with early diabetic ketoacidosis, including a very high blood sugar, which were not recognised.

The only doctor on duty, Dr Raju Palissery did not recognise the symptoms and discharged her into the care of her GP with a course of oral antibiotics.

In his evidence, Dr Palissery, who had worked at Newark Hospital since 2013, said he told Mrs Henson to see her GP in 24 to 48 hours, but did not record that in his notes. He said he asked her to bring up her high blood sugar results and she may need treatment for diabetes, although again this was not recorded.

He completed a discharge letter, adding the details of the suspected urinary tract infection and its treatment, but did not include any information about the high blood sugar or the significance of the ketones in the urine, nor did he request further checks.

The coroner said Dr Palissery had relied on Mrs Henson relaying the information to her GP.

MARIE HENSON'S death was preventable, a coroner ruled.

The GP, Dr Heer, a locum, who saw Mrs Henson two days later, said he was given false confidence by the omission of any mention of high blood sugar in the discharge letter and did not do a fresh blood sugar test, something he accepted he should have done, along with a check of the urine for ketones.

Dr Heer could not check Sherwood Forest Hospitals test results because the practice's IT was linked to Nottingham University Hospitals, where the majority of its patients were treated.

This only came to light during the inquiry and will be resolved.

Mrs Henson returned to Newark Urgent Care Centre in the early hours of the next day after vomiting, yet, said the coroner, the diagnosis of diabetes, now with severe diabetic ketoacidosis, was not made.

Dr Palissery, again on duty, suspected sepsis with severe acidosis.

He gave oxygen, fluids and an antibiotic. He realised she was critically ill and arranged transfer to King's Mill following a dose of insulin.

The ambulance arrived promptly and Dr Palissery rang the on-duty registrar at King's Mill to prep her.

He claimed he had told the registrar Mrs Henson had a high blood sugar, but the statement of the registrar, whose area of expertise was diabetes, refuted this.

It was in the emergency department the severity of Mrs Henson's now grave condition was recognised and the diagnosis of DKA made.

She was started on insulin and DKA protocols followed.

It was expected that a clear improvement would follow, so intensive care unit admission was not needed.

With the treatment under way, Mrs Henson's husband and daughters, who were at her bedside, were told she was improving.

However, Mrs Henson began deteriorating and the insulin pump machine alarmed frequently. This, however, was described to her family as a faulty machine and 'attempts to pump too much insulin through too small a tube', and Mrs Henson's agitated arm movements.

When re-set, the display would show it was infusing on each occasion. A nurse realised the pump was not infusing properly, by which time it had alarmed 33 times.

It was realised by one of the now attending doctors the line from the pump was clamped, preventing the correct levels of insulin passing through.

Mrs Henson had received four litres of fluid in attempts to improve her blood pressure from a second line, but it was likely that she had received only 0.9mls of insulin, rather than the 17 to 18mls that should have gone in over a three-hour period.

Mrs Henson had a cardiac arrest and could not be resuscitated despite the very best of attempts.

Dr Gareth Moncaster, a consultant in anaesthesia and intensive care medicine at King's Mill, was called when Mrs Henson's condition deteriorated.

He told the inquest he felt the lack of insulin was the main factor missing from her treatment.

He said escalation in her care should have happened sooner.

The coroner said: "When asked if the outcome for Marie could have been different, he was very clear that both on February 3 and on February 5, she would have survived had she been given an insulin infusion.

"He also felt on the balance of probability Marie would have survived had she been given insulin as per the DKA protocol on February 6. He felt that sepsis had not been the cause of her clinical presentation."

Sepsis was an area of significant disagreement between Dr Moncaster and consultant physician Dr Andrew Molyneux, author of the trust's serious incident investigation report, who believed sepsis was a key contributor and should be included on the death certificate.

The coroner did not agree and ruled untreated DKA was the cause, saying there had been missed opportunities in diagnosis.

The trust admitted fault in the areas of lack of recognition of DKA, lack of effective insulin treatment, delays in escalation, lack of monitoring of blood tests and also the lack of completion of DKA paperwork, which had not been done hourly and could have led to the discovery of the lack of insulin infusion earlier.

Dr Molyneux said the trust accepted that on the balance of probabilities, Mrs Henson's was a preventable death.

Concerns raised are addressed by hospital

IN HER conclusion, after hearing two days of evidence, assistant coroner Dr Elizabeth Didcock said a series of failures and neglect led to Marie Henson's death.

She said: "I am clear that the failures on February 3, February 5, and February 6, 2019, have a clear and direct causal link to Marie's death. But for the lack of insulin treatment Marie would, on the balance of probability, have survived."

She said the lack of recognition of diabetes at Newark Hospital was a gross failure.

She accepted that although the GP at Southwell should have looked for type one diabetes or DKA, it did not constitute a gross failure to provide basic medical care.

She said Dr Heer had reflected on the care that he provided, as had the nurses involved, and they had learnt from their mistakes.

At King's Mill Hospital, Dr Didcock said: "The lack of delivery of insulin, and that this was not discovered for nearly three hours, is also in my mind a failure to make a simple basic check.

"I have identified at least four missed opportunities to provide insulin treatment — a basic medication for a common condition. Overall, I am satisfied that neglect contributed to Marie's death."

Dr Didcock said the trust commissioned a serious incident investigation report, which was converted into a detailed action plan, and training had been carried out.

Dr Didcock described Dr Palissery's evidence as muddled and inconsistent.

She said: "I did not find his evidence convincing nor sufficient in relation to his learning following Marie's death. I ask that the responsible officer at the trust (Sherwood Forest Hospitals) to review his current competencies and ability to work without consultant supervision at Newark Urgent Care Centre.

"If there remain concerns then, as would be usual, I would expect Dr Palissery to be referred to the General Medical Council for further assessment of his fitness to practice."

The trust has provided four weeks of additional supervised training for him and he is rotated to work in the King's Mill Hospital emergency department where he can develop expertise with more ill patients and have direct access to a consultant on site.

"This higher level of support is not, however, available when he and other middle grade doctors are working at Newark Hospital without direct consultant supervision," said the coroner.

'Wonderful mother should still be here'

DEVASTATED: Marie Henson's daughters, Holly and Lucy, and grandchildren.

MARIE'S husband and two daughters attended the inquest and spoke afterwards of their sense of betrayal from those who took an oath to protect their mum.

They described a wonderful mother and grandmother, but also their anger and disbelief over what happened.

Daughter Holly, a mum of two, said: "Mum was a shy lady, but friendly. She was always happy and a fantastic mum and granny.

"She has three grandchildren now. One of the most distressing things is that she never got to meet my sister Lucy's baby as she was still pregnant when mum died.

"To this day we feel angry and let down — we were betrayed by the people who were supposed to help her.

"We trusted the medical professionals to get it right and we trusted them when they told us she was improving.

"We went to the inquest because we had to hear what the trust had to say and to try and understand what went wrong.

"What we heard was that mum would have survived if she had received the insulin. The coroner said that it was a basic treatment for a common condition, and that was very hard to hear.

"I'm so angry and it still upsets me. I know they could have saved her life."

Holly said she was pleased the coroner had gone further in her judgment and asked for a a review into the operation of the Newark Hospital Urgent Care Centre and the competence of Dr Raju Palissery.

"That's why we pursued the negligence claim," said Holly: "We wanted to make sure no other family went through what we did.

"Our mum was taken away from us.

"We miss her every day and it's hard knowing that she should still be here."

Mrs Henson's husband, Kevin, brought a clinical negligence claim against the trust, represented by Julie Hardy at Barratts Solicitors in Nottingham.

The trust made full admissions in relation to the claim and an award of compensation has been paid.