Salford Royal
NHS Foundation Trust

University Teaching Hospital

safe • clean • personal

NHS

Executive Nurse Director
Elaine Inglesby

Telephone: 0161 206 5862
Facsimile: 0161 206 2185

Ref: C0104/08 Date: 24

June 2008

Mr Gary S Brown 63/69
Lambton Road Worsley
M28 2SU

Dear Mr Brown

Please find attached the response letter in relation to your complaint to this Trust.

Under normal circumstances response letters are always signed by Mr David Dalton, the Chief Executive. At present Mr. Dalton is out of the office for a period of time and it has been agreed that I would sign your response letter in order to avoid further delays.

Please be assured Mr. Dalton will see the attached letter upon his return back to the Trust. I do hope that you find this acceptable.

Yours sincerely,
ELAINE INGLESBY EXECUTIVE NURSE DIRECTOR

TRUST EXECUTIVE
HOPE HOSPITAL

Direct Line : 0161 2061520
Fax Number : 0161 **206 2185**

Ref: CO 104/08

23 June 2008

Mr Gary S Brown
63/69 Lambton Road
Worsley
Manchester
M282SU

Dear Mr Brown

I write further to previous correspondence regarding the circumstances surrounding the death of your wife, Mrs Marlene Brown, at this hospital on 6 March 2008. I was extremely sorry to read of your concerns and I would like to begin by offering to you and your family my sincere condolences for your sad loss.

Following receipt of your complaint, an investigation into your concerns was instigated on my behalf by Mr Rob McDougall, Patient Advisor. Mr McDougall has been assisted by Dr Ali Hassoon, Consultant in Neuro-Rehabilitation Medicine, Mr Scott Rutherford, Consultant Neurosurgeon, Mr Sean Loughran, Ms Sue Pemberton, Assistant Director of Nursing for Neurosciences and Orthopaedics, and Mr Conor Lomas, Lead Manager for Neurosciences. The findings of the investigation are given below, however, at the outset, I would like to offer you the opportunity to meet with the staff who were involved in the investigation of your complaint should you feel this would be helpful. If you have any further questions when you have read this letter and if you would like to accept this offer to meet with staff, please do not hesitate to let Mr McDougall know, as we will do all that we can to resolve with you your complaint.

In June 2007, Marlene was diagnosed with a very large and extensive petroclival meningioma (a tumour arising from the linings of the skull base) and she underwent the first stage of her surgery to remove it under the care of Mr Rutherford on 9 July 2007. This involved the removal of the part of the tumour in the posterior fossa, Following Marlene's surgery she required the insertion of a tracheostomy (a tube that was inserted into the windpipe to allow Marlene to breath freely) on 11 July 2007 which was subsequently removed on 20 July 2007.

Marlene continued to make good progress, although she was unfortunately left with sixth nerve palsy (characterised by double vision which is caused by damage to the nerve controlling the muscle responsible for side-to-side eye-
movements), a left facial palsy (weak muscles of facial expression on the left side of the face) and reduced hearing on the left side in addition to slight motor (movement) weakness involving her left-sided limbs. Marlene was treated for these symptoms following her transfer to Ward C2 on 7 August 2007 and on 15 August 2007 she was discharged home to await further surgery.

On 5 November 2007, Marlene was readmitted to this hospital for a second procedure which was performed the following day under the care of Mr Rutherford. Marlene underwent a supratentorial craniotomy (a type of surgical procedure used to gain access to the upper part of the brain) at that time, the purpose of which was to remove the remaining part of her extensive skull base tumour.

Unfortunately, following Marlene's second operation she suffered multiple complications largely related to blood vessel injury and this resulted in strokes to several areas of her brain. This left Marlene in a profoundly disabled condition and in the early period following this surgery, it was clear that Marlene's condition was such that she required the re-insertion of a tracheostomy. This was performed during Marlene's stay on the Intensive Care Unit on 8 November 2007. Marlene was subsequently stepped down

from the Intensive Care Unit to the High Dependency Unit on 9 November 2007 and later to a standard care neurosurgical ward (Ward 68) on 30 November 2007 where she remained until 26 February 2008 when Marlene was transferred on to the rehabilitation ward, Ward C2, under the care of Dr Hassoon. During Marlene's stay on Ward C2, she became more comfortable, particularly as the pain in her left hip started to resolve, and she appeared more alert. When Dr Hassoon reviewed Marlene as part of his ward round at 10.30am on 3 March 2008, he noticed that the secretion from her tracheostomy was slightly blood stained and Marlene was intermittently noticed to be showing signs of discomfort and hyperventilation. Otherwise, all her observations were satisfactory and stable. Dr Hassoon requested an urgent assessment by an Ear, Nose and Throat (ENT) specialist and he ordered that a sample of her tracheostomy secretions should be sent to the Pathology Department for analysis.

In response to Dr Hassoon's request, Marlene was assessed by Dr Mahmoud Zico from the ENT Department at approximately 1.55pm that day and he commented that on his arrival to see her, Marlene was apyrexial (she did not have a fever) and all her observations were stable. Dr Zico also noted that she was being fed by a Percutaneous endoscopic gastrostomy (PEG) feeding tube, that her tracheostomy tube had been changed recently (it had been changed from a size 7 uncuffed fenestrated tube to a size 6 uncuffed fenestrated tube as part of the weaning process to eventually remove the tracheostomy) and that the tube was in a good position with no surgical emphysema (a condition whereby air escapes from the respiratory tract into the subcutaneous tissues) and erythema (redness of the skin) or discharge around the tracheostomy site. Dr Zico also assessed Marlene and passed a naso-endoscope (a flexible fibreoptic tube) through the tracheostomy and saw some evidence of tracheitis (a bacterial infection of the windpipe) but no obvious bleeding point and no focal lesion (abnormality).

Dr Zico's impression at this time was that Marlene's blood stained secretion from the tracheostomy was due to tracheitis, and he therefore advised the clinicians on Ward C2 to continue on her regular saline nebulisers, and to start her on an antibiotic called Augmentin for 7 days. Dr Zico also advised that Marlene's tracheal secretion should be suctioned as required and he arranged for Marlene to be reviewed again in one week's time. Subsequent to this, Dr Hassoon received a number of verbal reports from the clinicians in his team, as well as the ward nurses, that Marlene remained quite stable and that the secretions from her tracheostomy tube had started to become clear.

At 6.30am on 6 March 2008, nursing staff were attending to Marlene when her tracheostomy site started bleeding. The bleeding was profuse and although the nursing staff immediately contacted a doctor on call, they informed the Ward Manager that they realised they would need to put out an emergency call for urgent assistance, which was duly done. The Ward Manager came on duty at approximately 7.10am and contacted you to ask that you come to the ward immediately, following which she supported the medical and nursing team, and at approximately 8.00am, the Ward Manager also contacted Dr Hassoon by telephone at home to inform him of Marlene's condition. The Ward Manger explained to Dr Hassoon that the efforts of the crash team, including the Intensive Therapy Unit and Anaesthetic Specialist Registrar, General Surgery Specialist Registrar and ENT Specialist Registrar, had been unsuccessful and that unfortunately Marlene had arrested with asystole (when the heart stops beating and there is no electrical activity in the heart) and that cardio pulmonary resuscitation (a way of trying to restart the heart and breathing) had failed. As a result, CPR was eventually stopped after consensus with all the team members. Unfortunately, Marlene sadly passed away at 7.40am.

Mr Rutherford has told me that Marlene suffered from a complication called a tracheo-innominate fistula (TIF), which resulted in uncontrollable bleeding from the innominate artery into her trachea. I note that following your research into this condition you believe that any bleed should be presumed to be a TIF until thoroughly ruled out and in response to your concern, Mr Rutherford and Mr Loughran have both told me that this is an exceedingly rare, albeit recognized complication of a tracheostomy. These fistulas are commonest in the early weeks following placement of a tracheostomy. In Marlene's case, however, this event occurred some four and a half months following the insertion of her tracheostomy. This condition is also practically unheard of in patients without predisposing factors; in particular, previous radiotherapy to the neck. In other words, the risk of Marlene developing such a complication was miniscule, making it very difficult to have a sufficiently high index of suspicion to have diagnosed this prior to the catastrophic events that led to her unfortunate death.

Mr Loughran has added that it was quite reasonable that tracheitis was the first initial diagnosis as Marlene's bleed did not appear to be significant. Normally, a herald bleed (a sign that a fistula is present) is usually a brisk short lived bright red bleed rather than some mild blood stained secretions. From the time of her transfer to Ward C2 on 26 February 2008 to her death on 6 March 2008, Marlene had required only minimal to moderate amounts of suction to clear the secretions from her chest and tracheostomy tube, and prior to Dr Hassoon's review of Marlene during his ward round on 3 March 2008 there had been no concern that her secretions had been blood stained. This scenario therefore does not fit with an innominate artery fistula as the first potential diagnosis and I am assured that an entirely reasonable diagnosis was arrived at, following the completion of appropriate examinations.

Marlene's sudden deterioration was unexpected by the staff who were involved in her care and I know that the cause of her death is currently being investigated by the Coroner. As a result, I am unable to confirm at this time the exact cause of Marlene's death, however, I hope you will find the information I have given in this letter to be helpful and that I have been able to reassure you about the care Marlene received. I am deeply sorry for your sad loss and wish to assure you that if you should have any further questions when you have read this letter that you would like to discuss further, we will be happy to help in any way we can. As suggested towards the beginning of this letter, you may find that a meeting with the staff who were involved with the investigation of your complaint may be helpful. Please contact Mr McDougall on 0161 206 1520 or Mrs Margaret Hadfield, Complaints Manager, on 0161 206 5862, in this instance as I know they will be happy to take details of your outstanding concerns and agree with you how best we might take them forward.

Yours sincerely

David Dalton **Chief Executive**