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By email

Dear

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

I refer to your email of **9 September** in which you requested information under the FOI Act from NHS Improvement. As you know, since 1 April 2016, Monitor and the NHS Trust Development Authority ("the TDA") are operating as an integrated organisation known as NHS Improvement. For the purposes of this decision, NHS Improvement means both Monitor and the TDA.

Your request

You made the following request:

> *"How many incidents were categorised as death incidents in England under NRLS for the period 1.1.15 to 31.12.15 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) from NHS England."*

Decision

NHS Improvement holds information relevant to your request. The information we hold is from the National Reporting and Learning System (NRLS). As you are aware, 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.

A recent search of the NRLS was carried out of all incidents reported by organisations in England as occurring between the dates 1st January 2015 to 31st December 2015 if these had been uploaded to the NRLS by 19th September 2016 and where the degree of harm was recorded as death and the incident type was 'Medical device/equipment' or 'Access, admission, transfer, discharge (including missing patient)'.

Table 1 below provides the number of incidents categorised as death in England under NRLS for the period 1.1.15 to 31.12.15 under the incident types (i) medical device/equipment, and (ii) access, admission, transfer, discharge.

Table 1

Base: Incidents reported as occurring between 1st January 2015 to 31st December 2015. England organisations only

		Incident Category		**Total**
		Access, admission, transfer, discharge (including missing patient)	**Medical device / equipment**	
YEAR	**MONTH**			
2015	**Jan**	20	1	**21**
	Feb	7	3	**10**
	Mar	13	2	**15**
	Apr	12	1	**13**

	May	15	3	**18**
	Jun	12	0	**12**
	Jul	12	1	**13**
	Aug	12	4	**16**
	Sep	10	0	**10**
	Oct	11	1	**12**
	Nov	10	1	**11**
	Dec	24	0	**24**
Total		**158**	**17**	**175**

Please find below a summary of each of these incidents. Please note the text is that provided by the original reporter of the incident and information has been redacted where it could potentially be used to identify persons involved with the incident.

#	Incident Category	Summary of incident (verbatim using [] to redact any potentially person identifying information)
1.	Access, admission, transfer, discharge (including missing patient)	Extremely busy department no twilight Registrar No beds . Unexpected death of patient who had yet to be seen by a Doctor . .
2.	Access, admission, transfer, discharge (including missing patient)	This patient was referred by their GP with progressive SOB and was brought into ECC at [time] . Due to workload the Patient was not seen until the patient had an episode of LOC at around [time] . According to SN , prior to this episode the EWS score did not raise any concern to require urgent medical review . .
3.	Access, admission, transfer, discharge (including missing patient)	Pt declined to travel . Repeat attendance by another crew later in the night . Pt became unwell whilst the second crew were on scene and Pt died in hospital later that day . . [description of events prior to ambulance being called]

4.	Access, admission, transfer, discharge (including missing patient)	Call made to 111 at [time],disposition reached of Green2 Emergency Treatment & Transport at [time] , transferred to dispatch . . Dispatch notes [time] - CFR not logged on , delay in allocation due to no available resources . High demand and stacking calls . Nearest resource in mealbreak window . . [Ambulance] dispatched at [time] and arrived at [time] . At [time] the crew of [ambulance] updated EOC this was now a cardiac arrest and requested a Team Leader with a Lucas2 device . . Response time to Green2 - 1 hour , 3 mins , 40 secs . Delayed response partially due to restrictions put in place by [ambulance service] mealbreak policy. .
5.	Access, admission, transfer, discharge (including missing patient)	A patient attended A&E on the [date 1] with abdominal pain and was treated and discharged home . The patienet remained unwell overnight in increasing pain and was re attended A&E on the [date 2] where patient died . The Post Mortom shows cause of death as torsion and infarction of gall bladder and the family have raised concerns about the discharge home on the [Date 1] .
6.	Access, admission, transfer, discharge (including missing patient)	Patient attended A&E with 48 hour history of chest pain and shortness of breath . Found to have low haemoglobin , ECG chnages and raised Trop T. Following discussion with A&E registrar and cardiology registrar (as suggested by the former) , was treated as Acute Coronary Syndrome with a plan to transfuse 2 units of cross matched blood prior to transfer to [Hospital]. Following further discussion between Charge Nurse and Cardiology registrar , it was decided that the patient would be transferred across to [Hospital] and the transfusion initiated on arrival . Following transfer , A&E staff were informally informed that the patient was found to be " in periarrest " on arrival . .
7.	Access, admission, transfer, discharge (including missing patient)	Patient attended with Hx consistent with pneumonia and sepsis . Difficult to manage due to morbid obesity . Referred to medical and ITU teams . Patient was to be managed on [Unit] with BiPAP however rapidly deteriorated and arrested at [time] in the resus department still 5 hours after arrival .
8.	Access, admission, transfer, discharge (including missing patient)	Emergency response requested at [time] . We arrived at [time] . By this time the GP was on scene and the patient had passed away . .

9.	Access, admission, transfer, discharge (including missing patient)	patient transfered from the acute trust arrived on the ward at [time] found to have a temp of 38.4 on admission . redaing though CIC notes note that for the last couple of days patient had not been feeling too well . complained of chest pain on the [date] . no mention of chest pain on the verbal handover given by CIC on the day of transfer . patient found collapsed at[time] seperate incident form submitted due to sudden death .
10.	Access, admission, transfer, discharge (including missing patient)	Telephone discussion with liaison Health Visitor at [Medical Centre] . [Child] died unexpectedly on [date] . Child presented in ED with a history of vomiting and diarrhoea with temperature for 12-24 hrs , ' child had been in mums bed as was feeling unwell . Mum checked child at [time]and then when she awoke she found the child unresponsive . . Rapid response team for child deaths have completed a home visit on [date] . . There is no safeguarding history or concerns and it is believed this unexpected death was caused by natural causes . . An Initial Child Death meeting was held [date] , a follow up final death meeting will be arrange for 3 months time when the post - mortem results are available . .
11.	Access, admission, transfer, discharge (including missing patient)	On [date] , I received a request from [Coroner] office Manager asking for information about the above patient and the [ambulance service] input . on pulling together a timeline I have established that the ambulance arrived on scene in excess of 2 hours after the first call . This had , until now , not been reported on DATIX and there was no record of a complaint or concern having been made . .
12.	Access, admission, transfer, discharge (including missing patient)	Home support worker was unable to gain access to patient home for morning visit . .
13.	Medical device / equipment	Pt brought in as collapse , hypothermia . Pt went into cardaic arrest with reversable cause hypothermia . No warm fluids availble in ED . No bair huggers , all 3 missing . Unable to record Pt temperature , no core thermometers available . Arrest prolonged as unable to determine Pt temperature . Delay in locating EZ - IO drill and only paediatric needles available . .
14.	Access, admission, transfer, discharge (including missing patient)	Patient attended ED on [date/time] with abdo pain . referred to on call surgery . Discharged at approximately [time] . Unable to find the surgical notes . Called [ambulance service] at about [time/date] with severe abdo pain . Cardiac arrest with [ambulance service] . Pronounced dead at hospital . .

15.	Access, admission, transfer, discharge (including missing patient)	Patient brought in by ambulance following fall / collapse -7th attendance in 6 month period - fully assessed by doctor . Due to number of recent attendances , referral to psychiatric team made (pt known to team). Mental health assessment carried out at [time] - medium risk . Moved to CDU to await review . Referral faxed at [time] . At approx [time] staff nurse notice patient was no longer in waiting room . Alert raised and psychiatric nurse who was coming to undertake review arrived in dept at approx [time] - has passed patient in the street - advised that they were not concerned & would follow up & assess patient at home later in the afternoon . .
16.	Access, admission, transfer, discharge (including missing patient)	No bed spaces available in A&E department so patient seen and bloods taken in minors . . [blood results]. Was awaiting infusion of potassium when found unresponsive without cardiac output . Hypokalaemia identified at [time] , 45 minute delay in receiving IV potassium due to a lack of bed space in department . Bed space found at [time] and patient cannulated . . Patient found in VF cardiac arrest at [time] . .
17.	Access, admission, transfer, discharge (including missing patient)	Patient was admitted from [Hospital] on [date/time] . Patient became unwell overnight and passed away . No EDF in place . .
18.	Access, admission, transfer, discharge (including missing patient)	I was the registrar on call for nights , and was called to review a patient in labour , with regards to concerns about the CTG . I had reviewed the patient the previous evening , , where there were no concerns raised . A plan was made to perform a vaginal examination after 4 hours of regular contractions . . I had just finished with another patient, when I was asked to review the CTG for this patient , at approximately [time] . I attended immediately . I was informed that the patient was fully dilated since [time]. The concern was regarding the FSE on the CTG reading at this time . Called and attended to review the patient in room [no.]. [Description of delivery]. Baby was born in poor condition , with no heart rate and was resuscitated by the Neonatal Team . The obstetric and neonatal consultants were in attendance . After approximately 30 minutes , a heart rate was found , and baby was transferred to the neonatal unit . . I was informed that the cord gases were [no.] for arterial and venous samples , and that the base excess was incalculable . .

19.	Access, admission, transfer, discharge (including missing patient)	We were called to the nursing home at [time] , cat A call as an upgraded GP urgent which was recived late afternoon with a 4 hour time frame . On arrival patient was cheyne stoking , DNACPR in place and family not wanting any medical intervention . Patient passed away at [time] . Family distressed due to our delay and the unexpected death . Out of hours GP also concerned due to our time delay , but accepted my medical opinion that patient was beyond medical help . . GP urgent , which was upgraded due to recieveing a 999 call regarding this patient , which we were informed was now short of breath but was initially going in to the [Hospital] with Anemia . Once patient had passed away I spoke wit the out of hours doctor who confirmed that this was now an unexpected death that may of been prevented . .
20.	Medical device / equipment	Patient had been on the defib cardiac monitor for about 2 hour just for monitoring when it was used as a defib the machine did not charge up . .
21.	Access, admission, transfer, discharge (including missing patient)	Patient discharged on [date] . Admitted with hyperglycaemia . Discharge letter states inflammatory markers raised but no source identified . Sent home without antibiotics . . Chest x-ray from [date] shows new right lower zone consolidation . Mention of CXR on discharge letter but no report and no mention of consolidation . . Patient reattended A&E on [date] acutely unwell and in severe sepsis with multiple organ dysfunction . ITU admission . .
22.	Access, admission, transfer, discharge (including missing patient)	pt transferred to [hospital 2 from Hospital 1] with pancreatitis . Unsafe transfer patient had cardiac arrest on arrival and died.patients bp unstable prior to transfer . Icu at [hospital 1] asked to see patient before transfer but not seen . Telephone call recieved from the nurse in [hospital 1] icu to myself saying the patient was very unwell and would need seeing by the H@N team on arrival I asked why the patient had not been seen by icu at [hospital 1] if patient was so sick patients relatives informed that patient was going immediately to surgery on admission to [hospital 2] site manager at [hospital 1] informed me the patient was tranferring to icu at [hospital 2] not [hospital 3] .
23.	Access, admission, transfer, discharge (including missing patient)	Telephone call from liaison Health Visitor at [Hospital] . Sadly baby died on [date], this is an expected death as baby had poor cardiac function . Liaison Health Visitor has informed the HV of this death . There are no safeguarding concerns and medics are satisfied that this baby died of natural causes related to cardiac function . The Child Death team will be arranging an intial child death meeting despite the child dying at [Hospital 2] . .

24.	Access, admission, transfer, discharge (including missing patient)	patient was admitted from A&E Patient need transfer to [hospital 2] retrieval service arrived to transfer patient . They were getting patient ready for transfer and then when moving patient to transfer trolley , patient became unstable and arrested . Consultants were called and present , cardiac anaesthetic team called and attended . After a further 2 arrests the [hospital 2] cardiologists were contacted and it was decided that the situation was unrecoverable and care was withdrawn . .
25.	Medical device / equipment	Patient had Coronary Angiogram at [hospital 2] on [date] . Presented to [hospital 1] with Abdominal pain . CTA showed bleeding from the Angio site (Right Femoral artery) . Transferred to us urgently . Arrived to A&E Resus in Periarrest status . Needed Urgent exploration of the right groin to control the bleeding . The closure device used in [hospital 2] was found to be dislodged . Currently in ITU , intubated and requiring dialysis . Most likely will die as not improving with raised lactate despite the dialysis . Then I recieved a second case on [date] with similar scenario of bleeding post angoi from [hospital 2] and also needed operation . The same finding of dislodged closure device . .
26.	Access, admission, transfer, discharge (including missing patient)	Unexpected admission to ITU post operative . ?unexpected death . .
27.	Access, admission, transfer, discharge (including missing patient)	The Shift Lead and a nursing assistant commenced the completion of the [time]hrs routine check of all service users admitted . Both professionals approached the corridor where the Service User was found laid down on the floor , one arm out reaching . The service users position was on their left side . The service user presented as unconcious , no signs of breathing , no pulse identified , both lower arm and neck checked for a pulse . No evidence of bruising , or any other identifiable injury . .

28.	Access, admission, transfer, discharge (including missing patient)	NON TRUST INCIDENT Patient transferred from [ward 1] for inpatient rehabilitation and arrived on our [ward 2] at [time]. Observations and Blood sugar taken by the late shift . One of the two registered Nurses on the night shift completed the patients admission data , and completed a [incident report] as the patient had a grade three pressure ulcer . The patient was settled by the other trained member of staff and HCA , and turned during the night . the patient was expectorating greeny yellow thick sputum . The patient had been admitted to [ward 21 following a fall on [date] and [name] surgery on [date] . Observations were taken again at [time] the patients Sats were in the low 80% . and was commenced on 2litres of Oxygen via nasal specs , which brought his Oxygen up to to the mid 90% immediately . The patient was handed over to the morning staff who contacted our Dr (over the phone) . Transfer back to[ward 1] was discussed with the patient but patient declined . The patient was assessed by the Dr and the patient was put onto the end of life care plan and died in the early hours of the next morning . .
29.	Access, admission, transfer, discharge (including missing patient)	Patient with a diagnosis of EUPD who is well known to psychiatric services . Patient has had multiple admissions to inpatient psychiatric hospital both voluntarily and under S2 of the MHA . Significant past history of substance abuse but clear on inpatient UDS . Had a period of relative stability between [year] and presentation for this admission was in response to psychosocial stressors precipitating increased self harm and suicidal ideation and planning . . Patient went on day leave on [date] . Patient did not return to the ward as expected that evening . Staff were unable to make contact with patient . . Staff reported patient circulated to police as missing from the ward. Family requested a welfare check and met the police at patient's address . . Patient was found dead .
30.	Access, admission, transfer, discharge (including missing patient)	patient who came for elective cataract extraction surgery . Was uncooperative for subtenons blockdespite sedation with Midazolam . The decision was made to convert to GA by myself and surgeon Patient's Son was informed . Pt had 100ugs of fentanyl and 100mgs of propofol . whilst being ventilated with 100% oxygen Ecg trace upheld but desaturating and EtCO2 dropping . No pulse detected on palpation . CPR commenced . Cardiac arrest call put out . Output restored after 4 cycles + Adrenaline 1mg x2 doses . .
31.	Access, admission, transfer, discharge (including missing patient)	Child seen at [time/date] after presentating with fever , diarrhoea nad rash . Seen and discharged home as possible chicken pox . Represented at [time/date] acutely unwell , with widespread petechial rash . . Raising as incident as discharged earlier and also as after intubation the C02 monitoring on the paediatric monitor in the resus bay was not working . .

32.	Access, admission, transfer, discharge (including missing patient)	Patient was admitted to the ward from [Emergency Unit] . Observations , Neurological Early Warning score of 11 . Patient was extremely unwell and tachypnoeic . ward was informed of patient poorly condition . site manager had been informed but apparently patient was already assessed in Resus Dept and patient to come down to the ward . .
33.	Medical device / equipment	Patient undergoing surgery for Abdominal Aortic Aneurysm , scheduled EVAR Procedure . Complications during surgery , conversion to open aortic graft and procedure . Unplanned admission to ICU . .
34.	Access, admission, transfer, discharge (including missing patient)	Patient transferred by Ambulance from [Hospital 1] to [Hospital 2] with a histroy of GI bleed , ?perforated DU . Admitted to EAU . Transferred to ITU . .
35.	Medical device / equipment	Patient suffering from a congestive heart failure with persistent bradycardia has had a cardiac pacemaker implant inserted on the [date] by cardiologic team . Shortness of breath detected at [time] . referred to ITU team by Dr A cardiologic consultant at [time] on the [date] for treatment of Left pneumo / heamo thorax with chest drain . Iatrogenic venous bleed following insertion of pacemaker leading to heamothorax (> 2 liter from the chest drain)causing respiratory failure . Case explained by cardiac consultant and myself to the family . patient died after further deterioration. I explain to the patient the need of limitation in invasive treatment because of premorbid condition . Patient did accept the DNAR form .
36.	Access, admission, transfer, discharge (including missing patient)	Child admited [date] , with likely Sickle Cell Disease Crisis . Treated with IV fluids , opiate and other analgesia and antibiotics . Discharged the next day despite ongoing pain and concerns . Still requiring PCA / NCA until lunchtime then had substantial oral opiate dose in the afternoon which may have masked the degree of symptoms . Substantial family , social and imigration pressures to be allowed to return home to [country] by plane the following day . Died shortly after arrival in [country] . Cause of death not known .
37.	Medical device / equipment	Patient fed via NGT by Night staff which Ph checked PH 3 as documented and handed - over to day staff . Feeding stopped by Night staff as respiration high . .

38.	Access, admission, transfer, discharge (including missing patient)	Patient just came back from Endoscopy at [time] in a peri - arrest state escorted by a nurse and porters x 2 . Apparently started vomiting blood in the corridor on their way back to AE . Nurse was told by in charge to send patient back though he knew patient was not stable for transfer to AE . On arrival to resus , patient was continuously vomiting blood / pale looking and unresponsive . .
39.	Access, admission, transfer, discharge (including missing patient)	Paramedics attended mother and child at home . Mother reports child not breathing . Paramedics attempted resus and transferred to [Hospital] to continue resus efforts . Child died at [time] in resus . Parents informed during event . .
40.	Medical device / equipment	Fitting child in A&E . Equipment availability a problem . No cuffed paediatric tubes , no soft suction catheter , no capnography attached to monitor , no paediatric circuit for anaesthetic machine . Generally very poorly managed patient who will have a hypoxic brain injury as a direct consequence of not being able to ventilate with sufficient PEEP immediately . .
41.	Access, admission, transfer, discharge (including missing patient)	999 call from patients spouse to us . coded as GP disposition . Spouse then calls 111 , this call comes to us as a Green2 . 111 advise at first look their call could have been coded incorrectly . (they are getting their call audited) . Crew arrive on scene . Request bariatric veh on lights . [names of Towns x3] veh all VOR . have one available at [Town] . as we were arranging for this to be collected patient passed away . Crew requested back up at [time], patient died at [time] with no bariatric vehicle on scene . .
42.	Access, admission, transfer, discharge (including missing patient)	Pt transferred from casualty on BIPAP with settings IPAP 26 and EPAP 10 with 35% o2 entrained . Policy states we commence BIPAP at IPAP 10 and EPAP 4 and titrate O2 to maintain SATs between 88% and 92% . Med SPR made aware and night manager pt was not for escalation or resuscitation . Medical SPR instructed casualty doctors to commence BIPAP settings at IPAP 10 and EPAP 4 when patient arrived to [ward] these settings were incorrect .
43.	Access, admission, transfer, discharge (including missing patient)	Child seen in ED on [time] and discharged home . returned the next day in spetic shock and died peri intubation in ED . .

44.	Access, admission, transfer, discharge (including missing patient)	Patient was brought to resus c / o new onsetof sore throat / unable to swallow / pt seen on arrival by DR , PT WAS ON 02 THERAPY 15 LITRES AS 02 SATS 89-90% ON AIR / tachypnoeic / tachycardiac , [DR] AWARE 02 SATS and obsewrvations . NEBULISHERS AND STERIODS GIVEN , PT REVIEW BY ITU REG ON CALL , AND WAS CLEARED TO TRANSFER TO ENT [Hospital] WITH TRAINED CREW . I WAS WITH PRIORITY CALL IN RESUS 5 , when asked to copy notes . Dr [Staff Name 1] booked transport no nurses informed / later informed patient arrest on route . .
45.	Access, admission, transfer, discharge (including missing patient)	Alerted to an unwell pt by another pts relative . Pt found unresponsive , making a laboured respiratory effort with palpible carotid pulse . I repeatedly loudly shouted for help (in the end another relative ran into the main dept to get help) , pulse then lost . Chest compressions commenced . Resusitation delayed due to location of patient and difficulty summoning help . .
46.	Access, admission, transfer, discharge (including missing patient)	Patient transferred from A&E resus without ITU review . Significantly unwell with a severe AKI , significant metabolic acidosis and anuriac . I was called to see pt with [condition] , came to review patient immediately . Med SpR on ward at time . Medical consultant on ward at time also and asked to review . Referred to ITU SpR who also came promptly . During this time patient was given IV fluids , antibiotics , calcium gluconate for hyperkalaemia and placed onto a cardiac monitor . Insulin infusion ongoing for high blood glucose of 30 . Whilst on ward at [time] patient had cardiac arrest . 11 mins of CPR provided according to ALS guidelines , however decision made to withdraw by ITU consultant based on futility . .
47.	Access, admission, transfer, discharge (including missing patient)	patient transferred from [Ward 1] and had already passed away when arriving on [ward 2] .
48.	Access, admission, transfer, discharge (including missing patient)	I received a telephone call from our elective booker to inform me that a patient who was listed for urgent angiography on [date] as part of their ' work up ' for valve surgery (to treat symptomatic severe aortic valve disease)had not yet undergone angiography , had been admitted acutely and died . .
49.	Access, admission, transfer, discharge (including missing	Cardiac arrest following complete airway obstruction secondary to acute epiglottitis / pharyngeal abscess . Initially seen at [Hospital] ED with sore throat and transferred to [Hospital 2] for ENT review . Sudden deterioration , ENT not on site . Attempted intubation failed , surgical airway difficult . Severe hypoxic brain injury / brain stem death

	patient)	. .
50.	Access, admission, transfer, discharge (including missing patient)	Report received that patient brought in less than 24 hrs after discharge in cardiac arrest . Unclear if discharge was inappropriate . .
51.	Medical device / equipment	PATIENT FOUND RIP . AIRVO OXYGEN NASAL SPECS NOTED TO BE OFF PATIENT . ON EXAMINATION OF SPECS THE RIGHT SIDE CONNECTOR OF THE NASAL CANNULA TO THE ELASTIC WHICH GOES AROUND THE PATIENTS HEAD WAS NOT CONNECTED .
52.	Access, admission, transfer, discharge (including missing patient)	Patient attended the Emergency Department on [date] and was discharged home . Patient was brought in by ambulance the next day critically unwell . Patient was admitted to ICU and died . .
53.	Access, admission, transfer, discharge (including missing patient)	Dr contacted endoscopy on [date] requesting gastroscopy . No gastroenterologist available in endoscopy , advised to bleep Dr on call if needed that afternoon and could be facilitated in endoscopy on [day] otherwise patient would be listed on [day] bleed list . Did not receive any further contact therefore patient was listed for [day] morning . Patient subsequently passed away overnight .
54.	Access, admission, transfer, discharge (including missing patient)	Information was received at the Daily Management Meeting at the local Police Station that the Service User had taken an overdose of their parent medication and had been taken by police to the local Hospital where they had subsequently died . .
55.	Access, admission, transfer, discharge (including missing patient)	Baby born [date/time] , early discharge from midwifery care , readmitted via T / C as parents had concerns about the baby , mum contacted midwife and advised to bring back to the ward . . Transferred to NICU on resuscitaire , IPPV via bag and mask . Baby placed in incubator , BiPAP , saline bolus , dextrose infusion , commenced antibiotics , intubated and ventilated , received actracurium . Medical staff liased with [transport service] team , abdominal and chest x-ray , catheterised . . Transferred out by [transport service] Team to[hospital] at approximately [time/date].

		UNEXPECTED READMISSION , SUBSEQUENT TRANFSER OUT AND RIP [date] .
56.	Access, admission, transfer, discharge (including missing patient)	Patient admitted to ICU on [date] following hypoglycaemia with GCS 3 . Discharged planned for afternoon of [date] and handed over to [ward] team , then delayed until [time], but actually discharged at [time/date] . Patient refusing cannulas , catheter , bloods and observations as documented by ICU . Had 1:1 special with patient who noticed incontinence and then cardiac arrest was confirmed . Cardiac Arrest call at [time] , treated as hyperkalemic arrest as potassium 9.6 . After 24 mins of ALS team stopped and patient died . .
57.	Access, admission, transfer, dlscharge (including missing patient)	Pre - Alert to ED of sick child , GCS 9 , tolerating oral airway . un - recordable BP , saturations of less than 90 , pulse 202 , resps 60 . On arrival child being ventilated by ambulance crew and on transfer to ED trolley the child suffered a cardiorespiratory arrest . .
58.	Access, admission, transfer, discharge (including missing patient)	Called to a patient panic attack . mobilised initially and stood down from incident due to coding . A duplicate csll was raised later which coded higher which I was mobilised on . Within 10 mins of arrival after an initial assessment I requested a crew to backup Priority 2 due to unexplained breathing difficulties at [time] . After waiting 40min with no backup the pt deteriorated quickly ultimately resulting in cardiac arrest . Backup request upgraded to priority 1 at [time] which arrived within a few minutes . We managed to regain a cardiac output and transported to [hospital] A&E where the patient later died . .
59.	Access, admission, transfer, discharge (including missing patient)	Two cases of legionnaires disease identified one in ITU [Hospital] [date] and one in ITU [Hospital 2][date] . Both patients have been cared for on the coronary care units at both hospitals so overlap in clinical areas visited . One patient has since been discharged home but th esecond patient remains in ITU at [hospital] . The Trust is working closely with Public Health England to identify the source of the outbreak ie whether this is hospital or community .

60.	Access, admission, transfer, discharge (including missing patient)	Patient admitted with constipation and faecal vomiting ? bowel obstruction . Was suggested in A&E that patient needed CT CAP . This was not performed . Abdo xray done . Showed dilated small bowel loops . Surgical SHO discussed the patient and said to refer to medics without CT scan . Surgical SHO did not show these images to the registrar . Patient arrived on [Ward] and seemed better . Then started to vomit large amounts of faecal matter and would not respond to staff instructions to spit out . Patient aspirated on vomit and went in to cardiac arrest . DATIX submitted on behalf of med reg . .
61.	Access, admission, transfer, discharge (including missing patient)	Patient had waited [no.] days as an inpatient on [ward] . . Gradual deterioration over the WC [date] with a more rapid decline [date-date]. . Significant difficulties experienced in escalating care with [hospital] which delayed transfer , eventually sent as an emergency on [date] . Patient had surgery [date] but died shortly after .
62.	Access, admission, transfer, discharge (including missing patient)	Patient transferred back from [hospital] for further treatment of infective endocarditis . This patient She arrested after being transferrd at [hospital] and was taken for emergency surgery but died the following night . . .
63.	Medical device / equipment	Patient had Coronary Angiogram at [hospital] on [date]. Presented to [Hospital 2] with Abdominal pain . CTA showed bleeding from the Angio site (Right Femoral artery) . Transferred to us urgently . Arrived to A&E Resus in Periarrest status . Needed Urgent exploration of the right groin to control the bleeding . The closure device used in [hospital] was found to be dislodged . Currently in ITU , intubated and requiring dialysis . Most likely will die as she is not improving with raised lactate despite the dialysis . Then I recieved a second case on [date] with similar scenario of bleeding post angoi from [hospital] and also needed operation . The same finding of dislodged closure device . .
64.	Access, admission, transfer, discharge (including missing patient)	[time]Telephone call received from Service user child expressing concern that they had not had contact with their parent for two days . Assistant Manager of [Service] spoke with child and options were considered [options]. It was agreed following above conversations that Assistant Manager would pay a home visit to try and assess situation and check on the service user welfare . [Time], Assistant Manager and [Service]Support Worker visited home address , initially unable to gain access. [Time] Neighbour opened door to allow access , unable to get obtain a response from service user flat door , key appeared to be on the inside of the door . [time]Telephone call made to the police 101 , for assistance . [Time] Police arrive on site , take staff details and details of incident , attempted to make contact , decision made by police to gain forced entry . [time] [service] Manager arrived on site .

		Entry gained to property , police inform staff that occupant of property was deceased , [service] Manager was asked to identify the deceased body . Body identified as the servcie user . Ambulance in attendance .
65.	Access, admission, transfer, discharge (including missing patient)	Standby call , Child in cardiac arrest , ? down time for 25 minutes . child arrived in ED with mum approx [time] , APLS continued until [time] , child passed away . . Child had attended ED last night after ? ? ingestion of ' TURPS' substance , was seen by ED , referred to Paeds team , admitted to Childrens Ward , seen by Paeds SHO , observed for a period of time as advised by toxbase and discharged home in the early hours of the morning . .
66.	Access, admission, transfer, discharge (including missing patient)	Patient was brought in by paramedics in cardiac arrest , CPR attempts were terminated as the pupils were fixed and dilated and there was no evidence of response to treatment efforts . On reviewing previous notes , it was seen that the patient had been discharged from [ward] [hospital] the day before , and that the blood results were grossly abnormal on discharge , with a worsening from the admission bloods . There was no mention of this in the discharge letter .
67.	Access, admission, transfer, discharge (including missing patient)	PROM , baby on IV antibiotics , history of poor feeding . Baby lethargic and floppy . Transferred to NNU for BM and lumber puncture . .
68.	Access, admission, transfer, discharge (including missing patient)	Support worker and family member raised concerns - welfare check on patient revealed patient deceased at home . .
69.	Access, admission, transfer, discharge (including missing	Patient fell down stairs , [Ambulance Service] took patient to an Urgent Care Centre at [Hospital] . Patient GCS 15 / 15 on arrival , however developed headache , vomiting and blurred vision , patient then sent to the [Hospital 2] , GCS 6 / 15 . CT scan at [Hospital 2] showed traumatic subdural haematoma with midline shift . Patient then transferred to [ward] as a trauma call , however , by this stage

	patient)	the patient had an unsurvivable head injury , patient RIP . .
70.	Access, admission, transfer, discharge (including missing patient)	Service user had unescorted leave at nursing discretion . The patient had written a time on the patient board of intended return time and had previously returned on time on all previous occasions . However , patien was over 1 hour late returning on this period of leave and was not contactable on mobile or visible in the hospital grounds and staff became very concerned . .
71.	Access, admission, transfer, discharge (including missing patient)	Approached by consultant who had had a letter from a gp enquiring why one of his patients was discharged without clexane . Patient had died 4 days after discharge and post mortem showed PE as cause of death . .
72.	Access, admission, transfer, discharge (including missing patient)	patient admitted at term plus 7 for augmentation of labour due to prolonged rupture of membranes.went to theatre for a trial due to a pathological ctg , FBS was normal prior to transfer to theatre . baby delivered by forceps in poor condition . [date] Unexpected death of a term baby born on [DOB] . Had prolonged resus at delivery . Baby was ventilated , required CFM monitoring , blood pressure was difficult to maintain with medication and gradually started to reduce .
73.	Access, admission, transfer, discharge (including missing patient)	The patient was admitted to [Unit] on [date] following a stroke . Patient was subsequently stepped down to the Stroke Unit to continue rehab prior to discharge . The patient was discharged on the [date] following a successful home visit . It was subsequently discovered that the patient died at home on the [date] . Following discussion with the coroner it has been confirmed that the cause of death was given as 1a) PE , 1b) DVT , 1c) CCF & II) Hypertension and Cerebellar Infarct . .
74.	Medical device / equipment	Nursing staff reported a patient who had become acutely unwell after starting naso - gastric feeding . CXR confirmed the NG tube was placed in the right lung and not stomach . .

75.	Access, admission, transfer, discharge (including missing patient)	The incident is a decision made to discharge a patient who is then brought back to the ED 4 days later in cardiac arrest. The patient was seen in the ED on the [date] after experiencing a brief period of breathlessness and pre syncopal symptoms . Patient was seen , discussed with the ED Consultant and referred to the cardiology team as ACS / NSTEMI because they had a strong cardiac history , was taccycardic and had a Troponin of 28 and a raised D - dimer . The cardiology reg felt the patient could be seen by the medical registrar . The medical registrar saw the patient and discharged the patient home ? after further cardiology discussion . The patient was brought in in cardiac arrest and died [date] It is unknown whether admission would have prevented this outcome but the case should be reviewed by the cardiology and medical teams . .
76.	Access, admission, transfer, discharge (including missing patient)	Patient admitted to [Unit] cardiogenic shock due to bilateral PE and with a concurrent ischaemic leg . Recent discharge from [ward] at [hospital] with rivaroxaban . Patient discharged with 40 days of treatment on TTO supply . Patient stopped 5 days preadmission as a result of running out of medication prior to anticoagulant clinic appointment . .
77.	Access, admission, transfer, discharge (including missing patient)	patient was awaiting a mental health bed under informal admission patient left the department . recieved confirmation from Mental Health team that patient had committed suicide [date].
78.	Access, admission, transfer, discharge (including missing patient)	Patient transferred to ward at [time] from ITU , having been allocated to the ward at approximately [time] , by Duty Site Manager . On arrival to the ward , patient had a NEWS score of 8 , due to respiratory rate of 56 , oxygen sats of 92 , on 4 litres of oxygen via nasal cannula , and a heart rate of 108 . Patient subsequently arrested at [time/date].
79.	Access, admission, transfer, discharge (including missing patient)	Maternal collapsed five days post CS in ITU . CS was done at 32 weeks on [date] . Mother underwent laparotomy for possible bowel perforation on [date] . Deterioration following laparotomy while in ITU . . Resuscitation attempted but mother had not responded . .
80.	Medical device / equipment	Patient, critically ill on Intensive Care . Percutaneous tracheostomy performed in attempt to improve chances of survival . Significant bleeding from tracheostomy site with subsequent blockage of tracheostomy , difficult ventilation , re - intubation , cardiac arrest and

		death . .
81.	Access, admission, transfer, discharge (including missing patient)	Patient was seen x2 in the A&E department on the [date] and was discharged on both occasions . Patients family presented to the A&E department the next day very angry and upset and informed me that the patient was discharged home and had died during the night . Family distressed and want to make a formal complaint . . .
82.	Access, admission, transfer, discharge (including missing patient)	Sudden collapse and death of extreme premature baby, assessed as stable and transferred back from [Hospital]NICU on [date] to [Hospital 2] NICU at [time] . .
83.	Medical device / equipment	Patient repatriated from [country] following head injury and surgery with tracheostomy in situ . Tracheostomy changed yesterday . CORTRAK NG feeding tube inserted yesterday and position confirmed on CORTRAK by 2 competent Ward Nurses as no aspirate . Patient fed but when patient started looking more unwell discussed with medical team and feed stopped approximately 4 hrs later . This am progressively more deterioration , CXR done , report inconclusive of NG position but on CORTRAK review was in the lung . Patient transferred to ITU and ventilated , commenced on antibiotics . Family informed by primary team . .
84.	Access, admission, transfer, discharge (including missing patient)	Patient attended yesterday with a collpase and minor head injuryassesdd by ed team , acute medicine and opal consultant seen by idt discharged but died at home on [date] gp has phoned to notify ed .
85.	Access, admission, transfer, discharge (including missing patient)	Patient revieweda on [date] when patient was drowsy and not eating . Patient was hypoxic with peripheral cyanosis and saturations were reading 59% on room air , patient was started on high flow oxygen and titrated down . Blood gas at [time] demonstrated a type 2 respiratory failure and medics were bleeped . The medical SpR reviewed the patient at [time] and accepted patient for IV antibiotics for a hospital acquired pneumonia . Bed managers were made aware at this point and a cannula inserted so as to not delay treatment when transferred . Patient was finally transferred to [Ward at [time] . (Delay of 7 hour and 30 mins for IV abx) . Patient passed away on [date] . .

86.	Access, admission, transfer, discharge (including missing patient)	Patient was pryrexic (38.5) at [time] on [date]5 , the duty doctor was bleeped who advised to give co - codamol , I arrived on the ward just before [time] and saw patient immediately , I took a full set of bloods , cultures and a blood gas . At this point Patient was less agitated and nursing observations were performed , patient's MEWS score was 8 (temp 38.5 , BP 95 / 40 , HR105 , RR 28 , Sats 80% RA) . Portable XR performed , cannula inserted , as MEWS score was peri - arrest so a stat dose of IV co - amoxiclav at [time] . The medical SpR reviewed at [time] and accepted for IV antibiotics . Patient was finally transferred to a medical ward at [time] . (Delay of 11 hours) . The following morning the medical ward requested that patient return to the psych ward as had pulled out cannula , this was later rescinded . Patient passed away on [date] . .
87.	Medical device / equipment	Patient had [surgery] and had started to bleed at the end of the surgery , massive heamorrhage activated . Colorectal surgeons and Vascular surgeons attended in theatre . patients condition had appeared to have stabilised prior to transfer to ICU at [time] , however prior to arrest patient had become hypotensive and surgeons had already been called back to ICU so was in attendance at time of arrest .
88.	Access, admission, transfer, discharge (including missing patient)	999 call received at [time] call taken through AMPDS , coded G3 and sent through to [Ambulance Service] for enhanced clinical assessment . CAT team called the patient back at [time] note entered into call " Line now continually engaged upgraded as failed contact " at [time] the call was escalated to a G2 call requiring a 30 minute response . First res - allocate completed at [time] , note entered into call 7 uncovered 999 calls holding in [area] division at this time . Further res - allocated completed at [time, time, time] with no resource available call held . CAT welfare call completed at [time] call escalated to G1 requiring a 20 minute response . Res - allocate completed again at [time] no available resource , note entered " 10 uncovered 999 calls holding in [area] division at this time " Further res - allocated completed at [time and time] . First available resource allocated at [time] with an eta of 22 minutes due to demand this resource was diverted by the dispatcher to an amber back up at [time] . The next available resource was allocated at [time] arriving on scene at [time] . FRV updated EOC at [time] patient in cardiac arrest . FRV advised patient K1 at [time] .
89.	Access, admission, transfer, discharge (including missing patient)	Cardiac Arrest of patient admitted 24hrs earlier with MI from [clinic] Patient subsequently died .

90.	Access, admission, transfer, discharge (including missing patient)	Reason for Admission & Diagnosis : Megacolon secondary to pseudoobstruction / multi - organ support . . Admitted to hospital with acute abdomen . Patient had elective total knee replacement on [date] . Discharged home with opioids leading to constipation (bowel not opened since then) pseudo obstruction . Came in multi - organ failure . Admitted to ITU and then had laparotomy . Died despite maximal therapy . .
91.	Access, admission, transfer, discharge (including missing patient)	Patient assessed in A E diagnosed with CAP . She was discharged with oral antibiotics despite tachypnoea RR 28 relatives described an e , hypotension bp 99 / 60 , consolidation on CXR , acute renal failure Cr 134 and CRP 455 . . She returned 2 days later . She required ITU admission and unfortunately died from the pneumonia . if she was admitted for IV antibiotics and fluids and oxygen she may have survived .
92.	Access, admission, transfer, discharge (including missing patient)	Unexpected child death Child presented with vomiting at [time] Provisional diagnosis of Pyloric Stenosis SVT diagnosed at approximately [time] Treated with Adenosine Decompensated and went into PEA and then Asystole Didn't respond to resuscitation The parents have expressed concerns around child's care / management , the coroners report is inconclusive at this stage . .
93.	Access, admission, transfer, discharge (including missing patient)	Patient attended A&E following GP concerned about a palpable inguinal hernia . Patient returned to A&E 4 days later and died shortly after . Primary cause of death was bronchial pneumonia and small bowel obstruction . Investigation following a complaint has raised concerns whether the patient should have been sent home with the small bowel obstruction . .
94.	Access, admission, transfer, discharge (including missing patient)	Patient collapsed with a severe headache and hemiplegia in [Town] at approximately [time] . Despite having a clear indication for a CT head scan and a likely neurosurgical consultation , was taken to [Hospital] where it was known there was no functional CT scanning facility and subsequently transferred to [Hospital 2] for a CT scan . A brain haemorrhage was diagnosed on the scan and the patient was subsequently intubated and ventilated prior to transfer to the neurosurgeons at [Hospital 3] . Patient left [hospital 2] ED at[time]on [date].
95.	Access, admission, transfer, discharge (including missing patient)	Tried to complete Home Call , no answer , rang daughter on mobile number in patient record , she informed me parent had telephoned her [weekday] night in ' a right state ' , daughter telephoned grandson who helped Grandparent to bed , patient telephoned daughter am Tuesday still not good , daughter telephoned Grandson again who was at work to check on parent , Grandson found him unreponsive (RIP) . Patient was discharged home from [ward] [hospital] on [date], daughter had requested discharge to take place on [date] when she was back from holiday as she was main carer for parent , stated also in discharge

		summary that no package of care in situ daughter does cooking and cleaning . Wrong name is also mentioned in discharge summary . .
96.	Access, admission, transfer, discharge (including missing patient)	A patient died in hospital . The coroner contacted the GP to request issue of a MCCD . A patient had died in hospital . The patient had not been seen in the last 14 days and GP declined . It went to postmortem and the death was confirmed from natural cause due to DVT and PE . GP rang spouse of deceased patient to offer condolences as is his routine practice . During the bereavement support discussion spouse disclosed that they came (walked in) to surgery [date/time] requesting a GP appointment . Spouse was advised by a receptionist that we were fully booked and to contact the practice tomorrow . The spouse admitted that they accepted this advice and did not push the issue . Later that day , the patient had leg pains and collapsed whilst climbing stairs . An ambulance was called and patient was taken to hospital where patient died during the night on [date] . Practice manager spoke to receptionist on duty that evening [date] and conducted an investigation . She advised she cannot recollect any unusual requests / nothing out of ordinary . PM contacted MDU to seek advice . convened an urgent meeting with GPs and nurse practitioner . all present agreed that this was a sad occurence but reception staff are very good at seeking help / advice and fitting extras in . there was clearly no urgency / worry from spouse / patient . MDU advised us to make coroner aware - apparently a post mortem had alredy taken place that morning [date] and cause of death was ' ; natural causes' ; . the coroner praised the practice for honest open culture . coroner had already spoken with spouse about the findings of the post mortem - massive PE as a result of a DVT and the case was closed .
97.	Access, admission, transfer, discharge (including missing patient)	Staff in ED informed by [ambulance service] staff that patient who had recently been discharged home had died at home . .

98.	Access, admission, transfer, discharge (including missing patient)	Patient admitted to [ward] from [hospital] A&E . SHO on call discussed with bed manager and myself about the transfer in the middle of the night . we all agreed that the best option for this patient was to be admitted during the day . Spr on call from CXH bleeped SHO on call and told he will send the patient immediately after CT scan of abdomen . Patient arrived at [time] to the ward , was alert and orientated but refused to answer questions into details . News Score on admission was 1 for temperature (36degree) . after 9am , News score was 7 and GCS of 11 . gcs reduced pateint not responding patient was self caring prior to admission to CXH following a fall .
99.	Access, admission, transfer, discharge (including missing patient)	patient who had been discharged against sons wishes from the local hospital 1-2 days previously (no discharge summary) following haematemesis was seen as an emergency with recurrence . Noted to be very unwell as soon as seen by myself , pale , sweating , difficulty talking . Attended with son and [spouse] who were able to tell me briefly that patient had continued to produce coffe ground vomit post discharge . I got patient to lie down on a couch immediately . As soon as patient laid down the patient said they felt sick and sat up to vomit . Whilst assisting the patient with this the patient started to loose consciousness . I thought this was vasovagal and laid the patient back down again and as I did so the patient arrested . I immediately started chest compressions and asked the relatives to tell the nearest member of staff there was a cardiac arrest , to get other mebers of staff to help and call a 999 ambulance . Almost immediately a doctor came in the room with a Defib and another doctor and nurse followed . We continued ressuscitation with chest compressions and bagging , having sucked out the airway , until the ambulance tean arrived aprox 8mins later . The patient was in EMD so DC shock not required . They then took over control of the ressus whilst we assisted . IV adreaine was administered and for a short time the patient re - gained an output . The air ambulance crew were called and took over when they arived again with our assistance . Eventually the patient was transfered by road ambulance to hospital with a cardiac output although no spontaneuos breathing . Unfortunately we later heard that the patient had died in hospital aprox 5 hours later . .
100	Access, admission, transfer, discharge (including missing patient)	Baby born by caesarian section at [time]Suspicious CTG prior to C / section , difficult delivery of head , impacted into the pelvis . Heart rate at birth 60bpm , cardiac massage commenced immediately . .

101	Access, admission, transfer, discharge (including missing patient)	At approx . [time] the police phoned to say that pt had removed the [vehicle] and managed to drive off in the [vehicle] . Police reminded of the risk history towards patient and others . Subsequent phonecalls from the police to clarify next of kin details so liased with crisis team for further details . At approximately [time] it was confrimed that pt had died in the crash and next of kin were being informed . . .
102	Access, admission, transfer, discharge (including missing patient)	Patient experienced a nose bleed at [time] . . The patients spouse dialled 111 for advice and guidance on how to help soon after . 111 advised the spouse they would pass the call onto [organisation] who would provide a clinical call back . . The call back was never received by the patient , so after waiting roughly an hour , the patients spouse called 111 back to find out how long the call back would be . 111 then advised the patient they had no record of the call so would have to log a new call . The patient was still experiencing a nose bleed and the patients spouse was becoming increasingly concerned . . After waiting again for a call back , the patients spouse called 111 for the third time , for advice as the patients nosebleed was not stopping and the husband was becoming concerned . During the third call the patients spouse was told to put the patient in the car and go to A&E . The patients spouse explained they could not do this as the patient uses a zimmer frame and the patient's nose was bleeding profusely . The patient was also very panicked and coughing . . The patients spouse then dialled 999 . I was dispatched to the CAT C 60 response at [time] . En route I was advised the patients spouse had called back to advise a change in the patients condition , the call was upgraded to a CAT A - RED 2 Unconscious @ [time] , then further upgraded to a CAT A RED 1 . . On arrival the patients spouse was performing CPR and after full resuscitation efforts the patient was pronounced deceased at [time]a . The police were informed of the full events leading up to our arrival . It is thought the patients cause of death was due to the amount of blood lost to a nosebleed . .
103	Access, admission, transfer, discharge (including missing patient)	Patient attended with falls after banging head . Discharged and readmitted within 4 hours with acute subdural and intra - parenchymal haemorrhage .

104	Access, admission, transfer, discharge (including missing patient)	It was handed over by the day staff that the patient proceeded for 5hrs section 17 leave with parents at about [time] and was due back at [time]. At about [time] the patient's mother rang the ward to report that [Patient name] has run away . At around 3am the British Transport Police , PS [Number 1] [Staff Name 1] and PC[Number 2] [Staff Name 2] attended the ward to inquire about the patient who they said match the description of someone who had [attempted suicide] , but they were not sure yet as they have not identified the body . They took the details of the patient's parents and were going to their place so as to inform them of same and also to get a recent picture to match the CCTV footage . So far they said they can`t confirm if it is the patient or not .
105	Access, admission, transfer, discharge (including missing patient)	A patient was referred by GP on [date] for an endoscopy , the referral said patient needs to be seen ' urgently' . Patient was added to the waiting list on [date] , but as a routine patient . The patient was then referred to outsourcing on [date]. An incorrect contact number was logged on PAS , which outsourcing attempted to call on [dates] . We then got the correct number from the GP and tried again on [dates] , but couldn't get through . We sent a contact letter on [date] and then made another attempt to call on [date] and got through , at which point the patient accepted private treatment and had not expressed a preference as to which hospital to go to, so went to [hospital] as they had the best capacity . the referral was sent to [Hospital] on [date], and the patient was given a TCI date of [date] . [Hospital] went to call the patient to confirm the arrangements on the [date] but were informed the patient had since passed away . The outsourcing team contacted the GP to confirm the date of death and were informed the patient had died at [Hospital 2] from spontaneous GI bleeding . .
106	Access, admission, transfer, discharge (including missing patient)	At [time] the patient suffered a large haemorrhage (800ml) from nose and mouth that settled with nose pressure . ENT scope did not show a bleeding point . The patient had a 3 unit blood transfusion and improved . . At [time] the patient had a huge bleed from mouth and nose . The major haemorrhage protocol was activated . The patient had a PEA cardiac arrest and had 15 minutes of CPR . The patient had several shorter periods of PEA and CPR . Blood products were given through a Level One infusor from theatres . . Nose and mouth were packed with foley catheters and swabs . It was then noticed that the patient was bleeding from the tracheostomy site . The patient was intubated in the mouth under sedation and the tracheostomy removed . Instead of packing a bleeding vessel , there was a huge haemorrhage and the patient suffered another cardiac arrest . The trachy was reinserted and pressure applied to the righ carotid artery which stopped the bleeding . . The patient was rushed to theatre where there was ongoing catastrophic blood loss . ENT , vascualr and

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		cardiothoracic surgeons managed to stop the bleeding , but the patient suffered another cardiac arrest and the heart did not start again . . The haemorrhage was unexpected and is unexplained . .
107	Access, admission, transfer, discharge (including missing patient)	I was asked by the Med SpR on Call to attend A&E to see an unwell patient who had a history of alcoholic liver disease , liver cirrhosis . Hepatitis C and ex - IVDU . The patient was admitted with central abdominal pain and had tried to stop drinking alcohol 1 week before . Was vomiting and had loose stool . On my arrival the Med SpR had spoken to the surgical SpR at [hospital] who had accepted the patient , however they needed a consultant referral to A&E . The ITU team were present but hadn't seen the patient and were waiting for my review . . [review] I spoke to the ITU consultant to transfer this patient to [Hospital] as remained hypotensive and was likely to need inotropic support on transfer . We were told that the journey was only 10 minutes and that the patient may be able to go with a medical doctor . . I then phoned [hospital] A&E who created an A&E bed for the patient, the surgical SpR would then assess there . The ITU consultant agreed that one of his SpR would take the patient to [hospital] but wanted a femoral line to be placed first for access . I asked whether the medical team should stay to be with the patient and was informed that the line would be placed and the patient would then be transferred by ITU to [hospital]. I believe at that stage , the patient would have been fit to transfer to [hosptial]. . I understand however that there was a delay after I left during which time the patient continued to deteriorate and unfortunately passed away . .
108	Access, admission, transfer, discharge (including missing patient)	The patient had a CT scan of the head performed in [month/year] . I was able to see the report of the scan , which described a colloid cyst and hydrocephalus . The conclusion of the CT report recommended an urgent neurosurgical opinion . I understand the patient was awaiting an outpatient appointment with Mr [Staff Name] this coming week . Unfortunately due to delays the patient has collapsed at home on [date/time], unconscious , and despite efforts to resuscitate and perform bilateral external ventricular drain insertions , the patient has died . .

109	Access, admission, transfer, discharge (including missing patient)	Coroner notification of death . Client referred to PCMHT via gateway [month/year]. No evidence of processing of referral on [Admin System] . .
110	Access, admission, transfer, discharge (including missing patient)	Patient self presented to the Emergency Care area of the ED at [time/date] and was seen by an FY2 doctor at [time] . History given was headache , neck pain , fever and D&V . Patient assessed and diagnosed as viral gastroenteritis and dehydration . Bloods taken and reviewed . Given analgesia and discharged home with the advise to drink plenty of fluids and to return if symptoms have not improved in two days . . Patient returned to ED at [time/date] into the resuscitation area critically unwell and was seen immediately on arrival by the SpR . Patient was reviewed by the RMO , general surgical SpR and critical care and transferred with diagnosis of severe sepsis . . Patient subsequently died on ICU with a confirmed diagnosis of meningococcal septicaemia . . On review of ED the notes it appears that the patient was inappropriately discharged on their initial attendance as patient had abnormal blood results and physiology . Further tests were not undertaken to establish a clear cause for symptoms . .
111	Access, admission, transfer, discharge (including missing patient)	Phone call from placement that Patient A was going too for respite . They stated that they were expecting Patient A yesterday and was wondering where they were . Staff A stated that they werent aware of this but would hand it over to Staff B. Staff B arranged for Patient A to go to the placement that afternoon . It was noted that the placement that Patient A was at had let Patient A out as they had asked to go to the pub . They agreed to this . Phone call from the police at [time] stating that Patient A had left the placement hours previous and had not returned . This was when Patient A was a missing persons and the police started to search . It was noted from Staff B that patient A was in a happy mood , no different to their presentation on the ward previous . Patient A was willing to go to the new placement at the time they were asked . Plan : For police to carry on the search . Staff to have supervision if required / requested . For the family to be updated of any news . Patient later found dead by the police . .
112	Access, admission, transfer, discharge (including missing patient)	Patient called NHS111 service , advised was feeling exhausted and had tried to [commit suicide] 4 times earlier . Difficult to assess as patient has kept putting phone down and has some hearing difficulties . Call handler has sought clinical and non clinical advice . A decision was made to send a G2 emergency ambulance to the address for clinical safety . . Later in the night shift a call came from EOC at [ambulance service] , they had responded to the address and found the patient deceased . They requested information as to whether the

		patient was the caller initially , which was confirmed . .
113	Access, admission, transfer, discharge (including missing patient)	Call received at [time/date]) who states that a passenger has come down to him and said has had a seizure and then collapsed (making funny noises and turning blue) . The call was coded a R2 and there was an overall response time of 14 minutes . The call audit came back as non - compliant (attached) A? key question of is patient breathing was not updated to say ineffective / agonal which would have identified that the patient needed immediate intervention . PAIA?s were not entered until 7 minutes and 30 seconds in to the call A? the crew have noted that when they arrived patient was in cardiac arrest and no CPR was in progress . Patient was pronounced dead shortly after arrival at A&E .
114	Access, admission, transfer, discharge (including missing patient)	Patient suffered from ventricular tachycardia while being operated for intra - abdominal bleed following laporatomy 48 hours ago . The ventricular tachycardia was unresponsive to 28 minutes of CPR and DC shocks as required and IV fluids and blood . .
115	Access, admission, transfer, discharge (including missing patient)	Patient absconded from ED last night following attendance with Overdose . Patient awaiting admission under medical team receiving active treatment . Patient pulled out lines and left department . ED staff reported incident to police . [Trust] have attempted to locate patient today and have been informed by relative that patient had been found and was pronounced dead . .
116	Access, admission, transfer, discharge (including missing patient)	patient was booked for an aneurysm repair on the [date], but was cancelled due to an emergency at the hospital . The consultant advised that he would like to use the delay to apply for funding for a bespoke stent , and that this would take around 6 weeks . A further date was arranged for the[date]but was cancelled on the morning of surgery as there was no ITU bed available . Surgery was re - booked for the [date] , but the patient died of a ruptured descending Thoracic aorta on the [date] . .
117	Access, admission, transfer, discharge (including missing	Patient apparently left the ward unnoticed at approximately [time] , phone call received from a staff member at [time] that pt had been sighted at the top of the hospital drive near the ambulance station Staff nurse and ward physio left immediately to collect the pt , by the time they arrived the staff member had left and there was no sign of the pt . Staff had informed the staff who reported the pt that they were

	patient)	on their way immediately .
118	Access, admission, transfer, discharge (including missing patient)	Patient presented at AAA [time] as a GP referal with leg swelling , seen and treated as DVT , fragmin administered , VTE , district nurse and doppler follow up arranged . . Patient represented [time] as an out of hospital arrest . Resusitation attempted but patient pronounced dead at [time] . . Police called following discussion with family and A / E consultant . . AAA lead consultant made aware of incident and rapid review to be completed for review . Contacted District nurses to cancel visit before they contact the family and will refer family to bereavement service . .
119	Access, admission, transfer, discharge (including missing patient)	this patient was referred by gp , arrived on ambulatory and was awaiting triage as 3 patients arrived at same time . whilst awaiting triage as another patient currently being triaged spouse assisted patient to toilet . Spouse called for assistance from toilet were patient was found in collapsed state on the toilet . crash call put out as patient not breathing . transferred to resusc as being resuscitated were patient died .
120	Access, admission, transfer, discharge (including missing patient)	Term baby admitted to the neonatal unit in poor condition , convulsions . .
121	Access, admission, transfer, discharge (including missing patient)	Pt was transfered as a stable medical pt to outlie to the ward . I came on shift to the previous nurse who had to run and get the pt from costa as was having severe chest pain . the medical reg was fast bleeped and on the ward at the time my shift started . He stated the pt needed to go to CCU and that there was a bed and that CCU would ring ASAP . Iv morphine given to pt prior to my shift starting . When i came on shift the reg was here and pt was stable with a non rebreath mask on - saturating 98% 60% O2 and stable bp . I asked fellow staff to ring CCU and get an update on the bed as pt was deteriortaing . The staff stated that the bed wasnt ready yet and they couldnt spare staff to come and get the patient as they were not fully staffed themselves . Bedmanagers rang the ward and spoke to fellow SN and said when it was ready they would help me transfer the pt . Pt complained of feeling sick - IV cyclizine given - pt a little while after became harder to arounse and sats started to drop to low 90% on 60% o2 i repeted the BP and that had dropped - Rpt ECG done as well . i asked fellow staff to fast bleep the medical reg as i wanted him back now - our ward dr heard this and came to see the pt and began to assess . Ambulance staff were also on the ward and asked if we needed help , they got gloves came to see the pt. Medical reg then arrived during this . Drs asked to cardiac monitoring - had to borrow from [ward] the a CCU nurse arrived . - A crash call was then put out at aprox [time] . team

		arrived and took over . .
122	Access, admission, transfer, discharge (including missing patient)	Serious Incident A call was received at [time/date]. The call was sent through as a 12 hour " speak to " with the message " been vomiting and not eating , pain in the abdomen , pain in throat " . The call was sent into the clinican call back queue and at [time] a triaging doctor assessed the symptoms documented on the S1 call and upgraded the call to a 6 hour routine . At [time] a triage doctor called the patients home and was informed by the patients spouse that the patient had passed away during the night and had been found dead in their chair at approx [time]. . .
123	Access, admission, transfer, discharge (including missing patient)	patient was admitted with high blood pressure . After medical review , patient was prescribed antihypertensive medication and nursing staff were requested to give this . On enquiry 2 hours later patient was still not given this . Blood pressure was consistently high and doctors were not informed regarding this . Patient was found less responsive in the morning , was taken for a CT scan but could not have this as deteriorated further and died . .
124	Medical device / equipment	ULTRASOUND EQUIPMENT NOT FIT FOR PURPOSE - SIGNIFICANT SUBOPTIMAL CARE AS RESULT . Critically unwell patient Cardiac cause Assessment underway by consultants in Emergency Medicine & Intensive Care Medicine . Unable to confidently make rapid diagnosis due to lack of working near patient imaging due to failure of cardiac (echo) probe on ED Ultrasound Machine - problem already recognised & appropriately reported prior to incident . Patient deteriorated to cardiac arrest & died .

125	Access, admission, transfer, discharge (including missing patient)	The patient had an elective left knee revision on [date] . From my point of view the anaesthesia / surgery was uneventful save the epidural insertion was hard / challenging . The patient received preop cefuroxime (the implant was not known to be infected) . . I understand the patient went home well , but became unwell at home and was readmitted . During the final stay the patient had positive blood cultures , imaging , returned to theatre and ICU care - but I wasn't involved in those . . the patient died on ICU . .
126	Access, admission, transfer, discharge (including missing patient)	Patient admitted to [Hospital] on [date] with NSTEMI , underwent coronary angiography on [date] which showed severe three vessel disease and was referred for CABG on [date]. Patient was discussed at surgical meeting and activated on [date]- [date] bed manager aware - needs to come over weekend . Next note [date] needs admission as priority today . Patient suffered acute myocardial infarction [date]r and died in [Hospital] after being transferred as emergency . .
127	Access, admission, transfer, discharge (including missing patient)	Informal patient left the ward at [time] and did not return . Patient was not signed out on the visible nurse sheet . Not on the ward for any of the ward checks and staff attempted to contact patient at [times] with little success . Missing person policy implemented at [time] .
128	Access, admission, transfer, discharge (including missing patient)	Patient suffered cardiac arrest on ward .
129	Access, admission, transfer, discharge (including missing patient)	999 call received at [time] A? No allocation advised to contact 111 111 call received at [time] . Triaged call and went to clinician . Self - care and worsening advice provided . 2nd 999 call received at [time] A? patient in cardiac arrest . Resuscitation on scene then ROLE . Call audits of the 1st 999 and 111 calls have found that both calls have fallen outside procedure and / or failed audit . Had it not been for this the intial 999 call and the 111 call may have generated a response .
130	Access, admission, transfer, discharge (including missing patient)	pt transfered from [Unit] unresponsive co2 level was 24 not responding to pain gcs of 7 . .

131	Access, admission, transfer, discharge (including missing patient)	Asked to come and see patient urgently by HCA . Found patient on commode , unconcious with no pulse and not breathing .
132	Access, admission, transfer, discharge (including missing patient)	patient died [date] following an operation on [date] discharged home [date] readmitted in [Hospital] [date] .
133	Access, admission, transfer, discharge (including missing patient)	Patient listed for biventricular ICD but cancelled on day due to no beds . On [date] a new date was allocated for procedure on [date] . Medical secretary received phone call from son on [date] informing her patient had died . No further details given . Death may have been related to delay in treatment . . Patient was also waiting for a TAVI after the ICD had been implanted . Patient was originally referred to[Hospital] on [date] from a district general hospital . . Patient had significant [co - morbities]. .
134	Access, admission, transfer, discharge (including missing patient)	Patient was transferred from [ward] at approx [time] accompanied by 2 HCA . Patient was very breathless on transfer and was cold and clammy to touch . Attempted to obtain observations , oxygen sats 88% on 4 litres , pyrexic (38.4*c) , blood pressure unrecordable . Ward SHO bleeped and during bleep process patient found unresponsive by other members of nursing team . Emergency call bell activated and CPR commenced . 2222 dialled and cardiac arrest team attended ward promptly . Patient did not appear stable enough to be transferred . [Ward] nursing team feel this was an extremely unsafe transfer . Patient was on the ward less than 10 minutes when arrested . .

135	Access, admission, transfer, discharge (including missing patient)	UNSAFE PATIENT TRANSFER FROM AMU TO [WARD] . PRIOR TO TRANSFER FROM AMU PATIENT WAS EWS=4 BUT WAS TRANSFER ANYWAY . ON ADMISSION TO [ward] PATIENT EWS=7 FOR HYPOTENSION (SYSTOLIC 63) TACHYPNEA (RR > 30) TACHYCARDIA (P > 120) . ON CALL SHO REG BLEEPED AND REVIEWED QUICKLY . ECG BLOODS IV ACCESS IV INFUSION GELOFUSINE WERE THE INITIAL CARE GIVEN . AFTER 3 BAGS GELOFUSINE IV FLUID PATIENT'S SYSTOLIC REMAINED BELOW 72 . REG ON CALL BLEEPED AGAIN AND URINARY CATHETER INSERTED ABG . THEN PATIENT BECAME HYPOXIC AND DESATURATED ON ROOM AIR BELOW 50% . 15L NON REBREATH MASK APPLIED AND SATURATION SLOWLY IMPROVED ALSO REMAINED OUTSIDE RANGE . CXR DONE ON THE WARD . AT THAT POINT ITU MEDICS WERE INVOLVED TO DISCUSS POSSIBLE TRANSFER . UNFORTUNATELY PATIENT WAS NOT SUITABLE FOR ITU . . TO MAKE THIS TRANSFER EVEN MORE UNSAFE THE STAFFING LEVEL ON THE WARD THAT DAY WAS 2 STAFF (INSTEAD OF 3) NURSE FOR 25 PATIENTS . THUS , FROM 3PM THIS PATIENT WAS ADMITTED TO [ward] AND NEEDED 1 - TO-1 CARE ONLY 1 STAFF NURSE REMAINED AVAILABLE FOR THE OTHER 24 PATIENTS . EVENTUALLY CARE TO THE REST OF THE WARD WERE MISSED , MEDICATIONS WERE DELAYED OR GIVEN LATE , AND RELATIVES WERE UNHAPPY ABOUT THE LACK OF NURSE"S PRESENCE / AVAILABILITY ON THE WARD . .
136	Access, admission, transfer, discharge (including missing patient)	Pt not responding on call to 999 , CPR commenced as per EMD advice . Pt deceased after clinicians on scene . Call exceeded 10 minutes so deemed to be excessive response) . .
137	Access, admission, transfer, discharge (including missing patient)	RED 2 Asthma attack . This datix is reguarding the poor response times to this detail . WE were in [Town] when we recieved this detail , this is approximatley 40 minutes drive away . We were informed that an RV in [Town] was also enroute . The RV arrived on scene and requested immediate RED 1 back up due to the severity of the patients condition . No other vehicle was available , and so at approximatley [time] , myself and my crew mate arrived on scene . The RV had followed all clinical protocals and had done everything possible for the patient to treat an asthma attack , unfortunatley minutes after we walked into the scene the patient went into respiratory arrest and moments later cardiac arrest , we called for immediate back up to help with extricating the patient should we get a ROSC , another DCA arrived within 10 - 15 minutes . All ALS protocols were followed and resucitation was attempted for 30 minutes , unfortunatley this patient could not be resucitated and died . Police

		were informed and R.O . L . E form completed . . .
138	Access, admission, transfer, discharge (including missing patient)	Delayed response to a Red-2 call ; 28 minute response . .
139	Access, admission, transfer, discharge (including missing patient)	Red 2 response , technician called as rapid responder to home address , patient vomiting for 2 days . Became clear that patient had sepsis . On scene at [time], back up requested , did not arrive until [time] . Requested for paramedic back up as patient went into cardiac arrest . Patient conveyed to Emergency Department . .
140	Access, admission, transfer, discharge (including missing patient)	Patient transfered to [Hospital] for CTPA - showed bilateral PEs .

141	Access, admission, transfer, discharge (including missing patient)	Patient attended by an [Ambulance Service] ambulance crew on [date]. The call originated from a call to NHS 111 at [time] and was prioritised to an R1 8 minute response . The patient was left at home after the attending crew requested a Safeguarding referral to be made via the [Ambulance Service] Control Logistics Officer . The patient died the following morning . This case was highlighted following an Adult Strategy Meeting held on the morning of [date] after concerns were raised by the Adult Social Care Services to the [Ambulance Service] Named Professional for Safeguarding Vulnerable Groups . . Concern (s) - Patient capacity - Crew advised they were unable to carry out a capacity assessment as patient was uncooperative and would not allow observations to be taken A!V could a best interests route have been taken and contacted an on - call clinician to ensure that by leaving the patient at home was the best decision for patient . - A Safeguarding referral was placed by one of the crew to the TrustA!A|s Logistics desk , but this was subsequently passed to the in hours Social Services safeguarding mail box when it should have been sent to the Emergency Duty Team as urgent at the time the referral was placed . - The referral had not been marked as urgent . - Had the referral been placed as urgent the Emergency Duty Team would have had the opportunity to follow up and further check on the patient . .
142	Access, admission, transfer, discharge (including missing patient)	Patient attended ED with chest pain on [date/time] . Seen by ED Doctor and assessed as moderate risk chest pain (Heart score 5 without troponin) . Patient had first and second troponin levels taken - Trop levels 5 & 5 . Discharged at approx [time]. Phone call from police officer at [time] informing me that patient had been found deceased at home at [time] . .
143	Access, admission, transfer, discharge (including missing patient)	2222 Cardiac arrest call to a patient on MAU . Patient was admitted via A&E with a working diagnosis of gastroenteritis and dehydration . Patient become unresponsive in front of family and they called for help . CPR was commenced and the ALS Protocol for a non Shockable arrest was followed as per Resuscitation Council Guidelines . The team corrected the hypoglycaemia with 10% Dextrose and IV fluids for hypervolemia , but unfortunately , the decision was made to cease the attempt . Patient RIP at [time]. .
144	Access, admission, transfer, discharge (including missing patient)	Patient attended following polypharmacy overdose [date] . Following day fit for discharge , not to see MHLT as had own Crisis team worker . Discharged via taxi to parents house . . Returned to A&E 2hours later in asystolic arrest following approx 1hour cpr following collapse and parents home . Unsuccessful resuscitation attempt patient died in department . .

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

145	Access, admission, transfer, discharge (including missing patient)	Child treated in resus for about 12 hours . Developed signs of sepsis whilst in department and progressed to be hypotensive needing intensive care support and maximum BP support . Patient died with the retrieval team enroute to [hospital] .
146	Access, admission, transfer, discharge (including missing patient)	2222 cardiac arrest call was made to CCU for a patient in cardiac arrest day 1 post elective PCI [date] . ALS protocol followed . Patient sustained a non shockable arrest . 12 Cycles of CPR where undertaken with appropriate drug and airway management being instigated . On review of the medical history , 4 H & T and duration of down time , resuscitation attempt was ceased at [time] . .
147	Access, admission, transfer, discharge (including missing patient)	patient attended ED as medical expected after fall at home . discharged home and then readmitted to Ed in early hours with brain haemorrage and died . .
148	Access, admission, transfer, discharge (including missing patient)	[time] spouse went to work and when retruned later there was no sign of spouse/patient . Patient had left all their belongings at home including mobile phone . Spouse reported patient missing to the police . . Patient subsequently discovered deceased . .
149	Access, admission, transfer, discharge (including missing patient)	Service inbound complaint declared as SI . Unresponsive patient , [hospital] inpatient rehab ward , staff doing CPR . Delayed response to R1 . . .
150	Access, admission, transfer, discharge (including missing patient)	Telephone call received from family member to request collection of temporary keysafe following patient death . It was reported that patient had a fall which resulted in admission to hospital . It was reported by family member that this fall may have contrubuted to the patient demise . It was reported that the patient fell when trying to open the door as unfortunately the key in the keysafe had not been used to by the carer to gain access .
151	Access, admission, transfer, discharge (including missing	Baby readmitted to [Unit] after being seen previous day with respiratory type illness . On arrival baby in cardiac arrest - full CPR commenced - paediatricians in attendance - baby declared dead within 2 hours of arrival . .

	patient)	
152	Access, admission, transfer, discharge (including missing patient)	Post - operative elective patient with multiple co - morbidities deteriorated on ward at [hospital] . Failure to correctly follow the escalation policy for deteriorating patients at [hospital] resulted in a delay in referral to and admission to critical care . .
153	Access, admission, transfer, discharge (including missing patient)	Patient was referred to Cardiac surgery clinic in [month/year] with an aneurysm . An appointment was made but patient did not recieve this . Patient contacted service in [month/year] asking what was happening and another clinic was sent for [month/year] but patient died of a ruptured aortic anerysm just after xmas . .
154	Access, admission, transfer, discharge (including missing patient)	Patient was re - admitted , having been discharged one week previously from a laparotomy to repair a large perforated gastric ulcer , with a catastrophic upper gastrointestinal bleed . This was uncontrollable via any medical or surgical managment and the patient died . .
155	Access, admission, transfer, discharge (including missing patient)	Patient attended ED AT [time/date] having been discovered by the Police to have cut wrists . Police subsequently brought patient to department . . She was subsequently placed under MCA and later assesed by EDPS who placed her under Section 2 of MHA . Patient subsequently moved to EAU whilst awaiting psychiatric inpatient bed . . At [time/date] whilst spouse was sleeping and nurse responsible for bay was attending to another patient , the patient absconded from the EAU . . Patient was subsequntly identified as having [committed suicide] .
156	Medical device / equipment	Written in Retrospect . It has been shown post mortality review that the insertion of a NG tube went through the pleura , on removal of NG a tension pneumothorax occured . .
157	Access, admission, transfer, discharge (including missing patient)	Patient discharged from Hospital on [date] following admission with sickle cell crisis and cholecystitis - had laparoscopic cholecystectomy pre - ceeded by exchange blood transfusion . Femoral aphereis line sited for exchange transfusion . Re - admitted [date] with sepsis - femoral line found in - situ (patient discharged with line in situ - ward staff not aware present) . Patient discharged from [hospital]on [date], well at that point . Admitted to [Hospital 2] [date] with acute painful sickle crisis . Unwell [date] (pyrexial , had ITU review) but felt to be stable . Found collapsed evening of [date] - cardiac arrest (PEA) ; resuscitation attempts failed . .[Hospital 2] clinical team have

		discussed with their coroner (and amongst clinical team) and Coroner happy for team to issue MCCD 1a) Pulmonary Embolus , 1b) Femoral Thrombus , 2) Sickle Cell Disease . .
158	Access, admission, transfer, discharge (including missing patient)	The Mental Health Trust has a service Level Agreement to provide Mental Health Assessments in the acute hospital for patients referred to them by [hospital] staff , including in the Emergency Department . The Patient absconded from hospital mid - assessment by ILAT team . Patient not under section . Efforts made to get patient to return to ED . Approximately [time] patient was struck by a motor vehicle and pronounced dead . .
159	Medical device / equipment	The patient was scheduled on [date] for Redo aortic valve replacement , mitral - aortic continuity patch , mitral valve repair for endocarditis . According with the surgeon it was a high mortality risk procedure . The patient was an AICU patient . The night before the procedure , the patient deteriorated. The patient was already intubated and connected to the ventilator. A bronchoscopy (done the day of the procedure) showed clear airways . At the chest X ray : signs of interstitial oedema . The plan was to transfer the patient to Lab # to insert a balloon into the LIMA to allow a proper action of the cardioplegia during the procedure . I increased the infusion rate of the noradrenaline and of the vasopressin before we moved because the systolic blood pressure was around 85 mmHg . The patient had a trilumen central line in the right internl jugular vein (RIJV) , a 20 gauge venous cannula in the right arm and an arterial line . All the lines were inserted in the previous hospital . We were in Lab# at [time]. After moving all the infusion pumps in a convenient stand to have enough length for the pumps extensions we moved the patient from bed to the table . Despite we tried to do it slowly and gently , the RIJV trilumen central line was dislodged . .
160	Access, admission, transfer, discharge (including missing patient)	40 / 40 gestation , baby intubated following Category 1 EMLSCS for abnormal CTG . Baby RIP . .

161	Access, admission, transfer, discharge (including missing patient)	Shoulder dystocia at birth with baby born in very poor condition & requiring NICU admission , cooling , intubation . Baby has died . Incident reported to the CCG as a Serious Incident .
162	Access, admission, transfer, discharge (including missing patient)	Vulnerable patient contracted infection / sepsis and died following long admission due to delayed discharge back to the community . .
163	Access, admission, transfer, discharge (including missing patient)	I was on ITU to see another patient at approx[time] when I was asked by upper GI reg to see a colleague patient in my capacity as on call consultant surgeon . Complex story shortened : High risk pt with multiple comorbidities had open cholecytectomy approx 3 weeks ago . Had OGD last night for UGI bleed ; not therapeutic . Sigt bleed overnight needing 6 unit transfusion ; evidence of ongoing UGI bleed. I therefore spoke with the gastro consultant who undertook the OGD and we agreed next step was vascular interventional radiology . I attempted to follow what I understood to be the agreed protocol and called the on call gen surgeon at [Hospital 1](approx . He accepted the pt but required that I seek agreement from an interventional radiologist (which I understood was not the agreed protocol) . I endeavoured to do so . The switchboard at [Hospital 1] found that the vascular interventional radiologist on the rota was not contactable (phone to voicemail x 2) and at my request tried phoning others . On third attempt I was put through to a vascular intervent radiologist who agreed to look at scans and phone me back ; which he did and he agreed appropriate to transfer to [Hospital 1] - but he worked at [Hospital 2]. He advised that he had liaised with his colleague at [Hospital] and we could go ahead and arrange ICU transfer . [Hospital] ICU staff informed . I was then contacted approx [time] by ICU colleagues and advised that the vascular inerventional radiologist at [Hospital 1]T wanted me to call him first , before he would agree to transfer . I managed to speak with him approx [time] and he accpetd patient . I advised ITU consultant immediately , so that transfer could be put in action . I see that patient arested and died [time] before transfer could take place . .

164	Access, admission, transfer, discharge (including missing patient)	After handover at the beginning of my night shift , on introducing myself to my patients I found that my patient had passed away . Patient had DNAR form in place . It was handed over from day staff that patient condition had been deteriorating over the past few days . Sons contacted and informed of theirparient's death , Son asked if he could call me back , I said that was fine to take his time . No return phone call by [time] , therefore called Sons back to check they were ok , explaned what would happen next , and asked what their wishes were for parent , and would they like to visit parent, they asked if they could discuss their wishes in private and call me back , I said that was fine . [time] Sons called back and stated they had spoken with the local funeral directors in town , and they are requesting a post mortem for their parent as they were not happy with the care received . .
165	Access, admission, transfer, discharge (including missing patient)	The service user was hit by an Express train [location] at approximately [time] . .
166	Access, admission, transfer, discharge (including missing patient)	Informed by the coronors office of service user death . Service user was found deceased in their car. Initial findings indicate carbon monoxide poisoning . Toxicology has been requested . A suicide note was in the car . Suicide had been attempted in January at their home address but was found by partner and taken to [Hospital], then referred to MH . Suicide note, noted: Assessed as fit for discharge , reporting there was no intention of self harm . Went back to work . . Worked at the same place as their family member , who saw the service user the day before their death and talked to them the night before by telephone . Family member said service user seemed ok at that time . .
167	Access, admission, transfer, discharge (including missing patient)	Patient returned from endoscopy following a colonoscopy . informed of the results of the colonoscopy and was informed that the patient was stable and that there was nothing to worry about . observations checked upon arrival. patient very agitated , complaining of pain in their stomach , and was unable to settle . Blood pressure significantly lower than their normal blood pressure . Patient not stable upon return to the ward even though informed that they were . .

168	Medical device / equipment	Called to see patient due to heart rate 120 . Background : Ischaemic stroke with haemorrhagic transformation . NG inserted . Documented as safe to feed at [date/time] . On reviewing the CXR : NG tube deviates at level of the carina . Highly suspicious for being in the right main bronchus . Ng tube removed . Repeat CXR showed large volume right lower zone pneumonia . Patient was fed via an NG tube that was incorrectly sited and incorrectly documented as being safe to feed . The nursing staff report that the X-ray was flagged up by the radiographer as possibly being incorrectly sited but this was overruled by the doctors on the ward and documented as safe to feed . .
169	Access, admission, transfer, discharge (including missing patient)	Patient attended A&E on [date] with chest pain , which resolved . Initial ECG showed changes and repeat ECG requested within 30 minutes . ? performed as not documented . No further observations recorded following triage . It is transpired that the patient was later taken to another hospital. Patient died . .
170	Access, admission, transfer, discharge (including missing patient)	Patient admitted 3 times in the space of two days . Was seen by an ED consultant on each admission . Concerns raised around ongoing and undiagnosed issues at the second presentation . Possible small bowel obstruction . New neurology . Advice given by myself to admit the patient to hospital after review by the surgical team and CT head / - medical review . Patient was later discharged home . Returned the following day having had an out of hospital cardiac arrest and died . I have met with the family about their concerns and the coroners report is awaited . Decision to raise this as a serious / red investigation . Complaints through PALS ongoing from family . .
171	Access, admission, transfer, discharge (including missing patient)	The bases for the SUI is that it would appear the wrong coding was used therefore delaying the response , the patient later died at [Hospital] . . Following the 1st 999 phone call at [time] C601 were dispatched then cancelled then a subsequent 4 AEUs were sent and cancelled at [time] when the 2nd call was madeB150 were dispatched then cancelled then C354, C308 and C450 were dispatched , C354 were the first to arrive on scene at [time] , the patient was confirmed as in A?cardiac arrestA? at [time] . . C308 passed a priority call at [time] to [hospital]with an ETA of 8-10mins , arrived at [time] . . K360 (advanced Paramedic) was also dispatched from a distance and met the crew enroute to hospital . .
172	Access, admission, transfer, discharge (including missing patient)	Patient passed out with difficulty in breathing . Arrival of [Ambulance Service] took 2 hrs 18 minutes . .

173	Access, admission, transfer, discharge (including missing patient)	cardiac arrest call for patient found unresponsive . Found to be in PEA . CPR started and ALS protocol followed . ROSC achieved after approx . 10 mins . ECG post arrest showed MI but on d / w cardiology and ITU decided not for cath lab or ITU . Further arrest at [time]a but team decided not for further resuscitation . RIP .
174	Access, admission, transfer, discharge (including missing patient)	Patient admitted on [date]with gross ascites as a result of alcoholic liver disease . Patient seen on the Acute Medical Unit and ascites drained overnight . Patient then moved to respiratory ward on [date] and discharged home on [date] . Patient seen by GP every day for three days but eventually taken back to A&E at [Hospital] on [date] due to rapid deterioration . Patient died post - cardiac arrest soon after arrival . . Incident came to light following complaint received from patient mother . Concerns raised regarding discharge on [date], lack of documentation and GP follow up . .
175	Access, admission, transfer, discharge (including missing patient)	According to the coroners ' report , the cause of death was mixed drugs toxicity and Chronic Obstructive Pulmonary Disease . The toxicity report showed evidence of the service user having taken both prescribed medications and illicit substances (Diazepam , Temazepam , Oxyapam , Sertraline , heroin and cannabis) . .

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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 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,

Kerri Kerwin
NRLS Oversight and Business Support Manager, Patient Safety

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