

Case Study – Lisa Richards-Everton



Husband's death caused by drug error – Amphotericin

Paul Richards lost his life in July 2007 in Heartlands Hospital Birmingham as a result of confusion of two different types of the drug 'amphotericin', which led to him receiving a massive and fatal overdose. His widow, Lisa Richards-Everton, who is now looking after their three children alone, took some comfort from the fact that as a direct result of Paul's and other deaths, the National Patient Safety Agency issued a "rapid response alert" on the safer use of amphotericin to all NHS trusts in September 2007, with a number of actions required by 1st October 2007. To her dismay, Lisa discovered as a result of AvMA's research that 10 NHS trusts had still not completed the actions over two years after the deadline, and no-one appeared to be chasing them up. Ironically, another patient safety alert issued in March 2007 may have saved Paul's life, had it been implemented at the time. Disturbingly, 104 trusts had still not implemented this alert nearly two years later.

Lisa said:

"This report is shocking it shows how the Government and the NHS are failing everyone. Paul's death could of been so easily avoided if there was a safe system in place, its to late for Paul but not for everyone else. This is clear evidence the systems that are currently in place are inadequate, and urgent changes need to be made. These are people's lives we are talking about, everyone deserves to be safe in Hospital, we trust adequate safety measures are in place but clearly this is not the case. I will continue to fight until adequate safety measures are in place, so other families do not go through the same tragedy."



Case Study – Dr Stuart Gray & Rory Gray



Father's death caused by massive overdose of Diamorphine

Mr David Gray died in February 2008 of a massive overdose of Diamorphine administered by an out of hours GP from Germany. His sons, Dr Stuart Gray (pictured left) and Rory Gray (pictured right) have been working with AvMA ever since to ensure that lessons are learnt about the safe use of Diamorphine and other powerful drugs, as well as out of hours care and regulation of foreign doctors. Mr Gray's death might have been saved if the patient safety alert 'Ensuring safer practice with high dose ampoules' or 'safer use of injectable medicines' had been implemented. Since then, an alert on 'reducing errors with opioid medicines' has been issued with a deadline of 30th January 2009 for compliance. As at December 2009 81 trusts had not complied with it.

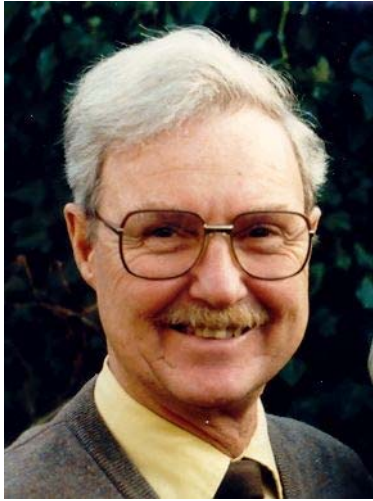
Dr Gray, himself a GP, said:

"It is deeply disturbing to be informed that so many NHS bodies still completely disregard the NPSA safety alerts. The NPSA alerts are issued for a reason - to prevent deaths and morbidity from unsafe clinical practices and procedures. They are not issued lightly, but after careful consideration and consultation once a safety issue has been identified. I cannot comprehend why any NHS body would choose to ignore them. In fact, I would go so far as to say that I find it personally deeply offensive that they would do so, especially in light of the fact that my father was killed by being administered a massive drug overdose of diamorphine, a potent analgesic, in a situation where the OOH provider was not carrying the drug in line with NPSA guidelines.

It is only a matter of time before another death occurs because an NHS body chooses to ignore these alerts. Of particular personal concern is that Worcester Acute Hospitals NHS Trust is one of the worst offenders, the Trust whose area my family and I reside in. I find it repugnant that my family are exposed to these safety risks by this Trust's negligent disregard of the NPSA alerts.

Procedures must be put in place by the DoH to ensure complete compliance with the NPSA alerts by NHS bodies. And I would consider any death that, God forbid, should occur through the failure to comply with an NPSA alert to be one of corporate manslaughter by the NHS body concerned."

Case Study – Amanda Cale



Father's death caused by drug error – Methotrexate

Amanda Cale lost her father as a result of problems with the drug Methotrexate. Her efforts to ensure lessons were learnt to protect others was in large part responsible for one of the first alerts issued by the National Patient Safety Agency. Here she tells her own story:

"The death of my father Charles Bootle was officially recorded as Methotrexate induced Pneumonitis, in other words the drug he was taking to relieve his Rheumatoid Arthritis caused him harm.

The NPSA worked long and hard to alleviate the potential problems associated with this otherwise useful drug, culminating in the first Patient Safety Alert issued for a drug, in July 2004. The recommendations and action plan devised in this alert were to be implemented by March 2005. However in June 2006 the alert was re-issued due to the fact that 18 per cent (104 out of 569) of NHS organisations in England had still not reported having fully implemented the actions set out in the patient safety alert. I have just been informed that as at December 2009 23 trusts have still not implemented the recommendations. Until they do more people may continue to be needlessly harmed by a drug given to help alleviate their pain. I fully support the NPSA and the sterling work they do, and cannot understand why the powers that be have not given them the support they need by introducing compulsory compliance with a method of chasing up and monitoring the results. The alerts are not produced to make more paperwork for hospital administrators, they have been raised to save REAL people from REAL harm!

I am also extremely concerned about the fact that the private healthcare industry does not appear to be obliged to implement any of the Patient Safety Alerts! This is laughable when you consider that many people pay to 'go private' believing they will receive a better level of care than within the National Health Service."