INQUIRY HELD UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976 FOR v. IMRAN KHAN

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

INQUIRY HELD UNDER FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976

SECTION 1(1)(a)

SECTION 1(1)(b)

DETERMINATION by EDWARD F BOWEN QC, Sheriff Principal of the Sheriffdom of Glasgow and Strathkelvin following an Inquiry held at Glasgow between the Twenty second day of February and the Fourth day of March Nineteen Hundred and Ninety Nine into the death of IMRAN KHAN

GLASGOW, 30 April 1999. The Sheriff Principal, having considered all the evidence adduced, DETERMINES: in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 section 6(1):

that Imran Khan aged 15 years who resided at 47 Durward Avenue, Glasgow, died at the Victoria Infirmary, Glasgow, at 0627 hours on 21 February 1998;

that the cause of death was toxic shock syndrome arising from infection at the site of a chest drain, propoxyphene toxicity and a stab wound to the chest being conditions contributing to the death;

and that the following facts are relevant to the circumstances of death:

That in the evening of 13 February 1998 Imran Khan was assaulted in or near Midlothian Drive, Glasgow. In the course of the attack he was stabbed four times on the upper body.

He was conveyed to the Victoria Infirmary, Glasgow, where he was examined in the Accident and Emergency Department. A chest X-ray revealed a 50% pneumothorax, caused by puncture of the lung by the weapon used in the assault.

Insertion of a chest drain is the appropriate, and essential, method of treatment of a pneumothorax. The insertion of such a drain involves administration of a local anaesthetic, followed by cutting of skin, intercostal muscle and the outer layer of pleura. The drain is then inserted along the created track into the pleural cavity. It is connected to a tube leading to a bottle, which is partially filled with water. The purpose is to allow air to escape from the pleural cavity thereby allowing the collapsed lung to expand. Failure to carry out this procedure may result in a tension pneumothorax leading to pressure on the heart and the "good" lung. That may become a life-threatening condition.

The insertion of a chest drain was carried out by Dr Jason Long, a Senior House Officer Grade III. After cutting the skin and tissue and inserting the drain Dr Long secured it by means of a suture to the skin and two wraps around the tube. He noted from movement of the water in the bottle once the drain had been connected that air was leaving the pleural cavity.

Following treatment in the Accident & Emergency Department, Imran was transferred to Ward 5 of the Infirmary. He was seen by Dr Proctor, a Junior House Officer shortly after admission, and by Dr Tan, a Senior House Officer, who arranged for a repeat X-ray which revealed that the lung had re-expanded. Dr Tan saw him again and reviewed his wounds in the early hours of 14 February. He was seen by Mr Iain Smith, Consultant General Surgeon, during a ward round on the morning of 14 February. A Note made at that ward round records "drain swinging", which implies that at that stage the lung was not fully re-expanded.

There is no record of Imran having been seen by a member of the medical staff on Sunday, 15 February. A ward round would have normally taken place on that day.

On the morning of Monday 16 February Imran was seen in the course of a ward round by Dr Alan Hair, a Senior House Officer, who was accompanied by Dr Proctor. Dr Proctor's note records that the drain was "still bubbling", which indicates a persisting leak from the lung. Dr Hair instructed that the a further X-ray be taken; this was seen by Dr Proctor and the pneumothorax was observed to "remain at 50%".

On the morning of Tuesday 17 February Imran was seen in the course of a ward round by Mr George Gray, Consultant General Surgeon, again accompanied by Dr Proctor. The patient appeared comfortable. No change in his treatment was proposed. Mr Gray observed the chest drain to be bubbling. He asked Imran if he would be prepared to allow examination candidates to examine him on the following day. Imran agreed.

Imran was not seen during the ward round in Ward 5 on the morning of Wednesday 18 February. He was seen by 5 candidates for Part 2 of the examination for Fellowship of the Royal College of Surgeons, all of whom would have had about 4 years' surgical training, accompanied by Mr Gray and an external examiner who on that occasion was a past president of the Royal College of Surgeons.

On the morning of Thursday 19 February Imran was seen in the course of a ward round by Dr Hair, accompanied by Dr Proctor. The patient was noted to be well and improving. Dr Hair considered that he should receive chest suction if the lung was not re-inflating that day. Imran was also seen twice on Thursday, between 09.45 and 10.30 hours and between 13.55 and 15.10 hours by further FRCS candidates accompanied by Mr Smith and an external examiner. At 11am his temperature was noted as being 38.2, which is above normal. A nursing note records: "Chest drain site dressing renewed; fairly foul smelling".

Imran was seen regularly in the course of the week by a cousin, Rashid Khan, who holds the degrees of MBChB in Pakistan. Rashid Khan was undergoing medical training in the Victoria Infirmary. He saw Imran around lunch time on 19 February and thought that he was unwell and that he had a high temperature. He asked Dr Kathryn Ewart, a Junior House Officer, to see him. Dr Ewart attempted to do so but found the FRCS examination in progress. Later in the day she asked Dr Proctor to see Imran and to take blood samples from him to enable cultures to be obtained. Dr Proctor saw Imran but he emphatically declined to provide blood samples. No further action was taken.

On the morning of Friday 20 February Imran was seen in the course of a ward round by Mr Kevin Robertson, Specialist Registrar in General Surgery, accompanied by Dr Proctor. Mr Robertson

considered that Imran appeared reasonably well. He confirmed that low grade suction should commence. He saw Imran about an hour later and personally connected the chest drain to the suction intake. He left Imran between 11.30 and 12.00 hours, instructing that there should be another chest X-ray. An X-ray was taken at 13.45 hours. It revealed that the lung had expanded.

At about 16.00 hours on 20 February a sudden and marked change in Imran's condition took place. He had a sudden urge to defecate. He became breathless. Dr Proctor was asked to see him by nursing staff. She noted, amongst other things, a red rash on his back, that he looked unwell and that his pulse was slightly raised. His temperature was not abnormal. By 16.30 his condition had deteriorated. He was seen by Mr Robertson and Dr Hair. His blood pressure was very low, suggesting a collapse of the cardio-vascular system. It became apparent that he was suffering either from septic shock or a pulmonary embolism. After his condition was stabilised he was transferred to the High Dependency Unit in Ward 12.

Imran was examined in the HDU by Dr Johann Harten at about 22.00 hours. Dr Harten noticed the presence of an extensive rash. He diagnosed septic shock and renal failure. He considered Imran to be very unwell and arranged for his transfer to the Intensive Care Unit.

Imran was transferred to the Intensive Care Unit around midnight on 20 February. He came under the immediate care of Dr John Davidson, Consultant in Anaesthetics and Intensive Care. In the course of treating him Dr Harten and Dr Davidson undid the sutures holding the chest drain and removed it. They noted that the drain was continuing to bubble, and that the area of the drain appeared infected. Imran's condition continued to deteriorate with evidence of multi-organ failure. Despite extensive efforts on the part of the medical staff to resuscitate him he did not respond to any form of treatment and died at 06.27 hours on 21 February.

Post-mortem examination was carried out on Sunday 22 February within the City Mortuary, Glasgow. The presence of four stab wounds, one of which had penetrated the chest wall into the pleural cavity, was noted, together with the surgical incision. There was extensive exfoliation of the skin in the area of that incision. Swabs from the drain site and pleural cavity produced a growth of staphylococcus aureus. Strains of that bacteria were examined at the Central Public Health Laboratory, London. They were found to be positive for TSST-1 (toxic shock syndrome), which means that they were capable of producing toxins of that type. Analysis of blood at the Department of Forensic Medicine & Science, University of Glasgow, showed an abnormally high level of propoxyphene, which is pain killing drug.

In the light of the above findings the cause of death was certified as Toxic Shock Syndrome due to chest drain with propoxyphene toxicity and stab wounds to the chest as conditions contributing to the death. The propoxyphene toxicity was caused by the failure of the liver to metabolise part of the drugs being administered in the course of intensive care.

Toxic shock syndrome is a rare cause of death. The mechanism of death involves major damage to vital organs caused by the circulation and spread of toxins (TSST-1). These toxins are not susceptible to treatment by antibiotics or by any other means. The source of the toxins is staphylococcus aureus, an organism that is permanently present on the bodies of 50% and intermittently present on 25% of the population. Antibodies to TSST-1 are acquired with age; the antibody being present in 40% of children aged 5 and progressively increasing until it is found in approximately 90% of the adult population. Serum tests carried out at the Department of Bacteriology, Yorkhill Hospital, Glasgow, revealed that Imran Khan did not possess the antibody to TSST-1.

Toxic shock syndrome is a two stage illness involving a prodromal stage which may last between 12 and 48 hours before the onset of acute illness. The prodromal stage produces mild influenza type symptoms such as muscle ache, malaise, and mild temperature. It may appear of little significance, particularly in a young and otherwise fit person. It provides no warning of the subsequent acute stage, which involves a sudden and precipitous collapse, with rapid development of a rash, fever and hypertension.

Measurements taken at about 17.00 hours on 20 February and in the ITU shortly after Imran's admission to that unit showed grossly abnormal production of urea and creatine. The levels recorded (urea 27 and 27.2 against a norm of 3 or 4, creatine 495 and 512 against a norm of below 80) suggest that toxins had affected the kidneys for a period of at least 48 hours prior to the time of recording. The administration of antibiotics within that period would have been unlikely to prevent the damage caused by the spread of toxins.

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Imran Khan was 15 years of age at the time of his death. On 13 February 1998 he was the subject of a vicious attack in the course of which he was stabbed repeatedly. One of the stab wounds penetrated his chest wall. As the result of the help of a complete stranger at whose door he arrived he was conveyed very swiftly to the Victoria Infirmary. He was found to have a collapsed lung, which was treated by the insertion of a chest drain. Unfortunately he died seven days later as a result of toxic shock syndrome. The purpose of this Inquiry has been to examine the events between the time of his admission to hospital and his death on 21 February 1998 to determine whether failures in care led or contributed to his death. It is no part of the function of the Inquiry to examine the circumstances or background to the assault.

There is no doubt as to the cause of death. The immediate sequence of events leading to it, involving multi-organ failure, pointed clearly to septic shock. Post-mortem examination of the body showed the presence of infection at the site of the surgical incision where the chest drain had been inserted. Cultivation of swabs from that site revealed the presence of bacteria known as staphylococcus aureus capable of producing toxic shock toxins (TSST-1). The presence of these toxins results, in the absence of antibodies, in catastrophic damage to the function of vital organs of the body, a condition known as toxic shock syndrome, which has a mortality rate in excess of 50%. The majority of the population develops, with age, an antibody that is resistant to these toxins. Sadly, Imran Khan fell within the small minority who do not possess that resistance. It is accordingly clear that, purely as a matter of functional cause, his death was related to the surgical incision made for the purposes of inserting the chest drain and not directly to any of the stab wounds. The broad issues for the Inquiry are accordingly (1) whether that surgical intervention was necessary; (2) whether the infection at the site of the insertion became infected by reason of act or omission on the part of the medical staff; and (3) whether there was any failure to recognise or cope with the signs of toxic shock once that condition developed.

In his submissions at the conclusion of the Inquiry the Procurator Fiscal in effect invited me to make only formal findings, coupled with a recommendation regarding the collation of information in the ward where Imran spent most of his stay. Although I am not disposed to make such a recommendation which might affect well established hospital practice in the light of one case which I regard as highly exceptional, I recognise otherwise the realistic nature of the stance taken by the Procurator Fiscal. There is not the slightest doubt on the evidence presented to me that the insertion of a chest drain was the appropriate manner of dealing with a collapsed lung, and indeed it would have been a gross failure of duty on the part of the medical staff in the accident and emergency department not to have taken that course. Whilst a spontaneous recovery from a pneumothorax is not unknown, the danger of it arises from the inability of air to leave the pleural space leading to pressure on the heart and the healthy lung. There might be scope for saying that Imran might have survived if he had not been treated; but there can be no question on the evidence that the treatment given to him was proper. Whatever the statistical justification, it is in my judgement emotive, unhelpful and irresponsible to say that he would still be alive if he had not entered hospital.

I accordingly turn to the second issue, which relates to the introduction of infection at the site of the surgical insertion. It is beyond dispute that staphylococcus aureus is present on the bodies of a high proportion of the population, and accordingly every break in the skin carries with it a degree of risk of infection from the presence of that bacteria. A recognised breeding area for such bacteria is the armpit, and the surgical incision for insertion of the chest drain was of necessity sited close to it. I cannot do other than conclude that it is every bit as likely that the infection developed within the site of the chest drain because of the very presence of staphylococcus on the body of Imran rather than from the introduction of it by something which occurred in hospital. It is, however, important to examine a number of aspects of the evidence relating to the chest drain to determine firstly, whether any aspect of the insertion of it or subsequent possible interference with it might have increased the danger of the introduction of infection, and secondly, whether any unnecessary prolongation of the use of the drain might have been a contributory factor.

On the first of these matters certain criticisms were directed at the technique used by Dr Long in securing the chest drain, and to the fact that it was inserted in a resuscitation room and not in the more aseptic atmosphere of an operating theatre. On the latter aspect it did not appear to me that there was any evidence critical of the use of a resuscitation room, and the matter of importance was not where the procedure was carried out but whether the conditions were sufficiently sterile. I could not possibly hold that there was any lack of attention to that requirement. As to technique, it is true that Dr Long's method of fixing the drain and securing the dressing around it appeared to differ from that adopted by others, but I am satisfied that this is an aspect of practice where techniques can differ. The "purse string" method used by others may have advantages when the drain is removed but may in fact be less secure than the method adopted by Dr Long. I was, in any event, satisfied that Dr Long had carried out the procedure with care and in accordance with the way he had been taught.

The next issue is whether the drain was moved or interfered with, and on that there are suggestions that it was moved by Dr Gillian Proctor, Junior House Officer who had been in Ward 5 for only a few

days when Imran arrived, or that Imran himself moved the drain. Although it was not articulated before me, I have the suspicion that there is a belief, at least amongst the ill-informed, that because the drain site was found to be infected it inevitable follows that there was interference with the drain tube. For the reasons given above I do not approach the issue with any such pre-conceived and in my view erroneous notion.

The suggestion in relation to the actions of Dr Proctor arises from a note made by her in the hospital records on 16 February following a ward round when she accompanied Dr Hair, a Senior House Officer. From the note it is clear that a chest X-ray was taken and that it showed the pneumothorax still at 50%. There is a reference to the oxygen content of the blood. The patient is recorded as not short of breath or symptomatic. There follows the phrase "pushed drain à apex". This has been interpreted as meaning that Dr Proctor pushed the chest drain inwards and upwards towards the top of the lung in an attempt to improve its function. That is an action which, if carried out at all, was generally accepted to be grossly improper and likely to substantially increase the risk of infection of the incision site. Amounting as it does to an allegation that a very junior doctor was directly responsible for Imran's death it is an aspect of the case to which I have given particular attention.

Dr Proctor herself had no memory of writing the note; she accepted that it sounded as if she had pushed the drain in but denied that she had done so and thought that she was recording the appearance of the drain as having pushed towards the apex. Some medical witnesses supported that interpretation whilst others did not. There are certain general considerations that make it very unlikely that Dr Proctor pushed the drain in the manner suggested. She was a very junior doctor, but was generally regarded as extremely sensible and competent. The note made by her at the ward round, "drain still bubbling. Continue" does not suggest any intention on the part of the SHO to alter the existing treatment and it is hard to see why Dr Proctor should have taken it upon herself to make a change. There was simply no need to do so. If she did push the drain it is difficult to understand how she could have formed a view that she had pushed it towards the apex without observing this on a further X-ray. No such X-ray was taken on 16 February. Aside from these general indications there are, however, two specific and compelling pieces of evidence which lead me to the very clear conclusion that Dr Proctor did not interfere with the drain. The first is that, other than by causing the patient extreme pain, it is impossible to imagine a pushing of the drain without removal of the original suture. That in turn would have involved replacement of it, since a suture was still in place and was removed from the drain site when Imran was subsequently in the Intensive Care Unit. Removal and replacement of a suture holding a chest drain by a junior doctor without assistance from nursing staff, and a record of it, is in my view inconceivable. Secondly, the radiological evidence does not support the suggestion of the drain having been "pushed". X-rays taken on 13th, 16th and 20th February were compared by Dr Allan Reid, Clinical Director of the Department of Radiology at Glasgow Royal Infirmary. He measured the length of drain tube shown on each and was of the opinion that there was no evidence of increase in length within the body. Having regard to these factors I am totally satisfied that Dr Proctor did not "push" the drain. The suggestion that she did so has no foundation other than the stark terms of her brief note and is based on the sketchiest view of the evidence.

I am equally satisfied that the patient himself did not remove the drain. At a late stage of the Inquiry a witness who, in February 1998, was a final year medical student attached to Ward 5 spoke to having been told by a student nurse on Thursday 19th February that Imran had said that his chest drain had "fallen out". She approached Imran who said that everything was "fine"; he refused to allow her to look at the drain. A further witness, an experienced staff nurse, recalled an incident on that day when Imran had called for a nurse and said that his drain had fallen out. The witness, Mrs Gatenby, spoke to him and noted that the drain tube was still in his chest. He indicated that the connection to the tube leading to the bottle had come apart and that he had "shoved it back together". Mrs Gatenby also encountered some difficulty in seeing the drain site and found Imran very uncooperative. She had some suspicions as to whether he could have re-connected the drain to the tube but also considered that the connection appeared inadequate.

It is difficult to know quite what to make of this episode. It is not hard to imagine that by that stage Imran, who appears at best to have been a somewhat restless patient, had wearied of the presence of the chest drain and found it increasingly uncomfortable. It may be that he was simply seeking some attention. It is, however, quite clear that the suture holding the drain was still in place less than 36 hours after this incident and there is no evidence of any of any weight or substance which supports the conclusion that it had fallen out or been pulled out at any time after the original suture was put in place.

I next turn to the question of whether the drain was in place too long, it being generally accepted that the longer the drain was there the greater the risk of infection. This is a broad issue, embracing not only questions of whether there was some inadequacy in the setting up of the drain itself but also more general matters relating to the level of attention given to Imran and whether enough was done to monitor his condition. Viewed entirely objectively, one could not say that the fact that the drain remained in situ for a period of a week is in itself a fact of any significance. All the evidence suggested that whilst recovery from a pneumothorax is anticipated within 3 or 4 days of the insertion of a chest drain a period of up to 9 days for it to remain in position is not uncommon. Recovery from a pneumothorax can be accelerated by the application of low grade suction to the chest, a step which would be considered within a few days if the simple use of the drain did not appear to be effective. On the face of the records consideration was first given to the application of suction at a ward round conducted by Mr Hair on Thursday, 19 February. Mr Hair considered that at that time there was a persisting air leak, a view that is entirely consistent with the findings of Dr Davidson, who subsequently removed the drain in the Intensive Care Unit. The note of 19 February indicates that if the lung was not inflating "today", suction should proceed. In fact, it not commence until the following day. It was generally accepted that patience is the wisest course in dealing with a deflated lung, and that suction carries with it certain hazards, notably that of sucking air through the lung and of causing damage to the alignment of thoracic structures. It was also accepted that the point at which it is most appropriate to commence suction is a matter for clinical judgement, depending on a number of factors. Mr Tullett, the surgeon who on the face of his original report was most critical of the procedures in relation to Imran, ultimately conceded that if he had treated Imran the only difference in his approach would have been to arrange for a further X-ray in the middle of the week. In the light of all these factors, whilst with the benefit of hindsight one might say that there might have been merit in proceeding to suction on Thursday, or perhaps even on Wednesday, on the evidence I am not prepared to direct any criticism in relation to the time taken to commence suction. I reject utterly the suggestion that there was some advantage to be gained in keeping Imran

off suction so that he could be used as an "interesting specimen" for the Royal College of Surgeons examinations which were held on 18 and 19 February. Bearing in mind that the chest drain would have remained in situ for the purposes of suction it appears to me that even if there was some delay in this respect, it was not a factor that had a bearing on Imran's death.

The absence of a mid-week X-ray does not appear to me to be a material criticism. It was perfectly clear to Mr Gray on the Tuesday ward round that Imran's lung had not re-inflated, and it is a reasonable inference that this situation was unchanged at the time of the FRCS examinations on Wednesday. An X-ray taken on either of these days would not have altered the course of events. It was also suggested that there was a lack of a clear plan once the recurrence of the pneumothorax was appreciated following the Monday X-ray. In my view the evidence supporting conservative management of a pneumothorax justified the position adopted, namely that a day or two should be allowed to elapse before considering the commencement of suction. I do not consider that anything more by way of a "plan" was needed. It is more difficult to reach any conclusion in relation to the adequacy of physiotherapy, particularly in the absence of evidence from a physiotherapist who may have seen Imran. Dr Hair indicated that this was an important part of the process of recovery from a pneumothorax, and physiotherapy was certainly indicated as part of the care plan in Dr Tan's note. What it meant, in effect, was that Imran should carry out deep breathing exercises. There is no record in the physiotherapy notes after 17 February, but the nursing notes of 19 February indicate that he was seen by a physiotherapist on that date and was "reluctant to co-operate". The note goes on "Patient again encouraged to sit upright and breath deeply". It is not realistic to pronounce, on this evidence, that any more could have been done with a 15 year old boy who had a drain tube in his chest had who was not willing to carry out the exercises suggested to him.

The final issue is whether there was any failure to recognise or deal with signs of toxic shock once that condition developed. There is no suggestion that once the acute signs became apparent at around 16.00 hours on Friday 20 February the attention and care given to Imran was anything other than exemplary. All that could be done for him was done. It was, however, generally recognised that there were signs that Imran was not well by around lunch time on the preceding day. This was noticed by his cousin, and indeed a slightly high temperature was recorded at 11.00 hours, a fact which might be indicative of infection. A nursing note records a change of dressing at the chest drain site and the words "fairly foul smelling appear". Unfortunately the nurse who made this entry was not available, and it is not clear if this comment related to the wound itself. It is more likely that it related to the old dressing, and if that is so is an observation which would be neither surprising not particularly significant.. Dr Ewart attempted to see Imran in the afternoon but was unable to do so because of the ongoing FRCS examination, and an attempt by Dr Proctor to obtain blood samples later in the day was thwarted by Imran's refusal to co-operate. With the benefit of hindsight it might be said that this should have been followed up, but again it is not a matter on which I consider that criticism of the medical staff is justified. It would be remarkable, to say the least, that the reasonably experienced examination candidates, and their eminent supervisors, had failed to notice that Imran was ill if there were any prominent signs of illness. It is in my view, almost certain that he was in what was described as the "prodromal" stage of his illness, the nature of which I have recorded in finding number 19 above. The findings pointing to kidney failure, which I have recorded in finding 20, are strongly suggestive of that. The symptoms at the prodromal stage may, however, be slight, and Imran's youth and natural resilience in all probability strengthened his resistance. By the early hours of the following morning his temperature had returned to a normal level and he appeared to

be reasonably well when seen in the course of the morning ward round. In these circumstances I do not find it established that his condition on Thursday called for any more action than that which was taken. The fact of the matter is, however, that if the prodromal stage had already been reached the damage caused by the spread of toxins must have commenced. There does not appear to be much doubt that with Imran's lack of natural resistance to the toxins the outcome was inevitable. I consider that it is impossible to say that any action taken on Thursday might have avoided his death.

In all the circumstances I do not consider that the evidence discloses any reasonable precautions whereby the death of Imran Khan might have been avoided, or that any defects in a system of working contributed to his death. It is not appropriate to make any findings in terms of sub-paragraphs (c) and (d) of section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. I shall, however, conclude with these general observations. It should not be inferred from the conclusions of this Inquiry that everything in the Victoria Infirmary was carried out "by the book". There are plainly imperfections in the notes, and the fact that Imran was missed from a ward round on Wednesday, and perhaps on the Sunday, cannot escape notice. But it would be surprising to expect perfection in record keeping, or indeed in medical practice, in a hospital which receives more than 70,000 patients a year into its casualty department alone. Such imperfections are no justification for an atmosphere of near hysterical criticism and distrust of the Victoria Infirmary that appears to have been generated at least in certain sections of the media. One would not have expected a patient with an injury such as Imran sustained to die. The very fact that he did, coupled with the misplaced interpretation of Dr Proctor's note, and other factors including the death of another boy of similar age in the same hospital (albeit in wholly different circumstances), have fuelled the fires of sensationalism. What must be emphasised is that even modern medicine cannot be expected to provide a 100% guarantee of success, and that the factors which caused Imran's death were exceptional. Nothing that I have heard leads me to conclude, or even suspect, the existence of a general lack of care or want of professionalism on the part of nursing or medical staff at the Victoria Infirmary.