2011 FAI 34

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 AGNES LAWRIE ADDIE DUNCAN, Advocate, Sheriff of the Sheriffdom of Glasgow and Strathkelvin following an Inquiry held at Glasgow on the Twenty Second, Twenty Third, Twenty Fourth, Twenty Fifth, Twenty Ninth, and Thirtieth of October Two Thousand and One, the Third and Fourth of December Two Thousand and One, the Twenty Eighth, Twenty Ninth and Thirty First of January Two Thousand and Two, the Twenty First, Twenty Second, Twenty Third, Twenty Fourth, Twenty Eighth, Twenty Ninth, Thirtieth and Thirty First of January, Twenty Eighth, Twenty Ninth and Thirtieth of April, Seventh of May Two Thousand and Three into the death of NORMA HAQ, aged 51, who normally resided at Flat 4, 20 St John's Quadrant, Glasgow, G41 5SR.

GLASGOW,

The Sheriff, having considered all the evidence adduced, Finds-in-Fact:-

(1) Mrs Norma Haq, born on 23 October 1946, an auxiliary nurse, resided with her husband and family at Flat 4, 20 St John's Quadrant, Glasgow, G41 5SR. She was 51 years old at the time of her death.

(2) In about 1996, Mrs Norma Haq, developed symptoms suggestive of gallstones, as a result of which her GP, Dr Madhok, arranged an ultrasound scan, which confirmed the diagnosis.

(3) She was thereafter placed on the waiting list for laparascopic cholycystectomy in Glasgow.

(4) While on the waiting list, she and her husband visited Pakistan, where she underwent an open cholycystectomy procedure in a hospital in Pakistan.

(5) In late 1997, Mrs Haq again developed epigastric pain and was referred to Dr Richard Park, Consultant Enterogastrologist at Bon Secours Hospital, Glasgow.

(6) After carrying out various non-invasive investigations, Dr Park referred Mrs Haq to Mr Douglas Hansell, Consultant Surgeon, to arrange an endoscopic retrograde cholangiopancreatography (ERCP).

(7) Dr Park had performed an ultrasound scan which showed that she had a dilated common bile duct, in addition to liver tests which indicated a slightly elevated bilirubin.

(8) ERCP is a procedure which allows the biliary tree and pancreatic ducts to be visualised using a combination of an endoscopic examination and radiological imaging. The procedure involves the passage of a side viewing endoscope via the patient's oesophagus and stomach to the junction of the second/third part of the duodenum. The endoscope is then pulled back and manipulated, allowing the ampulla of vater to be visualised on the medial wall of the duodenum. The ampulla is then cannulated with a fine bore plastic tube and radio-opaque dye is injected into the biliary tree (cholangiogram) and/or the pancreatic duct system (pancreatogram). X-ray films are taken of the dye within the duct systems. Further procedures can then be undertaken, such as balloon dilatation of the ducts, removal of gallstones from the common bile duct, or sphincterotomy, where a division of the muscle fibres of the sphincter of Oddi situated at the lower end of the common bile duct is performed.

(9) Mrs Haq was seen by Mr Douglas Hansell, Consultant Surgeon, at Ross Hall Hospital on 19 February 1998, who arranged for her to be admitted for an ERCP procedure.

(10) An ERCP and sphincterotomy was carried out at Ross Hall by Mr Hansell on 25 February 1998, Mrs Haq being discharged home the following day.

(11) Mrs Haq was seen by Mr Hansell on 3 March 1998 at review and a further appointment made for 23 April 1998.

(12) Mrs Haq returned earlier, on 12 March 1998, complaining of slight epigastric discomfort, having been commenced on cimetidine, a drug to alleviate ulcers, by her GP, Dr Madhok. Mr Hansell requested her to continue with said medication until her review on 23 April 1998.

(13) On 23 April 1998, when Mrs Haq was seen at the out-patient clinic at Ross Hall by Mr Hansell, the epigastric pain had settled, and accordingly, Mr Hansell recommended to Dr Madhok, that if the pain returned, Mrs Haq might benefit from a further course of cimetidine. No further appointment to Mr Hansell was made at that time.

(14) On 18 August 1998, Mrs Haq was again seen by Mr Hansell in the out-patient clinic at Ross Hall, complaining of epigastric pain during and after eating. Her liver function tests were normal.

(15) Arrangements were made for her admission to Ross Hall Hospital on 25 August 1998 for an upper GI endoscopy and ERCP.

(16) Ross Hall Hospital was an appropriate hospital for a patient to undergo an ERCP, performed by a competent general surgeon.

(17) The ERCP was to be of an exploratory nature, to inspect the site of the previous sphincterotomy.

(18) At about 10.45 am on 26 August 1998, Mrs Haq was taken from her room to a well staffed X-ray department in Ross Hall Hospital, where the upper GI and ERCP were to be performed.

(19) The procedure commenced, after sedation, with an attempted ERCP. It is unusual to do ERCP before the upper GI endoscopy, although some endoscopists may choose to do so.

(20) During the course of the attempted ERCP, a perforation of the duodenum occurred retroperitoneally, that being recorded in the medical notes by Mr Hansell as "a mature duodenal perforation was noted. For contrast meal later". He immediately withdrew the scope and made no attempt to cannulate the ampulla or inject dye. He did not inspect the ampulla of vater.

(21) A perforation of the duodenum, particularly retroperitoneally, is known to be a very serious condition requiring surgery as soon as possible, in order to prevent the spread of enzymes and fluids from the pancreatic duct spreading into the retroperitoneum and intra-abdominally.

(22) At that time it was thought to be at the first and second parts of the duodenum, which is a "C" shaped organ.

(23) An instrumental perforation may occur even although the endoscope has passed with ease and has been gently advanced and carefully manipulated by the endoscopist.

(24) At 12 noon, it was noted by Dr G J Paterson, Consultant Radiologist, that "decubitus X-ray films of the abdomen confirm the presence of free intraperitoneal air". Films taken on the table after ERCP showed that there was considerable retroperitoneal gas. Three abdominal X-rays taken during screening at 10.23 and 10.39 am on 26 August 1998 demonstrate extensive retroperitoneal gas with insufflation around both kidneys and the retroperitoneal extending along the psoas muscle. An erect chest X-ray of 26 August 1998, demonstrates elevation of both hemidiaphragms with extensive gas present beneath both diaphragms.

(25) At 1.00 pm when Mrs Haq was returned to her room she was complaining of severe abdominal pain, for which she was given 7.5 mg of morphine intramuscularly. She required the administration of a further 3 mg of morphine intravenously by the resident medical officer within an hour.

(26) A blood sample report timed at 3.15 pm on 26 August 1998 showed an elevated white cell count of 15.8 (normal range 4-11) and an elevated serum amylase of 315 IU/L.

(27) The elevation in the white cell count indicated an inflammatory response to some form of injury. The elevation in the serum amylase is normally indicative of inflammation of the pancreas. Cannulation of the pancreatic duct may cause a rise in amylase level.

(28) There was availability in theatre at Ross Hall Hospital at 2.30 pm on 26 August 1998. It was also possible to re-schedule other operations to accommodate an emergency.

(29) There was a note, timed at 5.00 pm by Mr Hansell "for laparotomy this evening".

(30) Ross Hall Hospital, Glasgow is the largest private hospital in Scotland, with facilities for cardiac surgery and has a fully equipped Intensive Care Unit. Intensive Care facilities can be provided within 15 minutes maximum to patients. It is licensed by the Greater Glasgow Health Board for the use of 101 beds. Had Mr Hansell wished to transfer Mrs Haq to a National Health Service specialist unit, that would have been arranged without difficulty.

(31) There was a note, timed at 5.45 pm, by Dr Colin Miller, Consultant Anaesthetist, "nasal gastric tube to be passed pre-operatively".

(32) At 9.30 pm anaesthetic commenced for laparotomy. The laparotomy was performed by Mr Hansell, assisted by Mr E Dickson.

(33) At laparotomy, a perforation, situated at the second and third part of the duodenum situated retroperitoneally, was repaired in two layers, and a gastrojejunostomy was performed. Mr Hansell did not biopsy a sample at the perforation.

(34) The second and third part of the duodenum is the classic site of perforation by an instrument in the course of ERCP. It is very rare for an ulcer to develop there.

(35) An instrumental perforation had occurred during ERCP earlier that day.

(36) About 11.50 pm Mrs Haq was admitted to the Intensive Care Unit, post-operatively.

(37) On 27 August 1998 Mrs Haq was transferred to the High Dependency Unit from the Intensive Care Unit.

(38) Thereafter until 2 September 1998, she had daily blood tests carried out, comprising a full blood count, urea and electrolytes. There were four occasions when she had liver function tests and blood amylase levels carried out. Her prothrombin time, which is an indicator of clotting ability, was carried out on eight occasions over the period.

(39) On 2 September 1998 Mrs Haq's white blood cell count was 18.8.

(40) The nursing notes for that day were "good morning. Shower taken with minimal assistance. More independent. Mobility increased. Vital signs stable".

(41) Mr Hansell wrote on that day to Dr Madhok, GP, to give an update on Mrs Haq's progress (production No 5 for the Crown). That letter states:-

"Dear Mr Madhok,

I thought I would write to give you an update of Mrs Haq's progress. You will remember that we planned to perform an upper GI endoscopy and ERCP at Ross Hall Hospital on 26 August 1998.

The findings of that investigation were most interesting, in that she had an old perforation of the second part of the duodenum. In view of this I took her to theatre later that evening and found a perforation in the duodenum at the junction of the second and third parts. There was no obvious pathology here and I simply repaired the perforation and performed a gastrojejunostomy to facilitate gastric drainage.

Her progress to date has been satisfactory and I will write to you again once she has been discharged."

(42) On 3 September 1998 Mrs Haq's white blood count was 24.8, as a result of which Mr Hansell ordered an ultrasound scan of her abdomen to be carried out.

(43) Mrs Haq was suffering from sepsis which became severe about 22 September 1998.

(44) Mrs Haq's condition required constant monitoring by way of a variety of scans, particularly CT scans, blood tests, cultures, biochemistry and all other available tests.

(45) Mrs Haq's condition required urgent aggressive surgery.

(46) The report of the ultrasound of Mrs Haq's abdomen, which was carried out on 4 September 1998, stated *inter alia* "some abnormal loops of bowel are noted in the right flank/RIF, lying just below the level of insertion of the drainage tube. Although no discrete collection is present, bowel at this site appears fixed, and an early localised infection at this site cannot be excluded".

(47) The white blood cell count remained elevated over the following days, peaking at 28.4 on 7 September 1998. Further it was noted that there was pyrexia at 5.30 pm that day.

(48) On 8 September 1998, Mr Hansell noted in records that a CT scan of Mrs Haq's abdomen showed the presence of fluid.

(49) Mr Hansell changed Mrs Haq's antibiotics, noting that if she was no better in the morning she would need a further laparotomy.

(50) On 9 September 1998 anaesthetic for the laparotomy commenced at 3.30 pm and ended at 6.30 pm, Dr Colin Miller being the anaesthetist.

(51) On that date Mr Hansell, assisted by Mr Dickson, performed a laparotomy, a right hemicolectomy and drainage of a retroperitoneal abscess on Mrs Haq.

(52) At 6.45 pm Mrs Haq was transferred post-operatively to the Intensive Care Unit at Ross Hall.

(53) Mr Hansell wrote to Guardian Insurance about Mrs Haq on that date (family production 2/5):-

"This lady is currently an in patient in Ross Hall Hospital. On 26th August 1998, this lady required an emergency laparotomy for a perforated duodenal ulcer. Her post operative progress was initially uneventful but over the past few days her condition has deteriorated. Radiology study shows no evidence of a leak from the repaired perforation, but a CT scan shows widespread intra-abdominal fluid, and in view of her worsening sepsis it is presumed that this fluid is infected.

Consequently, a further laparotomy is being undertaken today (9.9.98) and obviously the patient will require a prolonged in-patient stay which initially will involve at least one night if not two in the Intensive Care Unit.

An up-dated report will be given as and when asked for."

(54) Following said laparotomy, Mrs Haq's biochemistry and haematology results returned to within normal limits.

(55) Her care was undertaken and monitored by Mr Hansell and Dr Miller until 19 September 1998, when Dr Miller went on holiday. Dr Miller had been told by

Mr Hansell that the original cause of the perforation was related to an ulcer. Thereafter, her care was undertaken and monitored by Mr Hansell.

(56) On 12 September 1998 Mrs Haq was transferred from Intensive Care Unit to the High Dependency Unit.

(57) From 13 to 26 September 1998, Mrs Haq had a full blood count daily, daily urea and electrolyte measurements, with the exception of the platelets result for 25 September 1998, which was unavailable.

(58) Serum amylase tests and liver function tests were carried out on only three occasions during this period.

(59) On 17 September 1998 Mrs Haq's white blood cell count was 10.9.

(60) Fluid taken from her abdominal drain on that date, subsequently grew enterococcus (which was reported on 21 September 1998).

(61) On 20 September 1998 her white blood cell count was 14.2.

(62) On 21 September 1998 her white blood cell count was 15.2 and platelets 595.

(63) On 21 September 1998 Mrs Haq was recorded as "being actively sick" by nursing staff.

(64) On 21 September 1998 a gastrograffin follow through X-ray was performed, which showed "incomplete obstruction of the post bulbar area of the duodenum and probably obstruction at the previous gastroenterostomy site".

(65) Mr Hansell recorded in Mrs Haq's notes to "continue as before".

(66) At 11.00 am on 22 September 1998, Mrs Haq's temperature was 38.5ºC. Blood cultures were taken.

(67) She was noted in nursing notes as "managing to use commode", "up sitting at bedside and walked around unit with assistance of physiotherapist" and "morning well in/out and around the bed".

(68) On that date her white blood cell count was 12.9 and platelets 371.

(69) On 23 September 1998, Mrs Haq was noted by nursing staff as complaining on two occasions, overnight, of severe cramp type pain. However, she was noted to have a "settled morning" and be apyrexial.

(70) The result of blood culture of 22 September 1998 was telephoned to the ward from pathology in the morning to the effect "cultures taken on 22/9 reported as gram positive for cocci and ?enterococci".

(71) Blood test results showed a white blood cell count of 13.3, platelets 187, haemoglobin 11, urea 4.

(72) She was commenced on IV ampicillin, seen by the infection control nurse and transferred back to a single room from High Dependency Unit.

(73) On 23 September 1998 Mr Hansell wrote to Dr Madhok giving an update of her progress (production 4 for Crown) stating:-

"Dear Mr Madhok,

I thought I would give you an update on Mrs Haq's progress. Having progressed nicely following her first operation she then became septic and further laparotomy was required. This revealed widespread infection within the retro peritoneum, although the duodenal repair was intact.

It was necessary to perform a right hemi-colectomy and she is recovering slowly from this.

I will keep you informed of her progress."

(74) On 24 September 1998 Mrs Haq's white blood cell count was 9, haemoglobin 9.2, platelets 71, urea 10.

(75) Mr Hansell noted "to continue monitoring all drains etc". She was noted to be mobilising gently, apyrexial.

(76) On 25 September 1998 her white blood cell count was 8.4, haemoglobin 9.5 and platelets were unavailable. Urea was 13.2.

(77) The formal report of the blood cultures taken on 22 September 1998 was produced.

(78) No entry was made by Mr Hansell in the clinical records on 25 September 1998.

(79) Mrs Haq constantly wanted in and out of bed, in and out of her chair, and could not settle. Despite being given a great deal of nursing care, Mrs Haq fell from her chair on 26 September 1998. She was assisted by nursing staff. The fall did not contribute to her death.

(80) On 26 September 1998 nursing staff reported Mrs Haq as "confused and disorientated".

(81) Mr Hansell noted Mrs Haq to be "confused but recordings okay" in the notes.

(82) On 26 September 1998 Mrs Haq's white blood cell count was 7.1, haemoglobin 9, platelets 50, urea 10.9 and bicarbonate 17.

(83) At 11.00 pm Mrs Haq was reviewed by the resident medical office, who discussed her condition with Mr Hansell.

(84) Arterial blood gases were performed and Mr Hansell ordered that intravenous fluids being administered were increased to the rate of 4 hourly bags.

(85) At about 4.40 am on 27 September 1998 Mrs Haq became very breathless. She was awake and responsive before suffering a cardio respiratory arrest at 4.45 am.

(86) At 5.00 am Dr Dell, Consultant Anaesthetist, was called into Ross Hall from his home, arriving at 5.15 am.

(87) Mrs Haq was transferred to the Intensive Care Unit at 5.50 am, by which time Mr Hansell was also in attendance.

(88) She thereafter developed persistent bradycardia and ultimately asystole.

(89) Resuscitation, which had been underway since the arrival of Dr Dell, was abandoned at 7.30 am and Mrs Haq was pronounced dead.

(90) Mr Hansell spoke with Mr Haq.

(91) Mr Hansell issued a death certificate giving the cause of death as pulmonary thrombo embolism, low grade intra-abdominal sepsis, perforated duodenal ulcer.

(92) Mr Hansell did not seek permission for a post-mortem examination from Mr Haq, nor did he report the death to the procurator fiscal.

(93) On 6 October 1998 Mr Hansell wrote to Dr Madhok informing him of Mrs Haq's death.

(94) At no time did Mr Hansell contact a specialist unit, such as that of Professor Imrie at Glasgow Royal Infirmary, or Professor Garden at Edinburgh Royal Infirmary, for advice or for discussion as to transfer of Mrs Haq from Ross Hall Hospital to a specialist facility in the National Health Service.

(95) The literature "Death and the Procurator Fiscal", outlining the circumstances in which it was appropriate to report a death to the procurator fiscal, was not sent to managers of private hospitals, such as Ross Hall, by the Scottish Executive. Said literature is now sent to private hospitals such as Ross Hall by the Scottish Executive.

(96) The death was not reported to the Scottish Audit of Surgical Mortality ("SASM"), which is a voluntary scheme under the auspices of the Royal College of Physicians and Surgeons in Glasgow, whereby surgeons are encouraged to participate by sending details of cases where death has resulted.

(97) Surgeons at Ross Hall Hospital are now encouraged to participate in reporting any deaths to the SASM.

(98) At the time of Mrs Haq's death, Ross Hall Hospital like many other private hospitals, did not have a formal system whereby a review of a patient would take place, where the patients stay in hospital was longer than expected, following an elective procedure. Such a system is now in place in Ross Hall.

(99) At the time of Mrs Haq's death there were no guidelines to consultants at Ross Hall Hospital like many other private hospitals, regarding participation in specialist areas, called managed clinical networks, regarding discussion of patients or the transfer of patients to specialist care centres. Such a system is now in place.

(100) The care by nursing staff was adequate and appropriate given their instructions regarding treatment by Mr Hansell.

(101) There was no full and frank disclosure of the true cause of the duodenal perforation by Mr Hansell given to Mr Haq, the family, the GP and doctors treating her.

The Sheriff, having considered all the evidence adduced, DETERMINES:

(1) In terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, Section 6(1)(a) (hereinafter referred to as "the said Act") that NORMA HAQ, born 23 October 1946, of Flat 4, 20 St John's Quadrant, Glasgow, G41 5SR, died at 7.30 am on 27 September 1998 within the Intensive Care Suite at Ross Hall Hospital, Glasgow.

(2) In terms of Section 6(1)(b) of said Act that the cause of death was:

(i) Septicaemia secondary to sepsis, due to

(ii) instrumental perforation of the duodenum.

(3) In terms of Section 6(1)(c) of said Act that reasonable precautions whereby the death might have been avoided could have been taken, namely (1) the transfer to, or the taking of advice from, a specialist NHS unit immediately after the occurrence of the perforation during the course of ERCP procedure; (2) failing which, the performance of the laparotomy as soon as possible after the perforation had occurred; (3) thereafter, intensive monitoring by way of a range of various scans, microbiology, haematology and all other available tests; (4) early surgical intervention in the course of the deceased's ensuing illness.

(4) In terms of Section 6(1)(e) of the said Act the death ought to have been reported to the procurator fiscal in terms of the literature "Death and the Procurator Fiscal"; said literature ought to be sent by the Scottish Executive to managers of private hospitals in addition to NHS hospitals; management in NHS and private hospitals should ensure that all doctors treating patients are aware of the terms of "Death and the Procurator Fiscal"; in any event Mr Hansell should have known such a report was required from his own NHS consultant practice; it would have been appropriate to report to the Scottish Audit of Surgical Mortality (SASM), and effort should be made to encourage the participation of surgeons in private practice in SASM, a voluntary scheme; there should be a system of review of cases in a private hospital such as Ross Hall Hospital where a patient's stay in hospital is longer than expected following an elective procedure; there should be participation in managed clinical networks in specialist areas by consultant surgeons in a private hospital such as Ross Hall Hospital; there should be guidelines for surgeons operating in a private hospital such as Ross Hall, regarding discussion of patients or transfer of patients to specialist care centres where an instrumental perforation of the upper gastro intestinal tract has occurred; that the Department of Health considers issuing guidance to surgeons relating to instrumental perforation of the upper gastro intestinal tract

in respect of transfer to specialist care centres. Mr Hansell should have made a full and frank disclosure from the outset to the patient, the family and other doctors involved with the patient, that the cause of perforation was instrumental, which in itself is a recognised complication of the ERCP procedure and is not considered medical negligence.

NOTE:-

In this case Mrs Mawdsley, Procurator Fiscal Depute, appeared for the Crown, Miss Dorrian, QC, and Dr Dougall, Advocate, for the family, Miss Newcombe, Solicitor for BMI Healthcare and Mr Ferguson, QC, and Mr J Griffiths, Solicitor, for Mr Hansell.

In this case, I have been assisted greatly by those appearing in this complex medical Fatal Accident Inquiry and by their preparation of concise written submissions.

The Inquiry has not been made any easier by the unfortunately protracted length of court proceedings (19 months) and the great passage time since the unfortunate Mrs Haq's death on 27 September 1998. Mr Haq attended every day of the case including 26 days of evidence in addition to days for submissions and other procedures.

Much of the evidence at the outset was involved with the anatomy of the abdomen, in order that the court could understand the procedures undertaken, which I have not repeated in the findings-in-fact or in this Note. They are contained at length in the Notes in Evidence. Further, there are a number of areas, inevitably touched upon in this Fatal Accident Inquiry which are pertinent to and more appropriately decided elsewhere, in a civil court and at the General Medical Council. It was stated in the course of the evidence of Mr Hamer-Hodges that the matter had been reported to the GMC, who are having a preliminary hearing in July 2003.

Ross Hall Hospital does not employ the consultant surgeons who perform procedures at the hospital. They are independent contractors who are given practising privileges at the hospital. Ross Hall has over 500 consultants with admitting privileges. The grant of practising privileges allows consultants to use hospital facilities, staff and support mechanisms.

Mr Hansell is a Consultant General Surgeon with a special interest in breast/endocrine surgery and biliary/pancreatic surgery, North Glasgow NHS Trust, Stobhill Hospital and has been since August 1992. He is an Honorary Clinical Senior Lecturer in the Faculty of Medicine, Glasgow University. He has held practising privileges at Ross Hall Hospital since 1992, and practises at Glasgow Nuffield Hospital. With the exception of Mr Haq's complaint, he has been the subject of only one other complaint at Ross Hall Hospital. Ross Hall Hospital has only one other record of a clinical complication arising with a patient under Mr Hansell's care. Mr Hansell is presently the Chair of the Glasgow Nuffield Hospital Medical Advisory Committee.

Mr Hansell has a commitment to the training of middle grade surgeons and gastroenterologists. He has given numerous presentations, lectures on ERCP and has published articles. His practice has overtaken his research since his appointment as consultant. At the time in question Mr Hansell performed about 300 ERCPs per year. He was a surgeon in Stobhill Hospital, to whom other colleagues referred complicated cases, including pancreatic injury. On occasions, he referred complicated cases to specialist centres, including Professor Garden's specialist centre.

Expert evidence was given for the Crown by Professor Garden, Edinburgh University and Royal Infirmary, Mr Charnley, Consultant in hepato-biliary and pancreatic surgery, Freeman Hospital, Newcastle, and for the family by Mr Hamer-Hodges, Consultant Surgeon and specialist in colorectal surgery, Western General Hospital, Edinburgh.

Professor Garden has been Regius Professor of Clinical Surgery at Edinburgh University since 2000. From 1997-1999 he was Professor of Hepatobiliary Surgery, Edinburgh University. His two specialist surgical interests are liver transplantations, and biliary and pancreatic surgery. He is an external examiner. He has innumerable publications, including several text books, and is invited to lecture worldwide.

The Freeman Hospital, Newcastle is the regional centre for similar surgery in the North of England, serving a population of 3.5 million.

Professor Garden's report was productions No 2 and 8 for the Crown, Mr Charnley's report production No 18 for the Crown and Mr Hamer-Hodges' report production No 4 for the family.

The experts all agreed that 95% of duodenal ulcers occurred in the first part of the "C" shaped duodenum, with the remaining 5% occurring in the post bulbar region (the junction of the first and second parts). All gave evidence to the effect that single duodenal ulcers did not occur in the second/third part. Professor Garden said he knew of only 10 cases being described in the literature up until 1989. Mr Charnley had never come across one in his extensive practice.

Mr Hansell, in dealing with questions regarding the site, ie 2/3 part of the duodenum, said that this was an unusual, but well documented area of the duodenum in which to find ulcers. The literature said that 5% or even 10% of ulcers occur outwith the first part of the duodenum.

It was said that in cases of fresh perforation, adventitia can be seen clearly, whereas the area around an ulcer would be reddened and there would sloughing of tissue. There would be no adventitia visible.

An upper GI endoscopy is normally undertaken by a forward viewing flexible endoscope to allow for the inspection of the oesophagus, stomach and duodenum. An ERCP is the passage of an endoscope into the second part of the duodenum to allow the passage of a small catheter into the duodenal ampulla and to outline the bile duct and the pancreatic duct to identify if there was any abnormality in the drainage system to the pancreas. An ERCP is a more invasive procedure than an upper GI endoscopy with a greater risk of complications.

Mr Hansell's intention was to carry out the two procedures at the same time on 26 August 1998 with the ERCP being the first procedure to be carried out. The ERCP was to be of an exploratory nature, to inspect the site of the previous sphincterotomy. He also wanted to look and see if there was a small tumour at the ampulla, at the lower end of the bile duct, which was unseen in February. In February there had been a query as to retained gall stones, although there was no sign of them then.

Criticism was made by Mr Hamer-Hodges of the decision to undertake an ERCP at all, on 26 August 1998, given the symptoms described by Mrs Haq. He appeared to question whether a greater fee was involved. However, having heard Mr Hansell's explanation of the system, that did not appear to be the case.

All the experts were agreed that ERCP carries a risk of perforation of the duodenum or ampulla of about 0.5 - 1%. It was an accepted risk and a perforation did not constitute medical negligence. However it was an extremely serious matter if such a perforation should take place. One of the recognised complications is instrumental perforation which carries a risk of death in the order of about 15 to 20%, according to Professor Garden, about 5 to 10% according to Mr Charnley. If, thereafter, severe sepsis developed mortality rate was about 50%, even in specialist centres.

All the experts felt that other non-invasive tests, such as ultrasound scan or MRI, if such a scan was then available at Ross Hall Hospital, should have been carried out first. Professor Garden found it difficult to support the need for an ERCP initially, while not ruling it out totally at a later stage. Mr Hamer-Hodges thought there were no indications at all for proceeding to ERCP at that time. Questions were asked as to how it was going to assist in diagnosis.

Mr Charnley, stated that the correct order of investigation in any medical investigation is to do the safer and more minor investigation first, followed by those more dangerous and invasive investigations later. He said that ERCP was not a minor endoscopic procedure, but in fact a dangerous endoscopic procedure with an 8% complication rate with about 1% life threatening complications.

Techniques have advanced since 1998 and much more use is made of endoscopic ultrasound and MRCP (magnetic resonance cholangiopancreatography) which would not generally have been available in 1998. These investigations are generally replacing ERCP now.

All of the experts felt quite strongly that none of them would have proceeded to ERCP at that stage. Further, their views were reinforced by the fact that Mr Hansell himself considered the problem to be acid related rather than a biliary problem. However, Mr Hansell wanted to be sure that the earlier sphincterotomy which he had performed in February 1998 had not stenosed and was causing the same pain as had been present prior to that procedure. Liver function tests on this occasion, were normal. Ultrasound scan, may or may not have been conclusive. He wished to inspect the sphincter.

Although Professor Garden was prepared to accept that, at ERCP, Mr Hansell may have thought there was a perforated duodenal ulcer, it would be clear, at laparotomy, that was not the case, and that an instrumental perforation had taken place. It was the classic place for such a perforation occurring where the endoscopist had placed the endoscope just past the ampulla, ready to pull back the endoscope slightly to cannulate the ampulla. Perforation could occur even when it was thought that the scope had passed apparently uneventfully. The hole was described as being about 1 cm in diameter, which was consistent with an instrumental perforation. It was said it did not bleed much. Mr Hansell said that it was a pretty clean punched out opening with slightly thickened tissue around it, a fibrosed type tissue. Professor Garden disagreed with Mr Hansell's conclusions from his description of the wound, in that he said it was quite possible for the hole to be round if there was an instrumental perforation. Mr Hansell accepted that he had caused an iatrogenic injury, but maintained that there had been a pre-existing weakness due to an earlier ulcer or perforation. In evidence, he maintained his belief that there had been a perforated duodenal ulcer. At p 887, however, Mr Hansell did accept that the commonest cause of perforation at that site was traumatic perforation.

The overwhelming opinion of the experts, having considered the hospital notes and Mr Hansell's evidence regarding the description of the perforation was that it was an instrumental perforation and that there was no pre-existing weakness. The sighting of adventitia indicated a fresh perforation by instrument. In addition, Mr Hansell had not biopsied any tissue from the site, which certainly would have been appropriate if an ulcer or malignancy had apparently been seen or suspected in such an unusual site. Mr Hansell stated in evidence that there was no lumpy or frondy tissue to suggest a tumour, and therefore no biopsy was performed.

Looking to all the evidence I accepted the evidence of all the experts that this was an instrumental perforation.

It was said by Mr Charnley that, while specialists in specialist units would not have proceeded to ERCP at that time, surgeons who were general gastroenterologists might have had a lower threshold to do an ERCP than a specialist. Professor Garden generally agreed with that.

Professor Garden agreed that it was likely that both procedures, ERCP and upper GI, would be required to establish the cause of the symptoms. An issue was raised in the course of the Inquiry, that, if an ERCP was justified, whether both procedures, ERCP and upper GI endoscopy, should be carried out together in the order in which they were carried out. All the experts indicated that upper GI was the obvious choice to commence as it was less invasive. Further, it was thought that Mrs Haq's symptoms might be acid related and accordingly an upper GI may have revealed the problem. It was thought by the experts to be somewhat unusual to have both investigations together. However Professor Garden stated that he was aware that others had occasionally undertaken these procedures, where they were indicated and it would be a matter of clinical judgement for the endoscopist. Mr Charnley who personally did two sessions of ERCP a week, accepted that some might do the ERCP before upper GI, but it was not something he had come across before. Mr Hamer-Hodges had not undertaken ERCPs. Mr Hansell maintained that his preference was for ERCP first when the sedative had best effect.

Given the evidence, that issue appeared to be one of clinical practice and not one in which a determination is appropriately made in this Fatal Accident Inquiry.

Mrs Haq signed the consent form for ERCP. There was nothing written in the notes to indicate what had been said Mr Hansell, which is hardly surprising. It would appear from Mr Charnley, that the medical profession has generally tightened up procedures in

obtaining consent to surgical procedures over the past few years. I do not feel it is appropriate to make comment on this matter, which should be left to the consideration of the medical profession, and is obviously in hand.

In the course of the ERCP, a perforation of Mrs Haq's duodenum occurred. Mr Hansell accepted that the perforation was related to the ERCP which he was performing and that the perforation was not a spontaneous perforation of an ulcer. He described seeing adventitia through the scope. He immediately withdrew the scope and made no attempt to cannulate the ampulla or inject dye. Professor Garden said there was no description of the type of endoscope in the notes. In evidence it was stated to be a side viewing endoscope.

Mr Hansell, in evidence, felt that the expert reports, and that of the pathologist Dr McFarlane, were based on a wrong assumption that he had attempted to cannulate the ampulla, when in fact that was not the case. There was no note at the ERCP procedure as to whether there had been an attempt at cannulation. When that was clarified with each of the experts, evidence was given, taking that into account.

At the time of the ERCP, Professor Garden thought that Mr Hansell might reasonably have believed that there was an ulcer in the duodenum, while Mr Charnley felt that assertion was somewhat bold and that Mr Hansell might have had a more open mind.

Films at the time of ERCP and immediately thereafter disclosed both intraperitoneal and retroperitoneal gas.

Mr Hansell told Mrs Haq that the passage of the endoscope opened up the ulcer and told others present that this was the mechanism. In the afternoon, he told Dr Miller that he found himself looking through the ulcer. Mr Dickson, who was asked to assist Mr Hansell at the operation recollected that Mr Hansell accepted his intervention resulted in perforation, although he did not think Mr Hansell had passed a scope through a normal duodenum.

Mr Hansell felt he had been proceeding gently, and thought that a retroperitoneal perforation with an instrument was difficult to achieve. He had never read of any significant series explaining how to manage that (p 1175).

In any event there was a laparotomy which commenced at 9.30 pm that evening, performed by Mr Hansell with Mr Dickson assisting. Mr Dickson was Mr Hansell's trainee at Stobhill Hospital.

Mr Dickson gave similar evidence to Mr Hansell regarding the appearances of the area to be repaired, he too believing that it was an ulcer. At that time he had very few years

experience in surgery and might not have been in a strong position to give a firm opinion. Mr Hansell described him in evidence as a fairly junior house officer. When he gave his evidence in October 2001, he was 29 years old, and was an experienced SHO in General Surgery at Victoria Infirmary, Glasgow.

Since then, he has not seen an instrumental perforation of the duodenum, although he had seen on of the bowel. He had not seen a perforated ulcer in 2nd and 3rd parts of the duodenum, but had seen such perforations in the first part. According to Dr Dickson, Mr Hansell, in explaining the proposed operation to him, had been very surprised to find a perforation in the duodenum while doing an ERCP.

The opinion of the experts given in various ways, was to the effect that a surgeon of Mr Hansell's experience, must have known that this was an iatrogenic perforation and not an ulcer, at laparotomy. It was untenable to maintain the stance that there was a duodenal ulcer. It was quite an exceptional site for the spontaneous perforation of an ulcer. There was clear, strong and compelling evidence from Professor Garden, Mr Charnley and Mr Hamer-Hodges on this point. None of them took issue with the manner of repair, the only comment being that it was quite a substantial repair, consistent with an instrumental perforation. Mr Hansell's evidence was that the perforation was on the posterior and lateral wall of the duodenum, more or less opposite the ampulla.

There were various comments from the experts as to why Mr Hansell had maintained his opinion of "perforated? DU at second/third part of duodenum" at this stage and subsequently to the patient, family and other medical persons dealing with her. It appeared that he had closed his mind to the possibility of instrumental perforation without an underlying weakness in the duodenum. Mr Charnley queried the possibility of Mr Hansell being unable to accept that he had caused the instrumental perforation, albeit it was a recognised risk of the procedure. Professor Garden thought that if Mr Hansell genuinely believed that there was an ulcer, even at operation, he was "misguided". Mr Hamer-Hodges raised the possibility of personal pride or vanity of the surgeon in not wishing to admit a mistake.

Mr Charnley raised the very interesting matter that there was a blurred area as to whether a person such as a surgeon, was maliciously withholding information or whether there was a mental block in being able to accept it. Having heard all the evidence and assessed the witnesses including Mr Hansell, I came to the conclusion that Mr Hansell had not acted maliciously in withholding information, but had convinced himself as to the

correctness of his diagnosis and his belief that he was dealing with an ulcer. He wrote on hospital notes and stated his diagnosis to others, who accepted what he said, possibly because none were in a position to challenge him on his diagnosis or his plan, and perhaps due to the respect in which he was held. This may have fortified his erroneous belief. It certainly underlines the importance of the specialist unit, whereby several consultants, experts in their own fields, can constantly discuss critically with each other a patient's condition, progress and plan of action. Had a specialist unit been contacted, it would have been unlikely that Mr Hansell would have maintained his erroneous belief in an ulcer without challenge. Nevertheless, even although not motivated by malice, information about Mrs Haq's true situation was therefore withheld from the patient and her family, and it is understandable as to why they feel that information was concealed from them and use the word "cover up".

Although it was clear, by noon, that there was free intraperitoneal gas and therefore a laparotomy would be required as soon as possible, that decision was not taken until 5.00 pm.

It was said that Mr Hansell had an NHS commitment in the afternoon at Stobhill Hospital. However he said that he could have rescheduled that if necessary. He did speak to Mr Haq about 2.00 to 2.30 pm that afternoon, when Mr Haq said that Mr Hansell had explained "there was some old ulcer somewhere in the stomach which he couldn't see". He would have to open her and see. Mr Hansell stated that he told Mr and Mrs Haq that he believed he had found a mature perforation that had presumably perforated and sealed at some point prior to his procedure and that the passage of the scope had opened up the ulcer, either by the mechanical passage of the scope or the air being passed through the scope, and that consequently there had to be an operation to repair the perforation.

Mr Hansell gave evidence that he had found Mr Haq's pronunciation of English rather difficult, with which I would agreed. Mr Haq said that his wife was much better in the spoken English, while he was better at grammar and writing. I did think that Mr Hansell had given them information about Mrs Haq as matters progressed, albeit it referred to "an old ulcer", but I am not entirely sure as to how much was absorbed by Mr Haq, due to second language difficulties, and to the stress and ultimate grief he sustained.

Mrs Haq had complained of severe pain for which she was given a substantial amount of morphine. At 3.15 pm on 26 August 1998, her white cell count was noted at

15.8 and there was an elevated serum amylase of 315 IU/L. That, according to Professor Garden, should have indicated a surgical emergency.

There was evidence that there was availability in the operating theatre at 2.30 pm that afternoon at Ross Hall Hospital and further operations could have been rescheduled if necessary for an emergency.

Mr Hansell thought that a perforation retroperitoneally could be dealt with conservatively if the leakage was contained. He had had experience of two perforations, one being an instrumental perforation by a colleague and one involving himself when his scope passed through a paper thin duodenal ulcer not expected to be there.

The evidence from the experts was all to the effect that a laparotomy should be performed as soon as possible, to prevent the spread of dangerous pancreatic juices outwith the duodenum. They are particularly powerful leading to contamination and destruction of tissue and infection in the upper abdomen and also in the patient being more likely to suffer shock and septicaemia. It was not a time for conservative management.

Professor Garden gave evidence to the effect that a surgeon who had not experienced that complication before might have considered it appropriate to wait and see what is happening to the patient, whereas, to a specialist experienced in that area, the development of intraperitoneal gas would mandate early surgical intervention and there would be little necessity for undertaking further radiology such as a contrast study.

Unfortunately the operation did not commence until 9.30 pm. It was said that in a similar situation in the NHS, great pressure would be put on the hospital administration to get space in theatre as soon as possible, but a theatre might not have been made available any earlier than the time when the operation in fact took place at Ross Hall. Delay lessened the chances of survival.

At submissions on evidence, it was conceded by Mr Hansell's counsel that, having heard the evidence of the expert witnesses for the Crown, and having the benefit of hindsight, he ought to have taken the decision to repair the perforation earlier in the day on 26 August 1998, and that had he done so, events might have taken a different course.

Mr Charnley's evidence was that he would expect a mortality rate following perforation to be about 5 to 10% and the earlier the laparotomy was carried out the better. Professor Garden thought mortality rate from perforation occurring would be about 15 to 20%.

Once the perforation occurred, the management of the patient was critical. Surgery would be required as soon as possible. Constant close monitoring was thereafter required.

According to the experts for the Crown, Mr Hansell was experienced enough to carry out the laparotomy and repair on 26 August 1998. Mr Hansell's operation notes do not make reference to mobilising the colon (in order to clean that area out). Mr Charnley would have expected that to have been done, but commented that it would not be the first time that it had not been done by a surgeon. It was critical that the first laparotomy was done very well. He considered it a specialist procedure. He said that a surgeon really only gets one chance to operate on such patients and it is essential that everything is done properly, as chances of survival diminish once a patient gets into a cycle of operations and repeated infections.

It was not entirely clear in evidence whether the colon had been mobilised and that area cleaned out. At one point Mr Hansell said that he looked in detail at the area of spillage and was happy that he did not need to pursue under the colon (p 1548). At another point (p 1549) he stated that the area was cleaned and aspirated as thoroughly as possible. He did not fully mobilise the colon lest he would have allowed the spread of infection, which otherwise might not have taken place. At p1563 he explained that partial mobilisation of the colon had taken place, but he did not actively cut tissue. At p 1623 he said that he did mobilise the right colon, explaining that he did not write that he had mobilised the colon in his operation notes, as it was obvious, since he had to do it to gain access to the duodenum which had to be mobilised extensively. Partial mobilisation of the colon was needed in any event, as a huge number of adhesions (from the operation in Pakistan) had to be divided to gain access.

There was criticism of the lack of very close monitoring of Mrs Haq in the days following the laparotomy of 26 August 1998. While there were many tests and results available, the experts thought that there should have been more available daily in particular, full blood count, electrolytes, liver function tests and coagulation. Mr Charnley stated that Mrs Haq required surgical review several times each day. The hospital complied with all requests made by Mr Hansell, but Crown experts and Mr Hamer-Hodges thought the management of the patient by Mr Hansell, who basically was on his own, fell short of the monitoring which would have occurred had Mrs Haq been in a specialist NHS unit. In essence, Mr Hansell had been alone responsible for Mrs Haq's care, with assistance from Dr Miller, intensive care. He was also able to speak to bacteriologists but, he was on his

own. The whole ethos of the private hospital system appears to be care under a named consultant. Professor Garden felt that he (Professor Garden) would not have been able to manage a difficult and complicated case such as Mrs Haq's on his own, without the benefit of contribution from his other specialist colleagues. In a specialist unit there was multi-disciplinary management with regular meetings regarding patients. There would be 15 to 20 patients a year in Professor Garden's specialist unit with similar problems.

Mr Charnley described a honeymoon period of about 7 days post-operatively when a patient is apparently improving. Mr Hansell dictated a letter to Dr Madhok on 2 September, and accepted he could have stopped the letter, given the changing situation. However on 3 September 1998, the seventh day after the operation, a number of problems declared themselves, recorded in the nursing notes and biochemistry results, which should have mandated a CT scan which may have identified areas of potential infection. In fact an ultrasound scan was carried out on 4 September 1998 which showed a probable abscess. Ultrasound is poor at showing abscess formation in the retroperitoneal and underestimates the degree of infection. Antibiotics were changed but Professor Garden thought that would be insufficient as they could not penetrate the tissues and clear away infected material. The infection had to be drained away. It was essential to identify all possible sources of infection. A CT scan would probably have shown the source of infection.

The situation of the perforation, whereby there could be extensive retroperitoneal contamination, would indicate a risk of retroperitoneal necrosis or infection. Mr Charnley thought CT scans should have been carried out from 2 September 1998, and would have been carried out earlier in his own practice. He said that type of perforation is notorious for causing widespread complications. Professor Garden thought that the need for a CT scan was demonstrated from 3 September 1998, after the results of 3 September 1998 had been obtained. However a CT scan was not taken until 8 September 1998.

Professor Garden thought that the clinical signs and information available indicated a patient with severe sepsis, and whose condition was deteriorating. He said steps should have been taken to identify whether or not there were other organisms in the blood, to check the blood cultures and to examine the patient for a chest infection. Intravenous feeding would have to be checked for potential to introduce infection and culture of fluid from the abdominal drains would be required as would a culture of the urine. It may have been necessary to have an exploratory laparotomy if the source could not be identified by 5 or 6 September 1998.

In submissions in evidence, it was stated by Mr Hansell's counsel that Mr Hansell, now appreciated that a CT scan should have taken place earlier than 8 September 1998 and might have indicated a laparotomy should have been performed before 9 September 1998, thereby improving Mrs Haq's prospects of recovery.

According to the experts, the effect of delay in the performance of a second laparotomy until 9 September 1998 did not assist Mrs Haq's prospects of survival. Mr Charnley thought it was more serious than the delay of hours up to the first laparotomy. If there was a collection of infected material, it was only a matter of time before it would develop or have other consequences, such as necrosis, severe sepsis resulting in septic shock and multi-organ failure.

Transfer to a specialist centre, according to Professor Garden, should have been made as soon as 3 or 4 September 1998, when there was evidence of sepsis following the initial repair for perforation. Mr Charnley was surprised that consideration was not given to transferring her to a specialist unit, with which sentiment Mr Hamer-Hodges agreed. At the very least according to the experts, she should have been in Intensive Care Unit and not a room or a ward.

Mr Hansell performed the second laparotomy, which involved a right hemicolectomy and the placing of a peritoneal lavage system. Professor Garden did not challenge that this was the appropriate procedure and Mr Charnley commented that he did not know if a surgeon at a specialist centre would have done a better operation. However, Mr Hansell had never before carried out that operation himself in totality, but had previously performed the constituent parts. It is done on a regular basis in a specialist unit. Mr Hansell felt that with 24 years experience as a surgeon he was well capable of looking after the problems she had.

Mr Dickson stated he saw no evidence of peri pancreatic necrosis. He had not dealt with any cases of retroperitoneal sepsis, but he was well aware of the seriousness of such a situation, which could be fatal.

The experts agreed that after the second laparotomy, even in a specialist centre the mortality rate would be 50%. Professor Garden thought, looking to the notes and results which had been obtained, that from about 21 September 1998, it would have been very difficult to "have turned back the patient's outcome", with which Mr Charnley agreed. Her best prospects of survival would have been at a specialist centre according to Mr Hamer-Hodges also, who gave evidence that there would be no guarantees as to

successful outcome at a specialist centre, as there was a significant mortality rate, but she would have a much better likelihood of survival.

Immediately after the second laparotomy on 9 September 1998 Mrs Haq appeared to have a reasonable response. However, there were various indicators thereafter, such as the presence of a temperature, an elevated pulse rate, and intermittent pyrexia. Cultures showed that organisms had been grown from blood, all indicating a severe sepsis which is difficult to control. Rigors were noted at 8.50 pm on 23 September 1998. On 26 September 1998 Mrs Haq was confused. There were biochemical abnormalities, which led Professor Garden to the view that there were indications of impending renal failure and obviously multi-organ failure and multi-organ dysfunction.

Dr Miller, who had been told by Mr Hansell that the original cause of the perforation was related to an ulcer, went on holiday for a week, on 19 September 1998. Effectively, Mr Hansell was in sole charge of the care of Mrs Haq. Although not seen on a daily basis by Mr Hansell, there would only be a very few days when he did not visit her. Dr Miller's input had been as an Intensive Care Consultant.

From 22/23 September 1998 there was no imaging in an attempt to exclude ongoing intra-abdominal infection. Professor Garden thought CT scans were necessary from one week after 9 September 1998. He summed the situation up "Looking at Mrs Haq's progress over the last 4 or 5 days of her life, there was not doubt she was slipping from systemic inflammatory response into severe sepsis. I would have concerns about a surgical trainee who was unable to recognise or interpret these signs as evidence of severe sepsis syndrome and multi-organ failure."

He said that insufficient was done to establish the cause of the septicaemia. This may be a matter of clinical practice which is appropriate for consideration by the General Medical Council rather than a Fatal Accident Inquiry.

In the hospital notes and various forms relating to biochemistry, blood etc, there was written a variety of headings "Peripancreatic necrosis" "Pancreatitis" "Perf DU" "Sepsis" "Intro Abdo Sepsis" "Hemi colectomy Ileostomy Septic". There was evidence from Mr Hansell disputing that Mrs Haq ever had peripancreatic necrosis or pancreatitis. He said he did not write those descriptions and presumed they came from other staff and, once on the system, had been repeated. Mr Hansell, in evidence, did not accept some parts of the experts' reports to which had proceeded on the basis of pancreatitis and

peripancreatic necrosis. He disputed Mr Hamer-Hodges' assumption of pancreatic injury. That was clarified in evidence.

Mr Charnley said that Mrs Haq did not have pancreatitis but had retroperitoneal (peripancreatic) fat necrosis of the right side of the abdomen which has similar appearances to pancreatic necrosis. Irrespective of the original cause, the conditions were very similar involving the same type of treatment.

One of the reasons given by Mr Hansell for not referring Mrs Haq to a specialist centre was that he believed the specialist centres dealt with acute necrotising pancreatitis and she did not have a condition with which they dealt. At the time, he felt that the problem was intra abdominal sepsis and any general surgeon, working in the abdomen, would, in most cases, be comfortable to look after that condition. Within Stobhill Hospital, Mr Hansell would be a surgeon to whom biliary/pancreatic problems were referred. Since considering the evidence of the experts, he had revised his views.

While Mrs Haq was becoming increasingly unwell, there was nothing to indicate to the hospital authorities or staff that Mr Hansell was failing to manage her care. He gave every appearance that he had a good understanding of the appropriate treatment for Mrs Haq. He made decisions regarding her care and his descriptions did not indicate he was unsure how to proceed. The decisions were not patently or obviously incorrect to nursing staff nor was his behaviour such that, at the time and on the information available to nursing staff, to approach management about Mrs Haq.

In giving evidence in court, Mr Hansell was courteous and confident, giving the impression of an experienced surgeon well in command of the situation. He was asked to give much detailed evidence regarding anatomy, which took some considerable time in court. He undertakes lecturing and teaches the techniques of ERCP.

Shortly before Mrs Haq's death, no time was lost in obtaining an intensive care consultant, during the night at short notice at Ross Hall.

The main thrust of the expert opinion, in respect of cause of death, suggested that even if finally pulmonary embolism was involved, it was certainly not the main pathology. Professor Garden considered the various blood results, particularly prothrombin times, and pointed out that as at 26 August 1998 her time was 25 seconds (normally 14-18 seconds), when fresh frozen plasma was given. After stabilising, she was put on anti thromboembolic treatment which was administered daily according to the drug kardex. He thought, that although possible, there was no past history to suggest pulmonary embolism.

No post-mortem was done, which would have shown if there was a pulmonary embolism. I accepted the evidence of all the experts regarding the cause of death.

It was suggested by Mr Hansell that Dr Dell, Intensive Care Specialist, called to the hospital on 27 September 1998, agreed with Mr Hansell's cause of death stated on the certificate, but Dr Dell denied that and explained that he was in a bit of a rush, so to go through the notes and try to decide the precise cause of death would have taken such a long time. He basically left the responsibility to Mr Hansell. Dr Dale had been sent for on an emergency basis.

Although there were clear signs of sepsis, she died a sudden death in hospital and she should have been referred to the Procurator Fiscal. It is difficult to understand why Mr Hansell, an experienced consultant qualified in 1987 and appointed Consultant in 1992, was apparently unaware of the requirements for reporting the death to the procurator fiscal, when he is practising in Scotland. It was said that the death was unexpected. He did not expect her to die suddenly, and felt her sepsis was improving. Further, the death had occurred as the result of a surgical procedure. As such, the death should have been reported to the procurator fiscal for consideration. If the death was clinically unexpected, then it still fell to be reported as a sudden death. Mr Hansell felt that it had been some time since the ERCP and two operations had intervened. None of the experts would have been prepared to certify the death in the circumstances.

At the time in 1998, the 1998 guidelines "Death and the Procurator Fiscal" had not been published, but guidelines in similar detail were published in 1996 and had been circulated to NHS hospitals, but not private hospitals. Mr Hansell said that no hospital had even given him a copy of "Death and the Procurator Fiscal". He knew and applied the basic rules for reporting deaths to the Procurator Fiscal.

Mr Hansell made an assumption that a request for a post-mortem would offend the religious views of Mr Haq, a Muslim, and did not make such a request. There should have been a discussion with the family to ascertain the true position, albeit such discussion may have been difficult and inevitably distressing to newly bereaved relatives.

Dr McFarlane, Pathologist, stated that in her experience as a pathologist, Muslims were one of two main groups of people who consistently for religious reasons are unwilling to consent to post-mortem examinations and sometimes complain if instructions are issued for such examinations.

Mr Hansell stated that he had never asked for a post mortem at Ross Hall before and although he did not know the system, he would have gone to the Director of Nursing who may have had a policy as to procedure.

As a result of the Shipman Inquiry in England, there is a necessity for two GPs to certify a death, but that apparently does not relate to deaths in hospital. Had two doctors been required to certify the death of Mrs Haq, it is unlikely that would have happened in the absence of the post-mortem or a report to the procurator fiscal. Dr Dell, having attended on an emergency basis, left the certification to Mr Hansell. He was not in a position to confirm the cause of death. It would appear that consideration is being given by the authorities in conjunction with the medical profession to widen the scope of the requirement for two doctors to certify a death, to include hospitals. Accordingly, if such consideration is being given it would be inappropriate to make further comment at this time.

The family's concerns could be summarised; that Mr Haq was not fully informed of the exact nature of the problems that arose as a result of the ERCP examination; that the circumstances or cause of Mrs Haq's death were not fully explained to Mr Haq; that there was no discussion about the possibility of having a post-mortem, when there was no religious reason involved; there was concern that she was not transferred to another hospital for specialist treatment; and that Mr Haq had concerns over the quality of the standard of the nursing care and treatment at Ross Hall Hospital in general.

So far as the explanation relating to the ERCP is concerned, Mr Haq said that he received information from Mr Hansell after the ERCP that "an old ulcer somewhere in her stomach" and that Mrs Haq required an operation. He maintained he was never told there had been an instrumental perforation. That would appear to be correct, as Mr Hansell still maintained that there was a perforated ulcer. He further stated that Mr Hansell told him the operation of 9 September 1998 was a minor operation, whereas Dr Miller told him it was major. He was very shocked and distressed when Mrs Haq died and felt that the circumstances of her death were not fully explained to him nor was a post-mortem suggested.

His concerns about the nursing care at Ross Hall mainly centred on his wife having fallen from her chair on 26 September 1998.

Mr Hansell and Mr Haq agreed that they had a conversation about 2.00 to 2.30 pm on 26 August 1998 after the attempted ERCP, when Mr Hansell told Mr Haq he would

have to operate. At that time, Mr Hansell had assumed that there was an ulcer. Over the course of the illness, Mr Hansell did speak to Mr Haq on a number of occasions, which is also reflected in the nursing notes. I found it difficult to believe that Mr Hansell had told Mr Haq that the operation of 9 September 1998 was minor and not a major operation. Mr Dickson's evidence was that Mr Hansell told him (Dr Dickson) that Mrs Haq was not particularly well.

I have previously dealt with the reasons as to why Mr Hansell did not ask for a post-mortem.

Mr Haq did not take these matters up until about a year later, when he wrote to Ross Hall Hospital. It may have been difficult to decide if his letter was a complaint. He thereafter also consulted a solicitor, who in turn contacted Mr Hamer-Hodges for an opinion on the notes and the records. Mr Hamer-Hodges advised that the matter should be reported to the procurator fiscal and in recent times he has contacted the GMC with a complaint regarding Mr Hansell.

The family's position is that Mr Hansell deliberately concealed information from Mr Haq and the family and other medical persons attending Mrs Haq and that there was "a cover up".

A portion of Mr Charnley's evidence is worth quoting. He says "I have absolutely no doubt that the perforation was caused by the instrument. I do not believe that the cause of the perforation can be put down to a mature ulcer. I would have thought that given Mr Hansell's experience, which he has outlined in his evidence that his conclusion would be the same. Because he fails to recognise this several conclusions can be drawn. One is that the concept of causing a perforation is so alien to his view of himself as a successful consultant that for some reason he has completely blotted it out from his mind and I have known that happen to other doctors where, for some reason, they just cannot appear to accept something that has happened, and that it might possibly be their fault. And so we get into the blurred area as to whether they are maliciously withholding the information or whether they have a mental block in being able to accept it."

As previously stated, I did not think that Mr Hansell acted maliciously. It appears that he closed his mind to the obvious finding at laparotomy that there had been an instrumental perforation and maintained his position that there had been an ulcer. Although accepting in evidence that his intervention had caused the hole in the duodenum and that was therefor technically an iatrogenic injury, he did not face up to the fact that

there had been an instrumental perforation through a normal duodenum, which was the overwhelming evidence of all the experts. It would be highly probable that belief would not have been maintained if a second opinion had been taken from another consultant or referred to a specialist unit. If Mr Hansell had that erroneous belief, it then becomes quite understandable as to why he wrote in the terms which he did to the GP and the insurance company.

There may well be an issue of clinical practice as to why an experienced consultant surgeon did not or was not prepared to recognise the true situation as an instrumental perforation. It was critical for the management of the patient, that a perforation of a duodenal ulcer, which is frequently dealt with at district hospital level in a routine, straightforward operation, is one matter, whereas the effects of an instrumental perforation, involving the retroperitoneum, which are notoriously difficult to control after repair and really require the attention of a specialist unit, were quite another matter. It was said a general surgeon would not have much expertise in such a rare case, whereas specialist units would have that experience. Mr Hansell described Stobhill Hospital as being effectively a "District General Hospital".

"Perforated duodenal ulcer" appeared consistently throughout the notes and appeared on the death certificate. It appeared that although there were massive complications in Mrs Haq's condition, re-consideration was not given to the original cause. By a certain point of course, there were very serious complications, irrespective of the original source, which overshadowed everything else.

Mr Hansell, through his counsel, at submissions acknowledged that the transfer of Mrs Haq to an NHS hospital together with greater discussion with other colleagues after Dr Miller left on holiday on 19 September 1998 would have been prudent and might have been of benefit in bringing to bear, in a difficult situation, a variety of options and a collegiate range of experience. If faced in future with a similar situation, he would use his experience of Mrs Haq's management to react more quickly and seek the counsel and assistance of professional colleagues.

It appeared that Mr Hansell was somewhat optimistic and rather selective in his description of Mrs Haq's condition which was fluctuating, and those optimistic views were transmitted to Dr Madhok, GP. No doubt Mr Hansell strongly hoped for Mrs Haq's recovery. However Mrs Haq's condition was notoriously difficult to manage. The

approach ought to have been to consider the patient's progress as a whole and make a full and frank report to the GP and inform the family accordingly of the serious situation.

It was clear that Mrs Haq was suffering from severe sepsis at least from 22 September 1998 onwards and this was minimised in the death certificate as "low grade intra-abdominal sepsis". That was not a full and frank description of her condition.

While the final route may have been pulmonary embolism, it was the overwhelming evidence of the experts that it was not the main pathology.

According to the experts for several days before the death, the warning signs of sepsis were present; Mrs Haq was sore all over and continued to feel unwell; there was confusion, intermittent pyrexia and rigoring; there were significant biochemical abnormalities, and multiple positive blood cultures.

The whole circumstances would tend to indicate the minimisation of her condition and the lack of recognition and acknowledgement of the original cause and subsequent notoriously difficult problems which Mrs Haq encountered thereafter.

The Scottish Audit of Surgical Mortality (SASM) is voluntary, under the auspices of the Royal College of Physicians and Surgeons in Glasgow. Surgeons are encouraged to report deaths there, and it is a way of providing routine objective peer review which may help to avoid problems in cases such as Mrs Haq's. The aim of SASM is more towards trends in surgery than specific criticism, recognising that equal quality of care cannot be provided at all locations by all surgeons at all times. Ross Hall Hospital now appears to have a system in place to refer all such deaths to SASM. The form requires to be completed by the surgeon. Ross Hall Hospital impressed as being committed to a high quality of medical treatment and were anxious to comply with SASM. Ross Hall Hospital supports reporting to SASM and it forwards the relevant forms to surgeons for completion. If a reviewing doctor in SASM is concerned about the circumstances of a death, the case will be referred to a third specialist who scans the records and issues a report to the individual consultant.

Further, evidence was given that there had been additional safeguards introduced since 1998 in Ross Hall Hospital as part of clinical governance in the health care sector. A number of specialist areas have also set up managed clinical networks to address amongst other matters, guidelines of the transfer of patients to specialist care and to discuss cases of interest and work patterns. Professor Garden provided an example of the guidance that might be produced regarding the management of complications and the circumstances in

which a case should be transferred to a specialist unit. A managed clinical network for upper gastrointestinal and biliary pancreatic surgery has recently been initiated. The network includes all surgeons who are practising in a particular speciality in the regions. Each surgeon reports on their own statistics and discusses his/her own issues and concerns in order to ensure learning from particular cases.

It was also stated that every death in Ross Hall Hospital is reported to the chair of the Medical Advisory Committee at the end of each quarter and includes an outline of the circumstances and whether or not the procurator fiscal has been informed. If there is any doubt about the circumstances of the case the matter is reported to the procurator fiscal. Where the chairman is unclear about the circumstances of the death he will write to the consultant involved. The Medical Advisory Committee considers all hospital deaths and unexpected returns to theatre. Such cases are discussed and any incidents of an above average complication rate is reviewed. There is also a monthly audit of notekeeping and inadequate notekeeping can be grounds for withdrawal of admitting privileges. In the present case there was nothing in the Death Certificate which might have alerted the chairman of the Medical Advisory Committee to consider a report to the Procurator Fiscal. That appears to underline the importance of a consultant being aware of the terms of the publication "Death and the Procurator Fiscal".

It was also stated that responses are being made at present to the Shipman Inquiry. Apparently the Royal College of Physicians and Surgeons in Glasgow has given consideration to a recommendation that any death in hospital be certified by two medical practitioners as is presently the case in general practice. Ross Hall Hospital, it was said, would support any recommendations regarding changes on the certification of deaths.

It was also stated in evidence that Ross Hall Hospital expects all consultants to be aware of their obligations in reporting deaths to the procurator fiscal, and that the circumstances in which a death should be reported are highlighted in documentation that is distributed throughout the hospital, which includes the documentation "Death and the Procurator Fiscal", issued by the Scottish Executive.

As stated previously, the Scottish Executive had not sent copies of "Death and the Procurator Fiscal" to private hospitals, at the time of Mrs Haq's death. Accordingly, looking at the whole circumstances, there can be no criticism of Ross Hall Hospital in failing to report her death to the Procurator Fiscal.

Where a patient is in hospital for a period that is longer than estimated, Ross Hall Hospital is considering a procedure requiring a report by the Consultant in charge of the patient to its Executive Director and the chairman of the Medical Advisory Committee drawing attention to that patient's circumstances.

I was satisfied that there are a range of internal and external protections relating to patient care, audit and accountability of consultants at Ross Hall Hospital, which already have been tightened up since the death of Mrs Haq and also in the course of this Inquiry.

Mr Charnley was most interested in the Department of Health producing a document, as they had done with the treatment of pancreatic cancer, on all pathologies of the upper gastro intestinal tract. If the guidance said that surgeons had to refer all instrumental perforations of the upper G1 tract to a specialist care centre, that would have to occur. It would be a matter of fact rather than opinion. At present he said there is no guidance at all for traumatic instrumental perforation. He felt that, while possibly taking away a certain amount of independence in the medical profession, it would improve health care, particularly from the patient's standpoint.