Mr Andrew Cox
Assistant Coroner for the County of Cornwall

Our ref: AJC/akd 4th October 2013
Your ref:

[redacted] - Interim Medical Director
Royal Cornwall Hospital
Truro
Cornwall
TR1 3LJ

Dear Sir

Re: Jean James deceased

On 2 October I conducted an inquest into the death of the above who died at Treliske Hospital on 19 November 2012. I write to you now formally under Paragraph 7, Schedule 5, of the Coroners and Justice Act 2009. Please note that you have 56 days in which to respond to this correspondence. Both my letter and your reply to it will be copied to the persons listed at the foot of this correspondence.

Background

Until November 2012 Mrs James was a fit and active 85 year old woman.

In the evening of 5 November she developed stomach pain. This was sufficiently uncomfortable for her to call the out of hours service. She was examined and a tentative diagnosis of appendicitis was given. She was told to see whether it settled overnight and, if not, to see her GP in the morning.

At approximately 09:00 on 6 November Mrs James was seen by her GP. He noted a deterioration from her condition the evening before. He arranged for her to be admitted into hospital with a diagnosis of appendicitis. At 11:00 Mrs James was admitted to RCHT.

Issues at inquest

The family raised a number of concerns at inquest only one of which is relevant to this correspondence.

The family were concerned that Mrs James was admitted at or around 11:00 but not seen by a doctor until many hours later. Mr Faux gave evidence on behalf of the Trust. On his review of the medical notes and records he was forced to accept that Mrs James was not seen by a doctor until 17:00 that evening, in other words, six hours from the time at which she was admitted. Mrs James was

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reviewed during the consultant's evening ward round when an x-ray was ordered to exclude a bowel obstruction. Although this was clear a later CT confirmed a diagnosis of a perforated appendix.

Mrs James failed to respond to a period of conservative management during which time she was administered antibiotics. She underwent an operation to have her appendix removed but eventually died in the hospital on 19 November 2012. The pathologist gave as the cause of death:

1(a) Localised fibrosis of the heart and a perforated appendix (operated)

Matters to be addressed by you

I wish to draw to your attention the evidence from [redacted] relating to the timeframe within which patients admitted to Treliske via their GP are reviewed by medical staff. I heard evidence that if a patient is admitted via the Emergency Department that patient should be seen within a maximum of four hours.

By contrast, where the patient is admitted to the Medical Admissions Unit or the Surgical Receiving Unit after referral by their GP there is no time threshold within which a doctor should review them. Furthermore, I was told that records in this regard are not kept.

On this occasion the question was asked whether, had Mrs James been seen earlier, the outcome may have been different. [redacted] felt this was unlikely but he could not exclude the possibility that more prompt treatment by antibiotics may have led to a different outcome.

I do not understand the rationale why patients admitted to hospital via their GP should not be seen within the same timeframe as patients admitted via the Emergency Department. I anticipate one justification for this may be that the GP has already conducted some form of medical examination. While that was the case in this instance I can easily see that there may be circumstances where it would not happen. In that situation it cannot be acceptable for a patient to wait more than four hours before being seen and assessed.

It is equally the case that patients seen by their GP could actually be more unwell than those who present themselves at the Emergency Department.

I would be grateful if you would consider the facts in this case. I would welcome your thoughts on whether there is a need to tighten the time limits for patients being admitted to Treliske via their GP rather than through the Emergency Department.

I look forward to hearing from you in due course.

Yours faithfully

Mr A J Cox
Assistant Coroner
[redacted]

Schedule of recipients

[redacted]

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