

Hospital 'neglect' led to boy's death in routine surgery

By Adam Fresco

THE death of a nine-year-old boy during a minor operation on his finger was partly caused by "system neglect," an inquest jury decided yesterday.

Tony Clowes, from Dagenham, East London, died after a tube leading from the anaesthetic machine to his face-mask became blocked as he was being prepared for surgery at the Broomfield Hospital, Chelmsford, Essex.

An inquest jury sitting at Chelmsford Coroner's Court returned a verdict of "accident contributed to by system neglect".

The foreman of the jury said: "Tony George Clowes died as a result of an accident and the cause of death was contributed to by system neglect, inadequate guidelines, failing to ensure the patency of all ancillary equipment, failure to disseminate important safety information to relevant personnel, and failure to follow guidelines concerning single-use medical devices."

The verdict was the strongest one they could have returned in terms of condemning the hospital.

Tony's father, George, who took him to hospital in July 2001 after the boy trapped his finger in a bicycle chain, criticised hospital staff for not observing medical guidelines.

He said: "We are appalled and angry that his death was due to a failure on the part of senior members of staff and management of the hospital to observe clear guidelines and safety notices that were intended to protect patients.

"Those failures, which amounted to neglect, resulted in the death of our nine-year-old son Tony, whose life we entrusted into the hands of the professionals who failed in their duty towards him."

The inquest was told that doctors ignored safety guidelines and reused a tiny oxygen tube that should have been discarded after just one use. The cap from another piece of



Tony Clowes: trapped finger in bicycle chain

equipment had become lodged in the tube when they were both stored in a drawer.

The inquest was told that a safety notice from the Medical Devices Agency in 2000 said all single-use devices should not be reused under any circumstances. The jury was told that the MDA also said in 2001 that hospitals must check all components of breathing systems, as incorrect fitting could cause patients problems and there had been instances of blockages.

Mr Clowes, who works for a pharmaceutical company, said the family would also report the matter to the General Medical Council.

David Scott, a consultant anaesthetist and medico-legal expert who investigated the case, told the inquest that Tony would probably have been saved if doctors had disconnected the equipment and given him mouth-to-mouth resuscitation instead of concentrating on what they thought was a problem with the machinery.

Tony's death led to a major police operation, Operation Orcadian, during which detectives looked at 13 similar but non-fatal cases all over the country involving blocked oxygen tubes.

Three members of hospital staff were arrested over the incident and a file was submitted to the Crown Prosecution Serv-

ice, but in July 2002 detectives said the boy's death was not the result of a criminal act. Speaking after the verdict, Detective Superintendent Win Bernard said that detectives would continue to work with the Health and Safety Executive while they considered what action to take.

Mr Bernard said: "No verdict today is consolation for Tony's family, who were devastated by the sudden and untimely loss of their son." He said shortly after Tony's death, a similar incident occurred at another Essex hospital when a man's life was saved because warnings had been given.

Andrew Pyke, the chief executive of Mid Essex Hospital Services NHS Trust, expressed the hospital's sadness to the Clowes family about what had happened. He said staff had been upset about the events and that changes had been put in place since the tragic event and the tube was now used only once then thrown away.