‘Doctors let my wife die’

Fury as doctors were left to repeat tragic mistake

ANGRY: Garth Erhart has accused FGH doctors of failing his wife
UHMBT has apologised to the families of Irene Erhart and Peter Read.

Medical director Dr David Walker (pictured) said: “We feel deeply sorry for Mr Erhart, and for the family of Mr Read and want to apologise to, and reassure them and your readers, that we take every case where a patient dies extremely seriously and that safety for our patients is our primary aim as a healthcare organisation.

“Because of that overriding concern with safety and in the light of a number of concerns raised about the Urology Department, including these cases from 2011 and 2015, we invited a review of the department by the Royal College of Surgeons in 2016.

“We have additionally carried out a huge amount of work to ensure the culture in the department continues to improve to ensure the best care for our patients and that our staff are well supported at work.

“In the autumn we will be undertaking a peer review of the department by expert clinicians from another trust to ensure that the actions arising out of the Royal College Review have been fully embedded and ensure there are no further actions required.

“In terms of the cases referred to, we have fully co-operated with the coroner in both cases at the time and ensured the coroner was satisfied we had taken all actions that we should.

“We appreciate that this is very traumatic for Mrs Erhart’s husband and Mr Read’s family and in Mr Read’s case we have met with the family.

“We would also be pleased to meet with Mr Erhart and discuss any aspect of the case with him.

“We want to assure them that our investigations have been thorough, we have learned lessons and of course if Mr Duffy has any further information we’d be grateful to hear from him.”

THE husband of a woman treated by doctors whose failings contributed to her death has spoken of his horror after discovering one made the same mistake again.

Garth Erhart from Walney has this week found out, following a lengthy investigation by The Mail, that four years after his wife Irene died the same consultant made similar mistakes which a coroner said contributed to the death of another patient.

Mrs Erhart, a former comp-tometerist at Barrow steelworks, was 79 when she died on February 6, 2011.

During the following four weeks her husband said two consultants, Ashutosh Jain and Kavinder Madhra, treated her solely with antibiotics and took no further action despite her deterioration.

“They never came and spoke to me, or my son, to explain what they were doing; because they did nothing for my beautiful wife,” Mr Erhart, 89, said.

Mr Erhart continued to worsen and, by the end of January, ward staff were so worried about the consultants’ failure to act that a senior sister called consultant urologist Peter Duffy who was then based at the Royal Lancaster Infirmary.

Mr Duffy, who was constructive-ly dismissed from UHMBT in 2016 after claiming his whistleblowing about his colleagues had been ignored, said the sister told him: “The two clinicians in charge of her care were doing nothing and all the ward staff were frightened she was going to die.”

The Mail has also spoken to the sister who took the unorthodox step of calling Mr Duffy.

She said: “On a number of occasions I called Peter and asked him to come over because I thought Mr Jain and Mr Madhra were failing patients.”

Mr Duffy, who now works on the Isle of Man, travelled to FGH on a day off and arrived to find “a very, very sick and septic lady who was clearly dying.”

He said: “The ideal time to operate had already come and long gone.”

Mr Duffy then advised Mrs Erhart’s that operating was very risky given her condition but without surgery she would die.

Mr Duffy rushed Mrs Erhart to theatre but ‘it was much too late and she died a few days later’.

Following an inquest deputy coroner Philip Sharp recorded a conclusion which stated: “The cause of death was contributed to by the failure to provide a stent to drain Mrs Erhart’s infection early in her treatment.”

The deputy coroner concluded that ‘Mrs Erhart should have been considered suitable for a stent much earlier in her admission which would have given her much better prospects’.

The deputy coroner praised Mr Duffy for his attempts to save Mrs Erhart’s life by carrying out an operation which ‘had not been considered by those previously treating her’.

Speaking from his home in Strathmore Avenue on Walney, Mr Erhart, a retired shipyard fitter, said the hospital trust should have sacked both consultants at the time.

“The pain, the anger, it’s never faded. You just learn to live with it,” he said.

“Both of those doctors should have been struck off. It’s scandalous that one is still there and the other was allowed to continue working there for seven years ‘til he left.”

Mr Madhra, 63, resigned from UHMBT in September 2018 after the General Medical Council imposed conditions on his practice following numerous concerns about his abilities.

One of the most serious of his errors during his UHMBT career almost resulted in a patient having the wrong kidney being removed.

A hearing at the Medical Practitioners Tribunal Service to decide if Mr Madhra is fit to practice has started and has been adjourned until January 2020.

Mr Jain continues to work at the trust.
Medics made mistake again

THE daughter of a man who died four years on from Irene Erhart has spoken of her disgust at discovering the same consultant’s mistakes contributed to his death.

Peter Read died after developing urosepsis, caused by ‘missed opportunities to change his ureteric stent’, a coroner later ruled.

Mr Read was treated by Ashutosh Jain, the same consultant who, four years earlier was involved in the care of Mrs Erhart.

A coroner said the failings of Mr Jain and fellow urological consultant Saleem Naseem contributed to Mr Read’s death. Both still work at the University Hospitals of Morecambe Bay NHS Foundation Trust.

The Mail has now obtained a copy of a Root Cause Analysis investigation carried out by the hospital trust after Mr Read’s death on the request of the coroner.

The report reveals the ‘catastrophic’ outcome was contributed to by Mr Jain’s and Mr Naseem’s ‘failure to undertake’ treatment and replace a stent.

NHS guidance states that stents should be changed every six months.

Mr Read was admitted to Royal Lancaster Infirmary in December 2015 after a series of admissions for vomiting and stomach pain.

His condition deteriorated over a number of weeks but neither Mr Jain or Mr Naseem changed the stent when he became acutely unwell with sepsis.

Peter Duffy was made aware of the situation on December 30 and replaced the stent during his lunch break as an emergency.

As with the case of Irene Erhart however, it was too late, and Mr Read died on January 2.

His daughters Karen Beamer and Nicola Read were horrified to discover this week, as a result of information obtained by The Mail, that Mr Jain had been involved in the care of Mrs Erhart and that a coroner ruled a lack of action contributed to her death.

“In 2011 a coroner ruled failings in the care of Irene contributed to her death and clearly, despite what the trust claim, lessons were not learned,” she said.

Mrs Beamer has praised Mr Duffy for trying to save her dad.

“Peter did everything he could. “The trust has lost quite possibly the best urological consultant they have ever had. And Mr Jain and Mr Naseem are still employed and earning huge salaries paid for by the public.”

LET DOWN: Doctors’ mistakes contributed to the death of Peter Read