	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr Andrew Morris, Chief Executive, Frimley Park Hospital NHS Trust** **2. [redacted], Clinical Lead, North East Hampshire & Farnham Clinical Commissioning Group** **3. Professor Norman Williams, President, Royal College of Surgeons**
1	**CORONER** **I am Karen HENDERSON, assistant coroner for the coroner area of Surrey**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 7th March 2014 I commenced an investigation into the death of Phyllis Barnes, 82 years of age. The investigation concluded at the end of the inquest on. The medical cause of death given was: 1a. Peritonitis 1b. Anastomotic Leakage Post Anterior Resection for Carcinoma of the Colon 1c 2. My narrative conclusion was: **Mrs Barnes died from a recognised complication of necessary surgery where there was a delay in the recognition of the severity of her symptoms which resulted in a delay in treatment which could have affected the outcome**
4	**CIRCUMSTANCES OF THE DEATH** Mrs Barnes underwent an elective laparoscopic anterior resection for carcinoma colon on 11th April 2013. She was discharged home on the enhanced recovery programme for laparoscopic procedures on 15th April 2013. Mrs Barnes became unwell with vomiting on or shortly after discharge from hospital and her daughter called her GP practice, the Downing Street Group Practice, on the day of discharge because of the vomiting and anti-emetics were prescribed. The Nurse Practitioner from the surgical department called as routine on the 16th April 2013 but reassured Mrs Barnes that 'it takes time' when she commented on vomiting and feeling unwell. It is unclear whether there was a subsequent phone call as promised. Mrs Barnes continued to vomit and the GP visited at her daughter's request but no treatment was instituted or referral made back to hospital. Mrs Barnes continued to deteriorate and she was readmitted as an emergency on 18th April for repair of an anastomotic leak arising from the original procedure but died of these complications at 0530 on 19th April 2014.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise for concern. In my opinion there is a risk that future death will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

	The MATTERS OF CONCERN are as follows: 1. Failure of visiting General Practitioner to appreciate the seriousness of Mrs Barnes condition in view of her recent operation and persistent symptoms 2. Postoperative nurse-led telephone consultation for the enhanced recovery programme for laparoscopic surgery' appears to have been superficial and perfunctory with doubts over a further telephone follow-up as promised 3. There was no formal communication or opportunity for Mrs Barnes's daughter to relate her mother's condition to the GP or the Nurse Practitioner
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation: Frimley Park Hospital, Royal College of Surgeons, and Clinical Commissioning Group, have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 24th March 2014. I, the coroner, may extend this period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons; [redacted] (daughter). I have also sent it to [redacted] and [redacted] who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE: 24-Mar-2014** **SIGNED: Dr K Henderson**