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Regulation 28 – Report to Prevent Future Deaths

	This Report is being sent to: The Newcastle upon Tyne Hospitals NHS Foundation Trust, Legal & Committee Services Offices, Freeman Hospital, High Heaton, Newcastle upon Tyne South Tyneside NHS Foundation Trust, South TYneside District Hospital, Harton Lane, South Shields, Tyne and Wear [redacted] Senior Clinical Quality Officer, North of England Commissioning Support Riverside House, Newburn Riverside, Newcastle upon TYne NE15 8NY [redacted] Trinity Medical Centre, New George Street, South Shields, TYne and Wear NE33 5DU
1	**Coroner** I am Terence Carney, Senior Coroner for Gateshead & South Tyneside.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/regulation/28/made http://www.legislation.gov.uk/uksi/2013/1629/regulation/29/made
3	**Investigation & Inquest** On 13th February 2013 I commenced an investigation into the death of Keith Fleming, aged 46 years. The investigation concluded at the end of the inquest on 18th December 2013. The conclusion of the inquest was the cause of death was due to : 1a Multi-organ failure - septic shock b Necrotising Fasciitis c Dehiscence of Colo-anal Anastomosis following closure of ileostomy after surgery for Carcinoma of the Rectum Conclusion: A recognised complication of such a surgical procedure which was neither noted nor diagnosed leading over some significant time to particularly severe consequences and effects..
4	**Circumstances of the Death** The deceased underwent an elective reversal in January 2013 of an illiostomy performed in 2007 due to a cancer within the lower bowel. The deceased was discharged home on 14th January 2013 to the care of his GP and Nursing Personnel.

	The deceased developed an unrecognised internal infection and on 6th February was admitted to the South TYneside District Hospital as an emergency patient. Despite urgent medical and surgical treatment the catestrophic infection overwhelmed the deceased and he died on the 10th February 2013.
5	**Coroners Concerns** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it I my statutory duty to report to you. The matter of concern are as follows:- The deceased underwent an elective reversal in January 2013 of an illiostomy performed in 2007 due to a cancer within the lower bowel. He was discharged home on 14th January 2013 from the Freeman Hospital Newcastle to the care of his GP Dr. [redacted] Practice Nursing and Community Nursing Staff. Immediate area of care was the management of the healing of his repaired stoma site. After an initial prescription of an antibiotic by his GP, the progress of the treating of this site was uneventful, and involved successive visits every two days by a member of the Community Nursing team. The team members did not however limit themselves only to the wound area but noted a measure of discomfort around the rectum and buttocks consequent on the deceased' need to evacuate his bowel up to some 60 times per day. The deceased understood and conveyed this understanding to the community nursing team that this phenomena was an expected Squeque to the reversal procedure and the settling of the bowel function as a consequence. Reddening of the external surface of the buttocks was a combination of potential pressure damage and the need of the deceased to constantly clean the area due to exposure to liquefied faecal matter , they successively sourced appropriate incontinence pads on request, prescribed and applied barrier creams to the affected area and obtained a good quality supportive cushion all designed to arrest any breakdown in the surface of the skin. The care plan devised during this period of community nursing care did identify a need to record temperature and blood pressure readings. Unfortunately these readings were not carried out and accordingly were not recorded. Physical symptoms were noted but only on a generalized –impressionistic basis - tiredness, responsiveness to questions and discussion – level of activity and mobility – diet. The General Practitioner and consequently the nursing staff were not aware of that the anastomosis of the bowel carried out during the original operation (2007) had dehised. Nor were they aware of an internal area of abscess adjacent to the repaired stoma site , only discovered on post mortem and togeother leading to a catastrophic infection within the deceased particularly and significantly in the area of his left buttock. The reality was the infection within the otherwise pelvic area had tracked through the pelvis into the area of the left buttock. It was the presence of the swelling of this area of the buttock which was to alert the deceased' wife several days after his discharge home to the growing crisis and resulted in her summoning her husband's GP Dr. [redacted] The Doctor immediately recognized the symptoms, arranged for the deceased' emergency admission to the South Tyneside District Hospital. Despite urgent medical and surgical treatment the infection overwhelmed the deceased and he died.

	Whilst it has to be acknowledged in early correspondence to his GP from Professor [redacted] the surgeon in charge of the patient at the Freeman Hospital the possibility of pelvic infection was mooted as a risk factor in the proposed reversal – no plans specifically provided on discharge for this possible contingency it appears. On discharge the care of the deceased was to be managed within the Community and the deceased was to be seen by the surgical team as "a follow up" some time in the future. It is not known when and how the dehisence of the original anastomosis of the lower bowel occurred. The initial degree of damage is not known, nor similarly is there any evidence of the subsequent progression and consequential damage of the phenomena. It is potentially possible to have been continuing in some degree for some considerable time. The recording of the deceased' vital signs, temperature and blood pressure would have provided some insight into the deceased' wellbeing and possibly given an early indication of a developing crisis. The absence of such records is regrettable and exposes the Nursing Staff to the criticism of not effectively monitoring their patient's needs. It also denies them the evidence of being able to promote the proposition this was an unknown crisis of sudden and catastrophic proportions. It is my view that in order to avoid a repetition of these events or mitigate the consequences to all concerned, the following practices, protocols and training be put in place : 1. Surgical patients discharged to the community should be accompanied by a clear and direct plan for their expected level of care in the community. This is not simply a discharge summary advising what has gone before. 2. There should be a direct and constant monitoring of their care and progress by medical personnel not only at primary level but also at secondary level. 3. Surgical teams should as a matter of course maintain ownership of their patient's care and progress until the patient is ultimately discharged having regained full health, from their care and responsibility. Leaving the matter exclusively in the hands of the primary sector and resuming (an interest) on and at "a follow up" appointment, is not good enough where the operation is complex and the potential risks are both known and identified as in this case. 4. General Practitioners and Community Care Teams have a responsibility to fully understand and appreciate their patients needs and risks. Where necessary they should ensure clarification of the level of care needed and moreover have a clear understanding of the known risks to the patient. 5. Unless they understand the risk no plan for the ongoing care of the patient can be said to be viable. 6. Effective care planning including risk evaluation (in itself an ongoing process) can only be properly effected : a. In full consultation between the surgical team and Community based Primary Carers b. The maintenance of effective two way communication, prior to as well as during the period of actual return to the community and up to final discharge, from Secondary care c. Such communication should only cease to be maintained between the Primary and Secondary Care Sectors if the patient has returned to full health. 7. The maintaining of appropriate care records is a priority at all times both at primary and secondary care levels. It is inconceivable in an inpatient's setting, in a hospital that proper and effective records of a patient's "wellness" would not be recorded. Nothing less should be the order of the day within the Community setting. 8. Failure to maintain records, thereafter to properly interpret and action them, can it must be remembered be a basis for legal both Civil and Criminal (the latter carrying with it personal penal consequences) as well as Professional Disciplinary proceedings. 9. It is clearly a matter of urgent need that the lesson of good and effective record keeping be reinforced both by an immediate directive to all staff by the primary and secondary authorities to the staff in their control and where necessary by retraining and repeated refresher courses on this point - so vital to the welfare of the patient and the professional standing and integrity of those who have their charge
6	**Action Should be Taken**

	In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation 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 2014. I, the Coroner, may extend the 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 & Publication** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] widow of the deceased and to the Local Safe-Guarding board (where the deceased was under 18). I have also sent it to the N/A 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.
	Date: 3rd January 2014 **{Signature}** **Senior Coroner – Gateshead & South Tyneside**