REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Matthew Hopkins, Barking, Havering & Redbridge University Hospitals NHS Trust. Executive Offices, Queen's Hospital, Rom Valley Way, Romford, Essex, RM7 0AG.**
1	**CORONER** I am Nadia Persaud, Senior Coroner for the area of Eastern Area of Greater London
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/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** **On the 7th February 2014, I commenced an investigation into the death of Ronald Alfred Smith. The investigation concluded at the end of the Inquest on the 28th May 2015. The conclusion of the Inquest was a narrative conclusion** *Mr Ronald Smith presented to Queen's Hospital on the 1st February 2014, with a sigmoid volvulus, causing a bowel obstruction and bowel ischaemia. He was severely unwell on admission. Surgical intervention was not considered appropriate, in view of his acute condition and co-morbidities. The only procedure considered appropriate to relieve his symptoms was a flexible sigmoidoscopy. It was not possible to access the flexible sigmoidoscope during the night and Mr Smith's condition deteriorated. He passed away at 09:40 on the 2nd February 2014, before the procedure had taken place. The lack of the flexible sigmoidoscope resulted in a lost opportunity to provide an intervention which might have avoided his death.*
4	**CIRCUMSTANCES OF THE DEATH** Mr Smith was admitted to Queens Hospital on the 1st February 2014 with a severely distended abdomen and evidence of metabolic acidosis, hypertension and kidney derangement. He was reviewed by the surgical registrar who considered the likely diagnosis sigmoid volvulus with bowel obstruction and bowel ischaemia. This diagnosis was confirmed by CT scan. The surgical registrar discussed Mr Smith with the consultant surgeon and it was agreed that a laparotomy would not be appropriate in view of Mr Smith's acute condition and co-morbidities. It was agreed that the only prospect of a hopeful intervention was by way of an endoscopic decompression. A rigid sigmoidoscopy was attempted but not possible due to the blockage. It was considered that the only further option was a flexible sigmoidoscopy. This was the only treatment option available to Mr Smith. The surgical registrar made efforts to locate a flexible sigmoidoscope by contacting the night theatre staff, contacting the medical registrar, attempting to access the endoscopy nurses and speaking to the gastroenterologist. He also obtained access to the clinical decision unit where he believed the flexible sigmoidoscope would be with the assistance of the night manager and security. A flexible sigmoidoscope could not be obtained. The endoscopy nurses contacted were King George's Hospital nurses and did not know were the equipment was kept at Queen's. The switchboard did not appear to be able to contact the endoscopy nurses at Queens's hospital. No consideration was given to obtaining the equipment from King

	George's hospital. A plan was eventually agreed for Mr Smith to undergo the procedure when the endoscopy day team arrived. Sadly he passed away prior to the procedure taking place. A post-mortem examination was carried out and the cause of death was confirmed to be: 1a; Intestinal infarction 1b; sigmoid volvulus 11; Hypertensive and Ischaemic Heart Disease
5	**CORONER'S 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 is my statutory duty to report to you. The **MATTERS OF CONCERN** are that there was a failure in this case to access a flexible sigmoidoscope out of hours. This item of surgical equipment was not available to the surgical registrar who considered that this was the only intervention that may have benefitted the patient. Mr Smith's death occurred in February 2014. The Trust's root cause analysis report identified the need for a clearly communicated and accessible protocol for access to flexible sigmoidoscopies out of hours. Notwithstanding the period of 16 months which has elapsed since Mr Smith's death there is still no protocol in place at the Trust. I consider that action should be taken to expedite a clear procedure for such equipment to be available to staff out of hours.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 27th July 2015. 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 and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons – [redacted] (daughter) and the Care Quality Commission. I will also provide a copy of your report to [redacted] (Director of Public Health). I am under a duty to send the Chief Coroner a copy of your response. I will also copy your response to the other persons listed above. 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] 1st June 2015** **[SIGNED BY CORONER]** [redacted]