ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Suzanne Rankin, Chief Executive Ashford and St Peter's Hospital Trust
1	**CORONER** I am Caroline Topping, 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 15 October 2015 an investigation into the death of Clifford Irwin Crofts was commenced, the investigation concluded at the end of the inquest on 12 February 2016. The conclusion of the inquest was that Mr Crofts died as a result of 1a. Respiratory failure, 1b. Lung collapse and acute bronchitis 1c Pleural effusions II Peritonitis due to gastrostomy leakage and a-typical Parkinson's disease. He died at St Peter's Hospital Chertsey on 10 October 2014 as a result of a respiratory failure. He had a previous medical history of COPD and Parkinson's disease and had recently suffered from peritonitis following a gastrostomy leakage. The conclusion as to death was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Mr Crofts had been admitted to St Peter's Hospital a number of times during 2014 as a result of aspiration difficulties arising from Parkinson's disease. Owing to difficulties in providing Mr Crofts with sufficient nutrition and medication it became necessary to try to insert a PEG feeder. That attempt failed. On Friday, 19 September 2014, a radiologically inserted gastrostomy tube (RIG) was inserted. Following the insertion the consultant radiologist filled in a post-operative care plan (no. 94) which is used by the trust. This document went missing from the Mr Crofts' notes. There was some advice recorded in the medical notes from a dietician, it was not identical to the post-operative plan. Feeding began through the RIG on 20 September 2014 at 15.45, with acute pain being experienced after 20-30 minutes. The plan called for advice to be sought from a senior medical adviser urgently and for a CT scan to be considered in such circumstances. Attempts to escalate Mr Crofts' care by the nursing staff were unsuccessful until 1.55 on the 21 September 2014 when he was seen by an SHO. A chest x-ray was undertaken but no CT scan. A further review by a junior doctor at 0800 took the matter no further. At 11.00 the surgical team was contacted but was unavailable. At 15.30 the surgical team was busy in theatre, but advised a CT scan be obtained. This was not arranged until 20.30. Mr Crofts was not seen until 23.40 by the surgical team and underwent a laparotomy and washout at 4.30am on 22 September 2014. He improved after the surgery but thereafter his respiratory difficulties could not be resolved and he deteriorated and died on 10 October 2014.
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 could 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) The Trust's care plan no 94 RIG was not followed. The SI report dated the 20 August 2015 (page 19) recommends that relevant staff members are aware of and understand the policies, guidance and supporting documentation which relate to the care of patients who have undergone enterostomies. I was informed this recommendation had not yet been put into effect. (2) There were considerable difficulties in escalating Mr Crofts' care on 20 and 21 September 2014. The SI report recommends that the process by which care is escalated within and between disciplines needs to be reviewed and clarified to ensure that patients receive timely attention. Again, I am not satisfied on the evidence I have heard that this recommendation has been implemented. (3)There were considerable difficulties obtaining a CT scan on Sunday, 21 September 2014. This was partly because it was not actioned at 16.00, when requested. After 17.00 on the weekend the request had to be made by a consultant to an outside provider Medica who read the scans when no-one is available at the hospital. It appears that junior doctors can now request CT scans and that a new arrangement is being put in place to obtain urgent CT scans in cases of suspected peritonitis. The SI report recommends that guidance relating to CT scanning on the trust intranet should be reviewed to clarify the process for arranging investigations and be made available as part of the induction process for junior doctors and on the ward areas, for other staff to access. I was informed this has not yet been actioned. (4)During the course of evidence it became clear that the delay in attempts to escalate Mr Crofts' care over the weekend was due in large part to staffing levels. Whilst I heard that staffing levels at weekends have increased since 2014, it was not clear that the number of doctors at all levels of seniority available at weekends is sufficient to provide safe care to in patients at the hospital particularly at times when emergencies arise in A and E.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 18th April 2016. 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 following Interested Person, [redacted] 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	**22.2.2106** **Caroline Topping**