REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted]** **Acting Chief Executive/Executive Medical Director** **University Hospital of North Midlands** **Chief Executive's Office** **Trust Headquarters** **City General Site** **Newcastle Road** **Stoke-on-Trent** **ST4 6QG**
1	**CORONER** I am Ian Stewart Smith senior coroner for the coroner area of Stoke-on-Trent & North Staffordshire.
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 9th September 2014 I commenced an investigation into the death of Nadim Muzzfar BUTT aged 48 years. The investigation concluded at the end of the inquest on 31st March 2016. The conclusion of the inquest was that Mr Butt died from a complication of gastric bypass surgery to which neglect contributed. The cause of death was given as:- 1a. Systemic inflammatory response syndrome leading to multi-organ failure. 1b. Hiatus hernia repair and gastric bypass surgery for obesity. II. Hypertensive left ventricular cardiomyopathy.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a history of hypertension and non-insulin dependent diabetes. He had an elevated body mass index and was clinically severely obese. In an effort to reduce his weight he was electively admitted to the University Hospital North Staffordshire, Stoke-on-Trent on 29th August 2014 for a laparoscopic gastric bypass procedure. During the procedure a previously undiagnosed hiatus hernia was repaired and omentum adhering to a known paraumbilical hernia removed. The paraumbilical hernia was not repaired according to protocols in place at the time. Following the procedure he complained of abdominal pain for which he was prescribed analgesia and his oral intake was much reduced. The pain persisted but he was discharged home in some discomfort on 1st September. Later that day he was seen by his own doctor at home who prescribed morphine for pain relief. At 7.25pm that same day he was readmitted to the University Hospital with continuing abdominal pain. He was not seen by a doctor until 12.30am on 2nd September when an urgent CT scan was ordered. Some limited attempt was made to contact the bariatric surgeon but this was not successful and was not pursued. The scan was not carried out until 6.44am because of difficulties over the amount of oral contrast he was required to take. The scan revealed a small bowel obstruction in the area of the umbilicus. A decision was made at 8.00am to return the deceased to theatre but he did not go to theatre until 1.00pm. A decision had been made to resuscitate him with fluids because he had become severely dehydrated but he was only given a maintenance level of intravenous fluid. At surgery the portion of small bowel which had become entrapped in the paraumbilical hernia was freed and a section of bowel removed. The hernia was repaired. A small anastomotic leak was found at the jejunal-jejunal connection and was repaired and the bowel washed out. Towards the end of the operation he developed low blood pressure and his lactate levels rose. He

	was taken to intensive care where he continued to deteriorate over the next few days and he developed systemic inflammatory response syndrome and then multi organ failure. A further operation was performed on the intensive care facility on 3rd September to relieve intra-abdominal pressure. He died at 6.45am on 5th September 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 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, Whilst the hospital sought a review of procedures and protocols the matter was not elevated to a serious untoward incident or root cause analysis where all matters including clinical and nursing decisions were reviewed and subjected to critical examination. 2. Despite the recognition that a consultant-led out of hours on-call rota is required for patients having undergone surgery, no such rota is yet in place.
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 Friday 10 June 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 Chief Coroner and to the following Interested Persons:- 1. [redacted] (sister of the deceased) 2. [redacted] Healthcare Governance Manager Patient Safety, RSUH 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	

7/04/2016