H M Senior Coroner for Gloucestershire
Ms Katy Skerrett

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive, Ms Lee, of the Gloucestershire Hospitals NHS Foundation Trust.**
1	**CORONER** I am Katy Skerrett, Senior Coroner for Gloucestershire.
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 the 25th May 2016 I commenced an investigation into the death of Steven John Amos. The investigation concluded at the end of the inquest on the 23rd March 2017. The conclusion of the inquest was a short form conclusion of accidental death, combined with a narrative conclusion. The medical cause of death was 1a Multiple Organ Failure and Peritonitis, 1b Post Operative Leakage from an Intra - Abdominal Anastomosis.
4	**CIRCUMSTANCES OF THE DEATH** Steven John Amos "Steven" was a 57 year old man who suffered with chronic pyloric stenosis, which was linked to his long term use of anti inflammatory pain killers and dependence on codeine. In June 2015 he underwent a gastrectomy. Post operatively his condition improved. However in April 2016 he was suffering with persistent vomiting and weight loss. His consultant suggested a further operative intervention which involved a reconstruction of the previous surgery. The risks were explained. Steven underwent the operation on the 10th May 2016. The operation was technically untoward. Post operatively his pain was difficult to manage. On days 1 to 3 post operation he was reviewed daily by the surgical team and the acute pain team. By Friday the 13th May his pain was improving. Over the weekend Steven experienced some chest pain on the Saturday, and penile pain on the Sunday. Both were investigated, and were settling. At approximately 1am on Monday the 16th May his condition deteriorated. His blood pressure dropped, and his pulse rate increased. It is probable that leakage began to occur from his operative site around this time. Steven was medically reviewed by a junior doctor at 3.15am who was concerned there may be a leak. No medical examination by a more senior doctor occurred until 8am. No antibiotics were administered until 8 am. An urgent CT scan was not actioned until 8am. Steven did not receive analgesia between 1am and approximately 9am. The scan demonstrated a lot of intra-abdominal fluid and free gas suggesting a leak and Steven was prepared for theatre. Steven underwent an emergency laparotomy at 2pm on the 16th, which revealed a small leak from the gastrojejunal anastomosis, which had led to peritonitis. The leak was repaired. Post operatively Steven was transferred to the intensive care unit, and despite maximal clinical intervention his condition continued to deteriorate. Steven passed away at 23.24 hours on the 17th May 2016. It is likely that if Steven had been taken to theatre sooner on the 16th May 2016, his chances of survival following the emergency operation would have been increased.
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. –

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	1. Whether there is appropriate escalation of care given to a patient who acutely deteriorates during the night shifts over the weekend period.

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 4pm 1st June 2017. 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] (2) NHS England, Legal Team, 4W08 4th Floor, Quarry House, Leeds LS2 7UE 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	Dated 6th April 2017 Signature Ms K Skerrett Senior Coroner for Gloucestershire