REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	THIS REPORT IS BEING SENT TO: **1. CEO, Wirral University NHS Foundation Trust** **2. Clinical Director, Wirral University NHS Foundation Trust**
1	**CORONER** I am André Joseph Anthony Rebello, Senior Coroner, for the area of Liverpool & Wirral
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 19th September 2016 I commenced an investigation into the death of **Paul James MADDOX**, Aged **54**. The investigation concluded at the end of the inquest on 19th July 2017. The **Medical Cause of Death** found at the Inquest was: Ia Massive Gastrointestinal Bleeding with Disseminated Intravascular coagulopathy Ib Delayed Post-Pancreatoduodenectomy Haemorrhage Ic Renal Cancer II Left Ventricular Hypertrophy, with Ischaemic Heart Disease **The inquest concluded**: Natural causes in part because of a failure to act upon a reducing haemoglobin trend, when something meaningful could have been done to give Mr. Maddox a chance of life.
4	**CIRCUMSTANCES OF THE DEATH** In January 2016 Paul James Maddox had a renal tumour removed at Arrowe Park. Part of the tumour had spread to the pancreatic head and he later had a "whipples" procedure at the Royal Liverpool University Hospital in August 2016. Both surgical procedures were technically successful. At 8.50 on the 7th September 2016 Mr. Maddox was admitted to Arrowe Park with coffee ground vomiting and was treated for Acute Coronary Syndrome with aspiring and low molecular weight heparin. The ambulance service had started treatment with aspirin but this was not appreciated in the emergency department as a result of a clerical error in transferring information from the ambulance report form. It is found that this second dose of 300 mg of aspirin did not contribute more than trivially to Mr. Maddox demise. It is found that he had a developing coagulopathy from before his presentation to the emergency department on the 7th September 2016. In Arrowe Park hospital he was appropriately treated for a presentation of abdominal sepsis. On admission to hospital Mr. Maddox had a haemoglobin level of 9.5. A staff nurse in acute medicine ordered a haemoglobin test to be carried out, this was reported to the clinicians at 13.17 am on the 8th September 2016 showing a falling trend to a level of 7.2. This was not acted upon and is found to be a missed opportunity to have detected, investigated and treated internal bleeding. At 23.00 on 8th September 2016 Mr. Maddox had deteriorated and was recognised as a surgical emergency. His haemoglobin had dropped to 5.8. Mr. Maddox underwent surgery and it was found that the gastrojejunal anastomosis had perforated with a large clot forcing the operation site open with perfuse bleeding and gastric content being free in the peritoneal cavity. In spite of the surgical intervention Mr. Maddox died at 16.10 on 9th September 2016

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. – In spite of a Trust Root Cause Analysis Report identifying a missed opportunity before 13th April 2017 the court has been told at inquest that strategies to avoid a repeated failure were still work in progress. The missed opportunity was not acting upon a reducing trend in a haemoglobin result. This is simply not good enough as this issue should have been fixed during the Root Cause analysis investigation and before the report was approved as soon as the error became evident. During the course of the inquest evidence was heard from several doctors including a surgeon and it was suggested that **"when there is a downward trend in haemoglobin of 10% or more the laboratory should always ring through the result as a potential surgical emergency for the urgent review of clinicians"** The court brings this to the attention of the Trust and for confirmation as to when a solution to this problem has been implemented
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 **13th September 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 the family of Mr Maddox. I have also sent it to the Care Quality Commission 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.
9	 **André Rebello** **Senior Coroner for the** **City of Liverpool** **Dated: 17th September 2017**