DAVID W. G. RIDLEY
Senior Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Ms Nerissa Vaughan Chief Executive Great Western Hospitals NHS Foundation Trust Great Western Hospital Marlborough Road Swindon SN3 6BB
1	**CORONER** I am DAVID RIDLEY, Senior Coroner for Wiltshire and Swindon
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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 24 November 2016 I commenced an investigation into the death of Jeremy Michael Holt Marshall and opened his Inquest on 27 February 2017 following receipt of the post mortem report. Dr Marshall was born on 18 August 1963 in Croydon, London and sadly died at The Great Western Hospital on 17 November 2016. He was 53 years old. I concluded Dr Marshall's Inquest on Wednesday 11 October 2017 and recorded a cause of death as follows:- 1a) Small bowel obstruction and serosal tears 1b) Colonic adenocarcinoma (operated 31.10.2016)
4	**CIRCUMSTANCES OF THE DEATH** Dr Marshall was diagnosed as having a colonic adenocarcinoma early Autumn 2016 and underwent an elective right hemicolectomy to remove the cancer which was carried out on 31 October 2016 at the Great Western Hospital. Dr Marshall's discharge was delayed due to an infection and slow progress but he was initially discharged on 09 November only to be readmitted a few days later on 12 November 2016. A CT scan subsequently carried out revealed that Dr Marshall had developed post operatively a small bowel obstruction and this was managed conservatively. Sadly Dr Marshall's condition dramatically deteriorated on the night 14/15 November 2016 when at about midnight his NEWS score reached 7. He was attended at that time by an F1 Doctor [redacted] as well as a Surgical Registrar [redacted] and a care plan was drawn up. [redacted] the Ampney Ward Sister, bleeped the F1 doctor shortly before 0300 on the morning of 15 November when Dr Marshall's NEWS score reached 10 following a drop in his blood pressure and also a drop in body temperature. He was attended to by [redacted] and the Surgical F2 at the time, [redacted] at around about 0300 that morning. It was noted that Dr Marshall was peripherally shut down. The care plan drawn up [redacted] in particular provided for a review by the Medical Registrar as well as discussing with the Specialist Registrar, [redacted]. The Site Manager, [redacted] believes that the doctors left Dr Marshall's bedside after about 40 minutes or so. Despite this it would seem that the General Registrar was not contacted until about 0430 that morning and it would appear that [redacted] only contacted Dr Mukherji and bleeped him as a result of the intervention of the Site Manager who having spoken to Dr Payne, the General Registrar, advised that the Surgical Registrar needed to review Dr

	Marshall urgently. This conversation took place at around 0500 between [redacted] and Dr [redacted] and I saw evidence of both an attempt by [redacted] to bleep [redacted] at 0513 followed by a bleep from the ward, presumably [redacted] at 0514. [redacted] attended at around 0530 and from then onwards steps were put in place for Dr Marshall to return to surgery. In the preparation for this Inquest I had obviously site of the Root Cause Analysis secured by your hospital but I additionally also instructed [redacted] to review the case. I should point out that I am very specific when I instruct an expert so as to ensure that they look at matters afresh. [redacted] in this case was not provided with a copy of the Root Cause Analysis. He highlighted concerns in relation to the delay in escalating Dr Marshall's case and was critical of [redacted] assessment of the situation at around midnight on 14th going into the 15th November 2016. [redacted] was of the opinion that [redacted] did not realise as a result of that assessment the serious nature of Dr Marshall's deteriorating condition and in his view the matter should have been escalated at that time to an organisation such as the Critical Care Outreach Team although of course at the time Great Western Hospital were not operating a 24 hour system. I accepted the evidence of [redacted] in respect of his opinion in relation to the failings to escalate Dr Marshall's case but one of the questions that I had put to [redacted] was to ascertain whether or not had the matter been escalated at midnight as to whether or not on a balance of probabilities, Dr Marshall would have survived. [redacted] response to that question was that even at that stage on a balance of probabilities, Dr Marshall would not have survived even if the case had been escalated – he was that unwell. The subsequent surgery confirmed the bowel obstruction and also revealed significant adhesions that when tissue was separated gave rise to serosal tears were repaired at the time. Sadly Dr Marshall's condition did not improve and in consultation with family, the painful decision was to withdraw life support and Dr Marshall died on 17 November 2016. Due to the fact that [redacted] evidence was clear that even if Dr Marshall's case had been escalated at around midnight on 14/15 November 2016 that more likely than not he would not have survived, case law prohibited me from recording and making determinations in relation to the failings on the Record of Inquest. That however does not preclude me from airing concerns in relation to Dr Marshall's case with a view to the preventions of future deaths about which I will discuss in the next section. In concluding Dr Marshall's Inquest I recorded a short form conclusion of Accident combined with a Narrative Conclusion as follows:- **Accident and Narrative Conclusion:** [redacted] died on 17 November 2016 at the Great Western Hospital, Marlborough Road, Swindon as a result of having developed complications (small bowel obstruction, adhesions and subsequent serosal tears) following an elective right hemicolectomy for a colonic adenocarcinoma which was carried out on the 31 October 2016."
5	**CORONER'S CONCERNS** During the course of the evidence the final witness I heard from was [redacted] who was involved in the Root Cause Analysis. In respect of the following areas he indicated that he would take those observations by me back to the hospital. In law the only way I can ensure a response and given that I did not have explained to me how my concerns would be resolved with any certainty, I decided that I would make a Regulation 28 Report covering the following areas of concern:- 1. **Expectations of F1/F2 doctors** – personally I have no experience of training or being involved in the training of F1/F2 doctors and my only experience in respect of which I do not see a fundamental dissimilarity is in relation to trainee lawyers or in particular training solicitors in respect of whom I have been involved in their training during my professional career. F1/F2's when appointed are given a provisional licence to practice at the end of their medical degree. Trainee solicitors are again allowed to work under supervision following the completion of their professional examinations which for example can be a degree combined with a post graduate legal practice course. My experience in relation to trainee solicitors is that the expectations of what they realistically can do is at a low level and having heard from [redacted] formed the view that it is not fundamentally different in respect of F1/F2 doctors. The Great Western Hospital of course is a teaching hospital and therefore in relation to the training of doctors it is often,

I imagine, imperative that what may seem obvious to you or I perhaps needs to be spelled out to those trainees who may be entering the working environment in their chosen career area for the very first time. In relation to Dr Marshall's case I was concerned that the evidence revealed that [redacted] had not contacted [redacted] until he bleeped him at 0513 despite the care plan in relation to a seriously ill patient who at the time was peripherally shutting down in respect of which both [redacted] and [redacted] had recognised the seriousness of the condition as to why [redacted] was not contacted sooner. There had been a 3 point increase in his NEWS score yet there appeared to be a delay in contacting [redacted] to a degree and significant delay in contacting [redacted]. No instruction had been given to nursing staff to bleep the relevant doctors and I am concerned as to whether or not in respect of all doctors that the point needs to be emphasised that whoever records the care plan on the notes at doctor level should have the responsibility of bleeping another clinician in a timely fashion unless the notes clearly indicate that that responsibility has been given to somebody else and then the notes to identify when and to whom that instruction was given.

2. **Review Point and fall back position when no further action is forthcoming** – [redacted] and also [redacted] care plan at midnight provided for action to be undertaken but neither care plan provided for a specific timescale for any further review in respect of a patient who was quite clearly critically ill. Both [redacted] indicated that with the benefit of hindsight that such a timescale would have been desirable. I am concerned that if there is not a review or further action undertaken and noted within a period of time which at the end of the day has to be reasonable but given the critical nature of patient scoring 7 and above should be relatively short, that if nothing happens that the nursing staff are empowered to refer the matter now to the Critical Care Outreach Team. My concern goes further than that that. If hypothetically the Critical Care Outreach Team at a time of significant demand were unable to assess a patient then there needs to be built into that system a fallback position similar to the same fallback position that is available to the doctors ie that the nursing team can contact ITU or even as a last resort the on call Consultant. I am satisfied and I have no doubt in a similar situation that [redacted] would have no hesitation in making such a call but I am concerned as to whether or not other members of the nursing team would be aware of those options and that is of concern to me as well as the reinforcement of a review point for a critically ill patient to be actually recorded in the care plan.

3. **Recording observations in a patient scoring 7 or above** – I was comfortable hearing that a monitor was connected to Dr Marshall when his NEWS score reached 7 which would record observations electronically every 15 minutes and I heard evidence that at some point in 2018 you will be moving to an electronic system. In the interim I am concerned that there is no guidance given as regards the frequency of recording the observations on an Observations Chart in respect of a patient scoring 7 above on the NEWS score. Between 2350 on 14 November 2016 and 0240 on 15 November 2016 nothing was actually recorded on the Observations Chart itself which causes me concern in the interim.

   I did indicate to [redacted] during the course of the proceedings that I would like to come and visit once this system is in place and have a look for myself at the new software that you have in relation to NEWS scores and other new software that you have introduced in the last 18 months or so. I fully accept that there needs to be a balance as regards overburdening the nursing staff but at the same time I believe conversely that a gap of nearly 3 hours in respect of recorded observations of a critically ill patient is simply too long a gap. Should the frequency of observations be something again that should automatically form part of a care plan in respect of a critically ill patient?

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 11 December 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 [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	Dated 16 October 2017 Signature  Senior Coroner for Wiltshire and Swindon