IAN S SMITH
LL.B, Hon DUniv
HER MAJESTY'S CORONER

for the
Stoke-on-Trent and North Staffordshire
Coroner's Area

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive** **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 Margaret J Jones HM Assistant Coroner for **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. 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 17/01/2017 I commenced an investigation into the death of Donald John TILL. The investigation concluded at the end of the inquest on 11th January 2018. The conclusion of the inquest was that the deceased was a 68 year old man with a history of small bowel adenocarcinoma treated by surgery and chemotherapy in 2014. He presented to the Accident and Emergency department at the Royal Stoke University Hospital, Stoke-on-Trent on the 2nd January 2017 with a history of abdominal pain and vomiting. A CT scan showed a large bowel obstruction and a primary sigmoid colon cancer was suspected. He underwent emergency laparotomy on the 4th January 2017. He had been kept nil by mouth on the day of the surgery. Previous anaesthetic charts were not available prior to the induction of anaesthesia. He was anaesthetised in theatre whilst in his ward bed. A number of co-morbidities made him a high risk patient; he suffered from obstructive sleep apnoea, using a continuous positive airway pressure machine at night (CPAP); he had prominent front tooth crowns and a limited degree of mouth opening; the presence of a small beard and an elevated BMI. A clinical decision was made not to use cricoid pressure. An epidural was administered and he was then positioned in a head up, ramped up position for anaesthesia. He was pre-oxygenated and anaesthetised using Fentanyl, Propofol and Atracurium induction agents. Immediately after he had received them he vomited large amounts of faeculent material. His ward bed did not rapid tilt so he was placed head down over the edge of the bed to try to avoid contamination of the lungs. It was apparent that aspiration had occurred. A bronchoscope was sourced from thoracic theatre, initially the suction button was missing but this was found and bronchiolar lavage was done using saline to wash contaminated lungs. A nasogastric tube had not been inserted prior to anaesthetic but

	was inserted during the procedure. Antibiotics were administered intravenously. In view of the surgery required a decision was made to proceed. Multiple lesions were found and the bowel was resected. He was transferred to the intensive care unit where he continued to deteriorate and he died at 11.30am on the 5th January 2017. The cause of death given after post mortem examination was 1a Aspiration pneumonia. 1b Intestinal obstruction. II Adenocarcinoma of sigmoid colon (operated on 4.1.17). -
4	**CIRCUMSTANCES OF THE DEATH** Admitted 2/1/17 with abdominal pain and vomiting, A CT showed large bowel obstruction. On 4/1/17 a laparotomy, bronchoscopy and limited right hemicolectomy were undertaken. History: small bowel resection for cancer 2014 followed by chemo, inguinal hernia repair.
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. The deceased's previous medical records were not available. Different clinical decisions might have been made had they been available. 2. The deceased was anaesthetised on a ward bed and it would have helped if he had been on a trolley with rapid tilt. 3. A bronchoscope was not part of the standard anaesthetic equipment trolley and when one was sourced it had a suction button missing. 4. Cricoid pressure and NG tubes were not used in this case.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or your organisation has 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 16th March 2018. 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] widow of the deceased [redacted] Healthcare Governance Manager Patient Safety, University Hospital of North Midlands.

	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	11/01/2018 Signature  Margaret J Jones HM Assistant Coroner Stoke-on-Trent & North Staffordshire