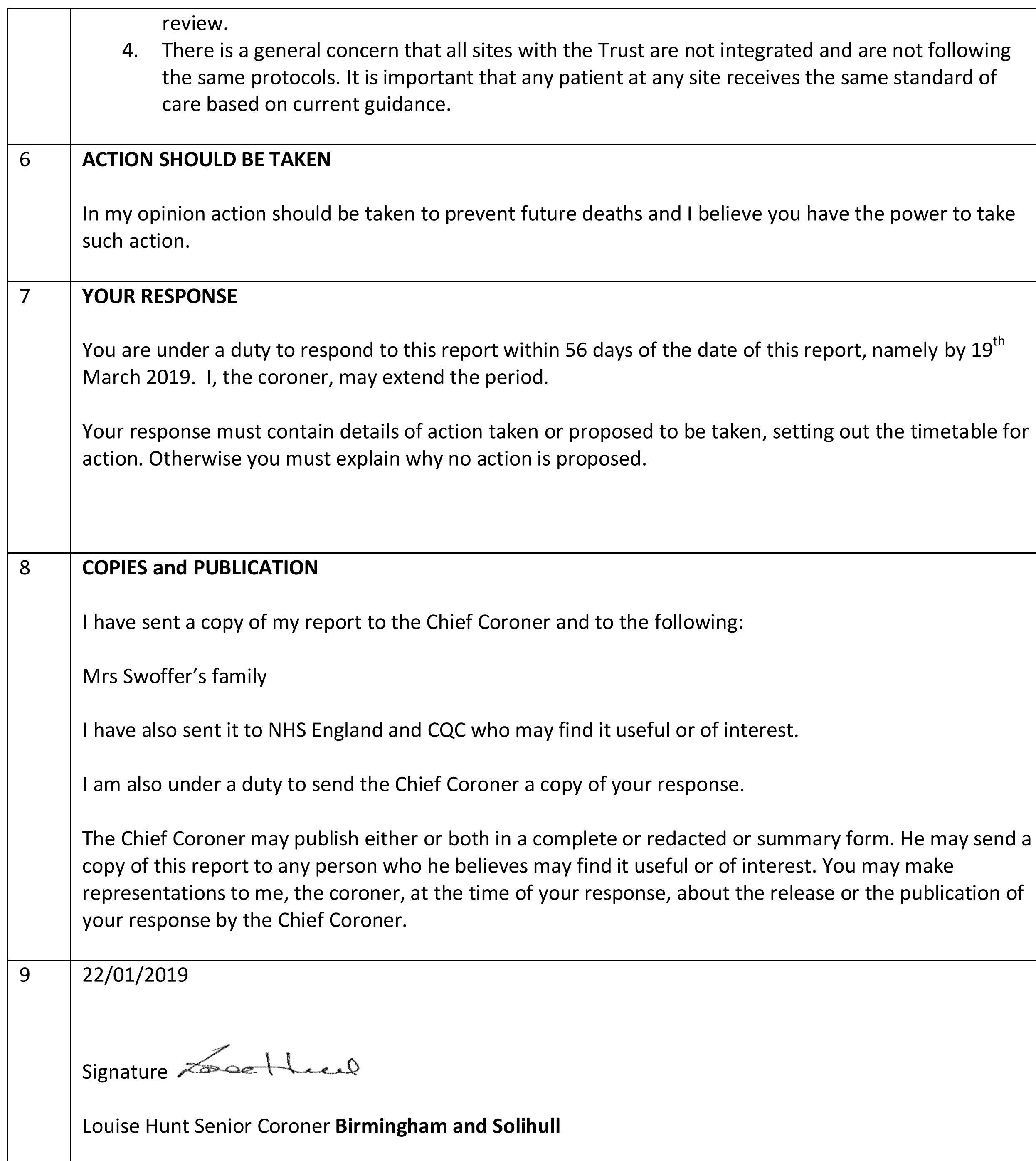
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **University Hospitals Birmingham NHS Foundation Trust**
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and Solihull**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 10/09/2018 I commenced an investigation into the death of Ann Swoffer. The investigation concluded at the end of an inquest on 22nd January 2019. The conclusion of the inquest was: Died from complications of oesophageal dilatation during NG tube insertion which was contrary to accepted practice. Alternative forms of feeding should have been considered earlier which would have avoided the oesophageal dilatation and subsequent perforation. A delay in recognising and treating the perforation contributed to her death.
4	**CIRCUMSTANCES OF THE DEATH** Following a diagnosis of squamous cell carcinoma in June 2018 the deceased underwent a staging laparoscopy on 25/07/18. She had near total dysphagia and consideration should have been given to placing a feeding tube at this time. Instead she was admitted to hospital for further management by way of placement of a naso-jejunal tube which was inserted following dilatation to 12mm during a gastroscopy on 21/08/18. On 25/08/18 she developed difficulty breathing and was confirmed to have a pleural effusion and pneumothorax caused by a late perforation as a result of the dilatation. There was a delay in recognising and treating the perforation which resulted in spread of the tumour and a stent was not inserted until 30/08/18. Despite further attempts to treat her she passed away on 02/09/18. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: 1a PNEUMONIA 1b OESOPHAGEAL PERFORATION 1c OESOPHAGEAL CANCER
5	<u>**CORONER'S CONCERNS**</u> 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. I heard clear evidence that the practice and procedures in place at Good Hope Hospital at the time were not consistent with accepted practice or national guidelines. This raises a considerable concern as to why the practise was so different and what monitoring is in place to ensure consistent practices in accordance with national guidelines are in place. 2. The deceased deteriorated as a result of a late perforation over the August Bank Holiday weekend. Junior staff did not identify the problem and did not escalate this to senior staff. I was told a "work force issue" meant senior staff were not present in the hospital at the time. Patients who become ill at the weekend need to receive the same standard of care as in the week. Consideration needs to be given to how this can be addressed. 3. The department caring for the deceased at the time were not following accepted practice or BSG guidelines. It is essential that the person who leads the restructuring of the practices and protocols is an expert and can ensure that the necessary details are considered and implemented. Consideration needs to be given as to who should lead the restructure and



	review. 4. There is a general concern that all sites with the Trust are not integrated and are not following the same protocols. It is important that any patient at any site receives the same standard of care based on current guidance.
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 19th March 2019. 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: Mrs Swoffer's family I have also sent it to NHS England and CQC 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	22/01/2019 Signature Louise Hunt Senior Coroner **Birmingham and Solihull**