REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **NHS Digital** **THIS REPORT IS BEING COPIED TO:** 2. [redacted] 3. **Care UK** 4. **Weston Area Health NHS Trust** 5. **Chief Coroner**
1	**CORONER** I am Dr. Peter Harrowing, LLM, Assistant Coroner, for the coroner Area of Avon
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 26th February 2018 I opened an Inquest into the death of Mrs. Susan Longden age 69 years. The inquest was heard 26th - 28th November 2018. The conclusion was that the medical cause of death was I(a) Acute intra-abdominal haemorrhage; I(b) Splenic injury ascribed to recent colonic perforation during colonoscopy The conclusion as to the death was: The Deceased died after suffering a very rare complication of a routine, but necessary, colonoscopy.

4	**CIRCUMSTANCES OF THE DEATH** The circumstances leading up to Mrs. Longden's death are that on the morning of 31st January 2018 Mrs. Longden attended Weston General Hospital where she underwent a routine surveillance colonoscopy. This procedure was performed by a Nurse Endoscopist. She was discharged from hospital at around 12:00 hours approximately one hour after the procedure was completed. During the early afternoon that same day Mr. Longden, the deceased's husband, telephoned the Endoscopy Unit and spoke to a staff nurse and reported that his wife was experiencing abdominal pain and requested some advice. The staff nurse advised she be given paracetamol tablets and a drink and she also spoke with Sister on the Endoscopy Unit who, in turn, telephoned Mr. Longden. Mr. Longden reported his wife's pain scored 9/10. Mrs. Longden had taken the paracetamol tablets and Sister telephoned Mr. Longden again approximately 45 minutes later at around 15:00 - 15:15 hours and was advised Mrs. Longden's pain was now 8/10 and she was feeling slightly better. The Sister made a further telephone call at around 16:10 hours when the pain was scored at 6/10 and Mrs. Longden reported feeling slightly better. At around 18:45 hours the Sister made a further call and Mrs. Longden reported the pain was 5/10 and she was feeling better. Mr. Longden states that his wife went to bed at around 20:00 hours and shortly afterwards she started yelling out in pain. He telephoned NHS 111 (operated by Care UK) at 20:53 hours. The call was taken by a non-medical Health Advisor (1) who followed the NHS Pathways computerised triage tool. The Health Advisor was told that she could not speak to Mrs. Longden and therefore all information was provided by Mr. Longden. At the conclusion of the telephone call the outcome generated was that a Category 3 ambulance was to be called. In accordance with the procedures of the NHS 111 service this required approval by a Clinical Advisor (a nurse). The call was passed to the Clinical Advisor who spoke with Mr. Longden and arranged for a doctor to call within two hours rather than a category 3 ambulance. A short while later at 21:41 hours Mrs. Longden became unresponsive and after calling NHS 111 (operated by Care UK) again the Health Advisor (2) a Category 1 ambulance was called immediately and arrived at around 21:49 hours. The paramedics confirmed she was in cardiac arrest. At 22:40 hours there was return of spontaneous circulation but she suffered a further cardiac arrest at 22:50 hours. Subsequently Mrs. Longden was taken to the Emergency Department of the Bristol Royal Infirmary where she arrived at 00:05 hours (1st February 2018). She had had a prolonged period of cardiac arrest and this was deemed an unsurvivable event and she was pronounced deceased at 02:00 hours.

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 NHS Pathways algorithm does not include a question with regard to recent surgical or interventional procedures where a patient is reporting severe abdominal pain. The close association in time between such a procedure and the onset of symptoms may well be significant in ensuring prompt action is taken to investigate the cause of the symptoms. (2) Where the caller to NHS 111 is not the patient then the Health Advisor continues to follow the algorithm by obtaining information from the caller and not the patient. There should be greater emphasis on trying to speak with the patient and the reason(s) why the patient cannot came to the telephone. The information provided by the patient themselves and the manner in which that information is provided may well affect the outcome of the triage process. (3) During the course of the Inquest I heard evidence from [redacted] the Medical Lead, SW111 Care UK,that concerns have been raised with your organisation on previous occasions. The case references provided by [redacted] are P130273, P132849 and P133040
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 19th February 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 Mr. David Longden, husband of the deceased, and Care UK. I shall send a copy of your response to [redacted], husband of the deceased, and Care UK. I have sent a copy of my report to the Chief Coroner. 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	**18th December 2018** **Assistant Coroner**