REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Officer** **Norfolk and Norwich University Hospital NHS Foundation Trust** **Colney Lane** **Norwich** **NR4 7UY**
1	**CORONER** I am YVONNE BLAKE, area coroner, for the coroner area of NORFOLK
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 11 August 2020 I commenced an investigation into the death John Graham Slope. The investigation concluded at the end of the inquest on 28 April 2021. The conclusion of the inquest was a narrative conclusion: "Mr John Slope underwent a total laryngectomy in 2019 with a tracheostomy and insertion of a voice box prosthesis. He developed a leak and a fistula and a salivary bypass tube was inserted at a later date. He had quite a long hospital stay developing pneumonia and difficulties with nutrition. He was discharged from hospital on 17 July 2019. He then asked to be investigated in March 2020, but no-one has documented the exact nature of his concerns. Overall the quality of the documentation was poor. He was being reviewed by another hospital's SALT team. Due to covid-19 and its restrictions, his voice box prosthesis could not be changed as it was a high risk procedure and he was a high risk patient. In August 2020 he became unwell with a painful guarded abdomen with reduced bowel sounds and nausea. CT scan showed small bowel perforation and a foreign body in the small bowel. Mr Slope was deemed too unwell for surgery and died." The medical cause of death was given as: 1a) Small Bowel Obstruction and Perforation 1b) Ingestion of Foreign Body
4	**CIRCUMSTANCES OF THE DEATH** Mr Slope underwent a total laryngectomy for pharyngeal cancer, he had a prosthetic voice box fitted, shortly after he had a salivary bypass tube fitted. It is not recorded whether this first tube was secured by sutures. He developed a fistula, a common complication of this type of operation which is the reason for the bypass tubes insertion. When the bypass tube was to be changed in November 2019, there was no tube present but a new one was inserted. The surgeon was unable to recall why there was no tube, if it had been removed previously and or by whom. The documentation of the operation was poor, but he thought he had been told by somebody, he couldn't remember whom, that the patient had coughed the tube out. However, he was unsure and otherwise could not account for its absence. An abdominal x ray was taken on that day which was later looked at and does show a foreign body in the fundus of the stomach. However, this was not noticed at the time because they were checking placement of the new tube. In March of 2020 Mr Slope asked to have a scope passed to see what was going on, no one has documented anywhere what his concerns were. He was unable to be investigated or have his voice box changed due to covid restrictions as this procedure was deemed to be high risk. In August 2020 Mr slope was admitted as an emergency,

	extremely unwell with a tense guarded abdomen pain and nausea. A scan showed he had a perforated small bowel and demonstrated the presence of a foreign body. He was too unwell to undergo surgery and died shortly afterwards.
5	**CORONER'S CONCERNS** During 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: That there is no method of noting in the medical records that a salivary bypass tube is in the patient's body. That this death happened nearly nine months ago and still there is no method of showing staff in the notes that a patient has this prosthesis and that no thought had been given to this simple measure e.g. a rubber stamp stating patient has a bypass tube in situ to be ticked and signed. The hospital already uses this method for when an intravenous cannulae is inserted and hip prosthesis. This is immediately noticeable and would alert staff. That the quality of the documentation pre and post operatively is of poor quality and would not assist other staff to find out what treatment had been given. That there is nowhere on the consent form or the anaesthetic checklist for the presence of a tube to be asked about and documented. These are basic common-sense measures which should have been in place. Had the absence of the tube been noted when it was only in the stomach it is likely that Mr Slope would not have died months later from a perforated small bowel. That the clinical specialist nurses did not contact anyone or document the concerns raised by Mr Slope in March 2020. That the hospital did not request a summary of Mr Slope's treatment at a different hospital before commencing the procedures, this could easily be requested via e mail.
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 5 July 2021. 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] and solicitors Fraser Dawbarns I have also sent it to: Department of Health Care Quality Commission HSIB Healthwatch Norfolk who may find it useful or of interest.

	I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	Dated: 07 May 2021  Yvonne BLAKE Area Coroner for Norfolk Norfolk Coroner Service Carrow House 301 King Street Norwich NR1 2TN