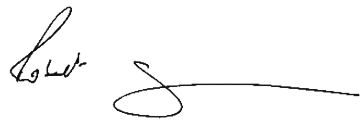
Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 The Chief Executive, Western Sussex Hospitals NHS Foundation Trust** **2 The Chief Executive, National Institute of Health and Care Excellence** **3 The Chair, Joint Advisory Group on GI Endoscopy** **4 The President, British Society of Gastroenterology** **5 The President, Association of Coloproctology of Great Britain & Ireland**
1	**CORONER** I am Robert Simpson, Assistant Coroner for the coroner area of West Sussex.
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 29 April 2020 I commenced an investigation into the death of Anne BRADLEY aged 74. The investigation concluded at the end of the inquest on 23 May 2021. The inquest recorded a narrative conclusion as follows: The deceased died as a result of a complication of a necessary surgical procedure. The procedure carried out was unusual but despite the lack of significant data the complication was a recognised one.
4	**CIRCUMSTANCES OF THE DEATH** On the 5th March 2020 Anne Bradley underwent a colonoscopy at St Richards Hospital, Chichester which identified a tumour. The location of the tumour was marked by tattoos and the endoscopist reported that it was approximately 40cm from the anal verge. A report on a CT scan carried out on the 13th March 2020 did not identify the location of the tumour. On the 30th March 2020 Anne Bradley underwent a colectomy in order to remove the tumour. The surgeon found an area of tattooing at approximately 40cm from the anal verge and removed a section of the colon at the junction of the sigmoid and descending colon. On examination after removal this section did not include the tumour and the surgeon then located a second area of tattooing in the mid transverse colon. The surgeon had to then remove a further section of the colon. The removal of such a large portion of the colon lead to post-operative complications which in turn lead to bowel ischaemia and ultimately to Anne Bradley's death.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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) Use of scope guides/scope pilots The colonoscopy was carried out without the use of a scope guide or scope pilot as none were available in the room used for Anne Bradley's procedure. A scope guide or scope pilot is an additional piece of equipment which assists the endoscopist in carrying out a colonoscopy. I heard evidence from the endoscopist and 3 consultant colorectal surgeons who all agreed that the use of scope guides or scope pilots assist in accurately recording the location of a tumour. The accuracy of this information is important in assisting the surgeons to locate the tumour especially during laparoscopic (keyhole) surgery with early stage tumours. I heard evidence that there are limited markers within the colon to assist the endoscopist to know the location and that tattoos used to mark the location of a tumour can, and in this case did, pierce through the colon and mark multiple areas. Whilst St Richards Hospital explained that they have now equipped all rooms with scope guides or scope pilots I heard that use of such equipment is not required by quality assurance organisations. The concern I have is that equipment which increases the accuracy of the localisation of a tumour is not required or recommended for use in routine colonoscopies. (2) Feedback to endoscopists at St Richards Hospital I heard evidence that at St Richards Hospital surgeons do not necessarily feedback information regarding tattooing problems or incorrect localisation of tumours to endoscopists. The concern that I therefore have is that there is no formal system at St Richards Hospital which requires surgeons to provide information about the incorrect localisation of tumours or tattooing problems which is then shared with endoscopists.
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 the 16th August 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: The family of Anne Bradley 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 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 by the Chief Coroner.
9	**Dated: 20/06/2021**  **Robert SIMPSON** **Assistant Coroner for** **West Sussex Coroners Service**