Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Chief Executive, Nottingham University Hospitals NHS Trust**
1	**CORONER** I am Miss Laurinda Bower , HM Assistant Coroner for the coroner area of Nottingham City and Nottinghamshire
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** I commenced investigations into the deaths of William DOLEMAN, Anita BURKEY, Peter SELLARS and Carol Christine COLE. The investigation concluded at the end of the inquests, heard together, between 15 November 2021 and 17 December 2021. The conclusion of the inquests were as follows: "**Bill** died on 1 April 2020, at the Queens Medical Centre, Nottingham, as a result of medical complications following an ERCP procedure performed on 19 March 2020, in which he suffered a recognised complication, namely a perforation to his duodenum, likely caused as a result of catheter trauma. At the time, the procedure was not clinically indicated, and ought not to have gone ahead. If the procedure had been postponed for further imaging, Bill would not likely have died when he did and in the manner that he did. Failures in his pre-procedure care directly contributed to his death. There were missed opportunities to have diagnosed and treated Bill's perforation during the procedure, and while this would likely have reduced his risk of dying, it might not have prevented his death." "**Anita** died on 5 April 2020, at the City Hospital, Nottingham, as a result of medical complications following an ERCP, performed on 19 March 2020, in which she suffered an iatrogenic perforation to her oesophagus. The procedure should never have been performed on this date and in the circumstances as it was unsafe to do so when Anita's capacity and consent had not been appropriately assessed, and her history of dysphagia had not been explored. Anita died as a direct result of the procedure which was performed as a result of significant failings in her care." "**Peter** died on 8 November 2020, at the Queens Medical Centre, Nottingham, from multi-organ failure caused by necrotising pancreatitis, which occurred as result of an ERCP procedure performed on 4 September 2020. Pancreatitis is a recognised complication of this procedure, which was necessary in order to treat Peter's symptomatic choledocholithiasis." "**Carol** died on 11 September 2020, at the Queens Medical Centre, Nottingham, as a result of acute haemorrhagic pancreatitis, that was induced by an ERCP performed to treat choledocholithiasis, on 10 September 2020. Carol was at an elevated risk of developing this complication based on patient and procedure risk factors."

4	**CIRCUMSTANCES OF THE DEATH** All four patients died from endoscopic retrograde cholangio-pancreatography related complications, within a 6-month period, caused by the same doctor, during his training for this high-risk procedure.
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. A lack of robust patient pathway to ensure that all patient factors relevant to the clinical indication for, and safety of, ERCP are identified in advance of the procedure and discussed with the patient. 2. A lack of robust system for the recording of vetting of the procedure, capturing what information has been considered as part of this process. 3. Consent is not personalised, contrary to recommendations made by the ESGE in December 2019. 4. A Lack of accountability between professionals for ensuring robust vetting and consent.
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 February 17, 2022. 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 **Nottingham University Hospitals NHS Trust** **Dr** [redacted] **The families of the Deceased** **Care Quality Commission** I have also sent it to **The British Society of Gastroenterology** **The Joint Advisory Group on GI Endoscopy** **The European Society of Gastrointestinal Endoscopy Guidelines Committee** 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 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: 23 December 2021** **Miss Laurinda Bower** **HM Assistant Coroner**