East London Coroners

MISS N PERSAUD
SENIOR CORONER

Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
Telephone 020 8496 5000 Email coroners@walthamforest.gov.uk

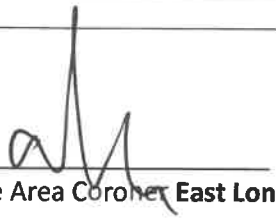
REF: 111483

12th November 2020

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted] Chief Executive, Barts Health, Royal London Hospital, Whitechapel Road, Whitechapel, London, E1 1BB – **Email:** [redacted] 2. Ministerial Correspondence and Public Enquiries Unit, Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU
1	**CORONER** I am Mr Graeme Irvine Area Coroner for **East London**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 20th September 2019 I opened an investigation touching the death of Amarbai Bhudia, aged 63 years old. I opened and inquest on the 14th October 2019. The inquest concluded on the 3rd November 2020. The conclusion of the inquest was a narrative conclusion, which I have utilised below to describe the circumstances of death. The medical cause of death was; *1a Aspiration of Gastro-intestinal Contents* *1b Small Intestinal Pseudo-obstruction* *1c Ulcerative Colitis treated with Colectomy*
4	**CIRCUMSTANCES OF DEATH**

	"Mrs Amarbai Bhudia was admitted to hospital with abdominal pains and vomiting on 16th September 2019. Mrs Bhudia was assessed to be suffering from a sub-acute small intestine obstruction and was admitted for ward-based, conservative management, incorporating; 1. Nil by mouth, 2. I/V Fluids, 3. A naso-gastric tube to decompress her stomach. Temporary clamping of the tube to facilitate a contrast CT scan, followed thereafter with 2-3 hourly aspiration of the NG tube. 4. Catheterisation. The instruction to aspirate was not recorded in clinical notes. Mrs Bhudia's NG tube was not aspirated. On the morning of 17th September 2019 Mrs Bhudia collapsed and suffered a cardiac arrest caused by aspiration of gastro-intestinal contents."
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. Instructions on the management of the NG tube were provided on a ward round by a consultant, the instructions were not clearly noted by the House Officer accompanying the consultant. 2. Nursing staff had no clinical instruction as to how to manage the NG tube. 3. Nursing staff dealing with the patient were agency staff without training or experience of NG tube management. 4. Concerns regarding the NG tube function were not properly escalated to clinical staff.

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 **7th January 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, to the family of Mrs Bhudia, the CQC, and to the Director of Public Health who may find this useful. 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	12/11/2020 Signature  Mr Graeme Irvine Area Coroner **East London**