IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Linda Doherty
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive Surrey and Sussex Healthcare NHS Trust Canada Avenue Redhill RH1 5RH
2	**CORONER** Miss Anna Crawford, HM Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INQUEST** The inquest into the death of **Linda Doherty** was opened on 11 August 2017. It was resumed on 21 May 2019 and 27 September 2019 and the conclusion was handed down on 27 October 2020. The medical cause of Linda Doherty's death was: 1a. Sepsis and Acute Kidney Injury 1b. Malnutrition 1c. Intestinal Failure secondary to Crohn's Disease and Ileal Resection (11 May 2017) AND Inadequate Nutritional Intake (23 June – 7 August 2017) The inquest concluded with a narrative conclusion which is set out below.

5	CIRCUMSTANCES OF THE DEATH On 2 December 2016 Mrs Doherty underwent a Computerised Tomography scan (CT Scan) in relation to a suspected mass on her gallbladder, an incidental finding of which was inflammation of the small bowel. On 20 December 2016 the results of the CT scan were discussed during an Upper Gastro-Intestinal Multi-Disciplinary Team meeting at East Surrey Hospital and it was agreed that Mrs Doherty would be referred to the colorectal surgeons for follow up. On 8 May 2017 Mrs Doherty was admitted to East Surrey Hospital due to abdominal pain and diagnosed with a small bowel obstruction. On 11 May 2017 she underwent a laparotomy during which a section of small bowel was resected and an earlier colostomy was refashioned into a double barrelled ileostomy. Thereafter Mrs Doherty remained an inpatient at the hospital until the time of her death. On 9 June 2017 she was diagnosed with Crohn's Disease for which she was begun on steroid treatment. On 4 August 2017 she was diagnosed with intestinal failure. On 5 August 2017 her clinical condition deteriorated and she was placed on end of life care. On 7 August 2017 she died at the hospital. Mrs Doherty succumbed to sepsis and acute kidney injury due to malnutrition. The malnutrition was caused firstly by intestinal failure due to her underlying Crohn's Disease and the reduced length of her small bowel and secondly by inadequate nutritional intake from 23 June 2017 until the time of her death. There was no follow up in relation to the findings of the CT scan carried out on 2 December 2016. This led to a delay in Mrs Doherty being diagnosed with, and treated for, Crohn's Disease.

	During the period from the end of June 2017 to 10th July 2017 there was an omission on the part of the clinical team caring for Mrs Doherty to recognise that she was not receiving adequate nutrition and to feed her by way of a nasogastric tube. This omission contributed to Mrs Doherty's malnutrition. During the period from 11 July 2017 to the beginning of August 2017 there was a failure on the part of the clinical team caring for Mrs D to recognise that she was not receiving adequate nutrition, had suffered significant weight loss and had entered into a state of intestinal failure. As a result they failed to feed her by way of Total Parenteral Nutrition. But for this failure Mrs Doherty would have survived. In relation to the failure to feed Mrs Doherty by way of Total Parenteral Nutrition from 11 July onwards, Mrs Doherty's death was contributed to by neglect.

6	**CORONER'S CONCERNS** The Coroner's concerns are as follows: See below. The **MATTER OF CONCERN** is: 1. There was no colorectal follow up in relation to the findings of the CT scan carried out on 2 December 2016 despite it being recommended by the Upper Gastro-Intestinal Multi-Disciplinary Team meeting at East Surrey Hospital on 20 December 2016. Consideration should be given as to whether the appropriate procedures are in place to ensure that recommendations stemming from MDT meetings are actioned appropriately. 2. The Malnutrition Universal Scoring Tool (MUST) charts for Linda Doherty were inaccurately scored during the period from 3 to 23 July 2017. Consideration should be given as to whether staff are sufficiently trained in how to score MUST charts. 3. The food charts for Linda Doherty were not completed from 23 June to 12 July 2017 and again from 18 to 23 July 2017, despite Mrs Doherty being at risk of malnutrition. Consideration should be given as to whether appropriate procedures are in place to (i) identify those patients who require food charts and (ii) to ensure that they are properly completed. 4. The MUST charts recorded that Mrs Doherty's weight was 65kg in early June 2017 and had reduced to 57kg by 11 July 2017, yet the multi-disciplinary team caring for her did not recognize that she had lost a significant amount of weight until 1 August 2017. Consideration should be given as to whether any additional measures or training are required to prevent similar delays in the future. 5. Mrs Doherty was placed on end of life care on 5 August 2017 by a Senior House Officer (SHO) following consultation with his Consultant, both of whom had had only limited prior involvement with her. The decision to place her on end of life care was made without any consultation with the Intensive Care team, to ascertain whether she would be suitable for intensive care, and without any consultation with the clinicians who had been treating her over the

	course of the preceding three months. Consideration should be given as to whether appropriate end of life policies and procedures are in place and whether staff are sufficiently aware of them.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Mrs Doherty's family
10	**Signed:** **Anna Crawford** **H.M. Assistant Coroner for Surrey** **Dated this 5th day of November 2020**