MR G IRVINE
ACTING SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 15729784

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted], Chief Executive, Barts Health, Royal London Hospital, Whitechapel Road, Whitechapel, London, E1 1BB **Email:** [redacted] • The Secretary of State for Health and Social Care 39 Victoria St, Westminster, London SW1H 0EU Email: [redacted]
1	**CORONER** I am Graeme Irvine, acting senior coroner, for the coroner area of 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 25th October 2021 I commenced an investigation into the death of Daniel John Xavier age 62 years. The investigation concluded at the end of the inquest on30th June 2022. The conclusion of the inquest a narrative conclusion summarised: "*Daniel Xavier was a 62-year-old man with a learning disability from birth.* *On 21st October 2021 Mr Xavier presented to his GP surgery with a history of painful haemorrhoids. After being reviewed by a pharmacist, advice was sought from a GP which resulted in Mr Xavier being referred to the surgical team at his local hospital Emergency department.*

	Mr Xavier was taken to the ED by his family and underwent a triage assessment by a nurse and a RAAT doctor in the presence of his mother who was relied upon to provide a collateral history. During the course of this assessment, a venous blood gas sample was taken and analysed. The results showed an abnormally high level of creatinine. The blood result was not considered by clinicians before a decision was made to discharge Mr Xavier from hospital with a prescription for laxatives, ointment, and an appointment with the surgical out-patients clinic. *Overnight, Mr Xavier became increasingly unwell, suffering from faeculent vomiting. Mr Xavier returned to the ED by ambulance where he later suffered a cardiac arrest. Despite the best efforts of the clinical team, he could not be resuscitated and was declared deceased.* *Mr Xavier's cause of death was offered following post-mortem as 1. a. Bilateral Bronchopneumonia."*
4	**CIRCUMSTANCES OF THE DEATH** See narrative conclusion
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 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. Prior to Mr Xavier's discharge from hospital on the evening of 21st October 2021, the deceased's venous blood gas results were not considered and acted upon by staff. The results, available from 13.17, indicated that Mr Xavier had a dangerously elevated creatinine level. Evidence heard at inquest indicated that had the results been considered, Mr Xavier would not have been discharged, he would have been escalated to the resuscitation department. Further, the Trust accepted that had the creatinine levels been acted upon, it is likely that the outcome for Mr Xavier could have been different. 2. Mr Xavier's referral to the surgical team by his GP was chaotic. No telephone contact was made between the GP and the on call surgical team. Mr Xavier was therefore triaged by a ED nurse and subsequently, a rapid assessment team junior doctor before he was brought to the attention of the surgical team. Despite these assessments, no formal handover was provided to the surgical team, setting out the extent of the history, clinical observations and diagnostic processes that had previously taken place. Despite these shortcomings, the surgical team accepted the referral without considering Mr Xavier's clinical records beforehand. 3. Due regard was not given to Mr Xavier's learning disability during his admission on 21st October 2021.Insufficient time and care was taken to establish a clear history from the patient, most pertinently his 7-day history of constipation.
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 **26th August 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 the family of Mr Xavier and the CQC. I have also sent it to local Director of Public Health 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	**[DATE] 1st July 2022 [SIGNED BY CORONER]**