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:** • [redacted] **- Chief Executive Officer, NHS England** • [redacted] **- Chief Executive Officer, Royal Surrey County Hospital NHS Foundation Trust** • [redacted] **- Chief Executive Officer, Surrey and Sussex Healthcare NHS Trust**
1	**CORONER** I am Karen Harrold, 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 12 October 2021, an investigation into the death of Stephen WELLS aged 59 years was commenced. The investigation concluded at the end of the inquest on 16 March 2022. The overall conclusion of the inquest was as follows: This was a death from natural causes, however, there was no follow-up for Mr Wells with an oncologist after his liver surgery on 3 August 2020 as recommended by the MDT meeting on 10 August. This resulted in a gap of one year in providing Mr Wells with any further chemotherapy or other treatment or monitoring, which his doctors agree would have prolonged his life. The medical cause of death was recorded as: 1a) Carcinoma colon with liver and lung metastases.
4	**CIRCUMSTANCES OF THE DEATH** Stephen Wells was 57 years old when he was referred by his GP to the Surrey and Sussex Healthcare Trust (SASH) on an urgent suspected cancer basis on 8 November 2019. He was seen in a colorectal clinic and investigations on 21 December 2019 led to a diagnosis of cancer with a tumour in the ascending colon. Following staging scans and a multidisciplinary team (MDT) meeting, Mr Wells had surgery to remove the tumour at East Surrey hospital on 16 January 2020. He was then referred to an oncologist as CT and MRI scans had previously shown multiple liver metastases. His care was transferred to the Royal Surrey County Hospital NHS Foundation Trust in order to receive chemotherapy. Four cycles were completed in Guildford from 20 March to 24 May 2020. The same day, Mr Wells had an MRI scan on his liver followed by a CT chest abdomen and pelvis on 9 June and these confirmed a moderate response to chemotherapy resulting in a referral to a consultant surgeon to consider liver surgery. This was performed on 3 August 2020 and Mr Wells was discharged home in the morning of 10 August 2020. In the afternoon of the same day an MDT was held at the Royal Surrey hospital and histology confirmed surgery

	had gone as well as could be expected but the results disclosed a lot more disease than had been expected. It was agreed there should be a follow-up appointment with an Oncologist. A post-surgery follow-up on 8 September 2020 noted that Mr Wells was making a slow but steady recovery. The surgeon explained the post-operative pathology findings to Mr Wells and why it was advisable to have a referral back to the oncologist to discuss the benefits of further chemotherapy or a period of surveillance. A referral letter from the surgeon to the oncologist in the same Trust was prepared dated 9 September 2020. During the inquest, it was accepted by both Trusts that despite an internal investigation no explanation could be provided as to what happened to that letter. The last step in the audit was that the letter was printed in the East Surrey hospital and it should have been sent internally to a secretary in Crawley Hospital. In addition, the internal investigation discovered that a colorectal cancer nurse specialist had reviewed the outcomes of the MDT held on 10 August 20 and emailed both the surgeon and oncologist secretaries asking if Mr Wells had been booked in at either SASH or Royal Surrey and requesting that a follow-up appointment be made. The last email that could be traced was from the Royal Surrey secretary to the SASH secretary confirming Mr Wells did not have an appointment at Royal Surrey and querying whether an appointment would be made at Crawley or Guildford. The outcome was that Mr Wells received no further contact from either Trust after the liver surgery follow up on 8 September 2020 and this resulted in a one-year gap in his treatment. Mr Wells saw his GP on 8 September 2021 who advised him to go straight to hospital. Further restaging scans demonstrated widespread liver disease and lung metastases that could not be treated. A referral was made to a hospice for palliative care, but Mr Wells was cared for by his family until his death at home on 4 October 2021. The internal investigation report noted the Oncologist confirmed that if he had seen Mr Wells in September 2020, he would have been offered three months of chemotherapy, but it was felt this would not have been curative as the patient had a poor prognosis at that time. It was accepted in the inquest that it was likely the additional treatment would have extended Mr Wells life expectancy by six months or more.
5	**CORONER'S CONCERNS** During 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: a) I heard evidence that Mr Wells GP wrote two urgent letters to the RSFT consultant oncologist and HPB surgeon dated 22 September 2021 raising concerns that the patient had heard nothing further after the liver surgery in September 2020. These letters were sent to the East Surrey hospital by the GP. I heard evidence that both consultants hold clinics in two East Surrey hospitals as well as within their own Trust area. Principally the letters were about lack of treatment for a cancer patient and I heard evidence during the inquest that the RSFT witness assisting the court on governance & risk issues did not know the doctors had received the letters and presumably were not logged on the Datix system thereby raising concerns regarding: i. whether additional guidance may be appropriate for GPs to know where to raise concerns about patient treatment in hospital or tertiary care; and ii. whether further guidance or refresher training is needed for hospital doctors regarding use of the relevant Datix system.

	b) I also heard evidence from SASH that they would not have expected Mr Wells to be transferred back to them after the liver surgery as further chemotherapy was needed. Conversely, RSFT were unable to explain why Mr Wells did not remain on the Somerset Cancer Registry (SCR) tracking system following discharge and the MDT discussion on 10 August 2020. I was told that the safety net to avoid a cancer patient such as Mr Wells failing to receive further treatment is an inter-provider transfer (IPT) to ensure the responsibility for care is formally transferred. In this case, a local process of consultant-to- consultant referrals, in other words a workaround, had evolved and both the hardcopy letter between doctors and an email from the CNS to two separate doctor's secretaries had failed resulting in no further appointment been made. It was accepted that the communication failure was not identified in a timely manner and that communication systems between both Trusts had blurred with the suggestion that these could be clarified by a renegotiation of the Service Level Agreement (SLA). I was provided with a copy of the current SLA dated 1 January 2015 and note that the particulars state the contract term was 36 months with an end date of 31 December 2017. Given the importance of good systems of communication between Trusts and the IPT system I remain concerned about: i. the lack of progress made in reviewing/renegotiating the SLA bearing in mind the difficulties in this case were drawn to the attention of the Trusts in September 2021. ii. an ongoing firewall problem between the two Trusts as this places a current reliance on email rather than automatic electronic systems especially given the failure of emails in this case to secure a much-needed appointment. c) I heard evidence that Mr Wells was told his key contact in SASH was a named Clinical Nurse Specialist. When his care transferred to RSFT, witnesses expected his key contact to be changed to a CNS based within the St Luke's Cancer Centre in Guildford. During the inquest I asked who the CNS was at RSFT and following enquiries learned that the St Luke's staff believed the key contact was the SASH CNS. I remain concerned that there is insufficient clarity for both patients and staff when there is an IPT from SASH to RSFT and vice versa.
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 1st November 2022, 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:- a) [redacted] b) Surrey & Sussex Healthcare NHS Trust c) Royal Surrey NHS Foundation Trust. I have also sent it to:-

	a) [redacted] (GP) Moatfield Surgery, East Grinstead b) [redacted] (Consultant Oncologist) St Luke's Cancer Centre, Royal Surrey County Hospital c) [redacted] (Consultant Surgeon) Royal Surrey County Hospital d) NHS Sussex 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: 05/09/2022** Karen Harrold **Karen HARROLD** **Assistant Coroner for** **West Sussex Coroners Service**