REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	THIS REPORT IS BEING SENT TO: 1. **Spire Healthcare Limited. F.A.O [redacted], 3 Dorset Rise, London EC4Y 8EN**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East)
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 20 October 2023 I commenced an investigation into the death of Carol Ann Hatch aged 73. The investigation concluded at the end of the Inquest on 26 June 2023. The conclusion of the Inquest was a Narrative which recorded the medical cause of death as (1a) Sepsis, (1b) gastric perforation (1c) revision Nissen Fundoplication.
4	**CIRCUMSTANCES OF THE DEATH** Carol Ann Hatch aged 73 underwent a surgical procedure in 2015 known as a 360 degree Nissen Fundoplication to repair a hiatus hernia and reduce the risk of reflux. On 31 August 2022 she underwent an identical procedure as a further hiatus hernia had developed, causing a recurrence of symptoms. The surgery was performed at the Spire Private Hospital in Leeds. Mrs Hatch became unwell during the night following the surgery. It was only the following morning when the surgeon returned to the hospital that the extent of her deterioration was appreciated. She was transferred to an NHS hospital in Leeds, underwent emergency surgery within a few hours and was admitted to an intensive care unit. Over the following six weeks she was treated on the intensive care unit for septic shock and organ failure. She died on 18 October 2022 at St James University Hospital in Leeds.
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. Mrs Hatch's condition deteriorated markedly during the night of 31 August/1 September 2022 (some hours after surgery). Neither the surgeon nor the anaesthetist were alerted to this unexpected deterioration. The Surgeon only became aware of the position when he contacted the hospital and came in around 7 am. 2. Mrs Hatch was cared for during the night by an agency nurse who had not

worked at the hospital previously. No records were produced to the Inquest to demonstrate she was (a) competent (b) had an induction to the hospital or (c) received a handover at the start of the shift.

3. The nurse took observations at times during the night but either omitted some elements or misinterpreted the information with the result that the NEWS scores were inaccurately portrayed. This resulted in missed opportunities to escalate concerns to a doctor, more senior colleagues or the surgeon.

4. No observations whatsoever were taken in the period between 3 am and 6.25 am, despite the patient having been recorded as "crying in pain" around 10pm.

5. The records kept were inaccurate; for example, there was no record of oxygen being provided around 2 am.

6. The RMO was called to review Mrs Hatch twice during the night but failed to appreciate that the deterioration in her condition necessitated an escalation to the surgeon and/or anaesthetist.

7. When Mrs Hatch was observed to be in pain there was a delay in moving her to an extended care unit ('ECU') bed or otherwise escalating the level of monitoring. This did not take place until 9.50 am.

8. When the surgeon sought an x ray at 8.35 am there was a delay until this took place at 10.09 am. There was a failure to appreciate the urgency of the situation in a patient who was displaying symptoms of septic shock.

9. It was not readily apparent to some of those involved at that time that an out of hours radiographer could have been called in. This was a further missed opportunity to investigate her condition before it deteriorated.

10. Blood samples taken at 8.02 am were not delivered to the laboratory until 9.06 am and then not reported on until 10.21 am as they had not been marked as 'urgent'. This also reflects a failure to appreciate the gravity of the situation.

11. The RMO was the senior doctor at the hospital overnight. The RMO recorded a note at 8.45 am "feeling much better now". The Inquest noted a discrepancy between this comment and the fact that Mrs Hatch was deemed too unwell to be moved to the radiology department at 9.10am, some 25 minutes later.

12. Overall, the cluster of failings on 31 August/1 September brought into question the competence of the staff looking after Mrs Hatch on duty at the Spire Hospital that night. The Inquest was informed that such concerns had not been reported to the regulatory bodies of those involved, The RMO continues to practice at the Spire Hospital.

13. The Inquest was informed that Spire Healthcare Limited rely on agencies who supply clinical staff to assess their competence (whilst retaining a power of veto any individual put forward). Given the importance of having competent nurses and doctors on duty overnight further consideration should be given to the methods by which professional competence is assessed and staff from agencies are engaged.

14. Evidence taken from a consultant surgeon at the Inquest indicated that the failings at Spire Hospital contributed (more than minimally) to the death of Mrs Hatch on 18 October. This view dovetails with the medical opinion obtained by Spire Healthcare Limited themselves to the effect that this death was "avoidable".

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 30 August (to make allowance for the holiday season). 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 [redacted] (husband). I have also sent it to RMO Agency, NES Healthcare UK Ltd, 66 High Street Aylesbury WP20 1SE, Stonor Medical Ltd, 112 Green Street, Northampton, NN1 1SY and Mr S.P. L Dexter C/O St James University Hospital Leeds who may find it useful or of interest. 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	Dated 28 June 2023 Kevin McLoughlin, Senior Coroner