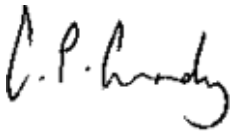
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Leeds Teaching hospitals** **2 York Hospital Legal trust**
1	**CORONER** I am Catherine CUNDY, Area Coroner for the coroner area of North Yorkshire and York
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 16 May 2022 an investigation was commenced into the death of Carole MCQUINN aged 66. The investigation concluded at the end of the inquest on 11 July 2023. The conclusion of the inquest was that the deceased died as a consequence of a recognised complication of necessary surgery to treat pancreatic cancer, namely a pulmonary embolism which was likely to have developed as a result of post-operative infection, inflammation and immobility.
4	**CIRCUMSTANCES OF THE DEATH** On the 21st of February 2022 the deceased underwent a distal pancreatectomy and splenectomy at St James's University Hospital, Leeds to treat a malignant pseudo papillary tumour. She subsequently developed leaking of fluid from the remnant pancreas which is a recognised complication of this surgery and for which an abdominal drain was sited. She had a prolonged in-patient admission, during which she required periods of intravenous antibiotic therapy to treat abdominal collections, drainage of a pleural effusion and nutritional support via naso-gastric feeding and total parenteral nutrition. Her abdominal drain was removed on the 11th of April 2022. She was discharged home on the evening of the 20th of April 2022 without a discharge note or medication, which were not supplied until the following day. No follow up appointment was booked for the deceased. On the 21st of April 2022 the site of her previous abdominal drain was leaking pus. A swab was taken of the site and booked in to St James's Hospital for testing on the 22nd of April 2022. The results of the swab were reported on the 26th of April 2022 but not reviewed by a member of the clinical team until the 3rd of May 2022 when oral antibiotics were commenced. On the evening of the 4th of May 2022 the deceased was found collapsed at home and was admitted to York Hospital by ambulance. She was treated for intra-abdominal sepsis and her observations stabilised, but she was found unresponsive in her hospital bed on the morning of the 7th of May 2022.
5	**CORONER'S CONCERNS** During the course of 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: (brief summary of matters of concern)

	In respect of concerns relating to St James's University Hospital, Leeds - 1. The deceased was discharged from hospital on the evening of 20th April 2022 with no discharge note, medications or follow-up appointment. I heard evidence that evening discharges are a cause for concern for the Trust itself, and that while consideration is being given to ensuring follow-up appointments are set on discharge, this is not yet currently in place. Trust staff were falsely reassured in this case that the deceased had this safety net in place when she did not. 2. Trust staff interacting with the deceased and her daughter regarding infection concerns arising in the post-discharge period between 21/4/22 and 3/5/22 made no records of the same. Nursing staff were shown photographs of the deceased's drain site, and issued stoma bags and a swab to her daughter for suspected infection, but did not flag this development to the treating team or make arrangements for the results of the swab to be reviewed. No clinical observations of the deceased were recorded when she attended the hospital on 3/5/22. The swab result did not come to anyone's attention or get reviewed until the deceased's daughter flagged the issue to staff on 3/5/22. These omissions led to missed opportunities for earlier assessment and treatment of the deceased. In respect of concerns relating to both St. James's University Hospital, Leeds and York Hospital - 3. The deceased had an emergency admission to York Hospital on 4/5/22 with suspected intra-abdominal sepsis. A York doctor was verbally tasked with communicating with the surgical team at Leeds to report back on a comparison of CT scans from both hospitals. No record of this contact - which was verbally reported in positive terms - was made by either hospital and no evidence could be provided as to who had spoken to whom and in what terms. Further, despite the lengthy and complex treatment the deceased had undergone in Leeds, and her attendance there the day prior to admission to York, no contact was made by the treating team at York with the treating team at Leeds, to allow for additional specialist input into the deceased's management and consideration of possible transfer of care.
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 September 07, 2023. 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] I have also sent it to **Department of Health & Social Care** 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: 19/07/2023**  **Catherine CUNDY** **Area Coroner for** **North Yorkshire and York**