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 Royal Stoke University Hospital**
1	**CORONER** I am Duncan RITCHIE, H M Assistant Coroner for the coroner area of Stoke-on-Trent and North Staffordshire
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 April 2022 I commenced an investigation into the death of Roy WALKLET aged 62. The investigation concluded at the end of the inquest on 03 April 2023. The conclusion of the inquest was that: Roy Walklet died on 9th April 2022 at the Royal Stoke University Hospital, Stoke-on-Trent of multiorgan failure caused by a massive gastroduodenal haemorrhage which was contributed to by the taking of ibuprofen. Mr Walklet had attended hospital on 12th March 2022 complaining of abdominal pain. Gallstones were identified and these were assumed to be the cause of the abdominal pain. An endoscopy test which could have been administered to check for an ulcer was not carried out at that stage. Mr Walklet was readmitted to hospital on 7th April 2022 suffering from a bleeding duodenal ulcer. Despite attempts to stem the bleeding he suffered multiple large bleeds which caused his death.
4	**CIRCUMSTANCES OF THE DEATH**
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) On 7th April 2022 the deceased Mr Walklet attended the Accident and Emergency Department of the Royal Stoke University Hospital suffering from a bleeding duodenal ulcer. A consultant gastroenterologist decided that a gastroscopy should be undertaken that same day to identify and treat the cause of the bleeding. The gastroenterologist felt that it was important for the gastroscopy to be undertaken without delay because there was potential for Mr Walklet to suffer another big bleed, which could be fatal. No gastroscopy took place on 7th April 2022. During the inquest I was told that this was because Mr Walklet had not been allocated a bed in the hospital and a gastroscopy would not take place until a bed had been allocated to him because a patient cannot be returned

	to the Accident and Emergency Department from the gastroscopy department. A gastroscopy eventually took place on 8th April 2022. Mr Walklet later suffered further bleeding from the duodenal ulcer which resulted in his death. The delay in undertaking the gastroscopy was not causative of Mr Walklet's death, but I was told that systems and procedures in the Hospital remain as they were at the time of Mr Walklet's death – i.e. that a stable patient with a gastric bleed who was being cared for in the Accident and Emergency Department could not have a gastroscopy until a bed for them became available in the Hospital. I was further told during the inquest that Mr Walklet was allocated a bed in the Hospital either late on 7th April 2022 or early on 8th April 2022 and that his care was allocated to a consultant gastroenterologist [redacted]. [redacted] should have seen Mr Walklet during his morning ward round but did not do so. [redacted] told me that he was not aware that Mr Walklet had been allocated to his list of patients. Mr Walklet's family believe that this error occurred because, whilst Mr Walklet had been allocated a bed on the ward, he actually remained in the Accident and Emergency department. As a result, Mr Walklet's condition and care was not reviewed by the consultant gastroenterologist until later that day. At the time Mr Walklet was still suffering from a bleeding duodenal ulcer from which he was to die later the same day.
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 June 21, 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 I have also sent it to 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: 15/05/2023**

	 **Duncan RITCHIE** **H M Assistant Coroner for** **Stoke-on-Trent and North Staffordshire**