REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **CHIEF EXECUTIVE SWANSEA BAY UNIVERSITY HEALTH BOARD** **1 TALBOT GATEWAY** **BAGLAN ENERGY PARK** **BAGLAN** **PORT TALBOT** **SA12 7BR**
1	**CORONER** I am **Aled Gruffydd**, Assistant Coroner, for the coroner area of SWANSEA NEATH & PORT TALBOT
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 the 20th August 2018 I commenced an investigation into the death of Shane Luke West. The investigation concluded at the end of the inquest on the 19th July 2023. The medical cause of death is 1a) multi organ failure 1b) carfdio respiratory arrest 1c) abdominal distention caused by faecal impaction 2 sotos syndrome, scoliosis The conclusion of the inquest as to how Mr West came to his death was a narrative conclusion and is as follows:- The deceased died from multi organ failure caused by cardio respiratory arrest due to increased pressure on the lungs from abdominal distention. The distension was caused by longstanding chronic constipation and fluid build up from his laxative treatment.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was Shane Luke West and he was pronounced dead on the 17th August 2018 at Morriston Hospital, Swansea. The cause of death was multi organ failure caused by cardio respiratory arrest due to increased pressure on the lungs from abdominal distention, which itself was caused by longstanding chronic constipation and fluid build up from his laxative treatment. Shane was admitted to Morriston Hospital on the 31st of July 2018 with chronic

	constipation and abdominal swelling. The treatment plan was conservative consisting of laxatives, enemas and colonic irrigation. Shane also had SOTOS syndrome and suffered from a learning disability. The learning disabilities team of the Health Board were involved to allow Shane to understand the treatment being offered. It was noted that the extent of the constipation on admission was causing significant abdominal distention the result of which meant that Shane's abdomen was pushing his diaphragm up into the chest cavity thereby restricting his lung function. Shane underwent regular examinations with varying results. On some occasions his abdomen felt distended, and on others it felt soft and non tender, suggesting improvement. On the 16th of August 2018 Shane deteriorated with respiratory compromise. Shane underwent a colectomy and ileostomy formation to decompress the abdomen to allow effective mechanical ventilation. Whilst this procedure provided temporary improvement, Shane eventually declined further and passed away on the 17th of August 2018.
5	**CORONER'S CONCERNS** During the course of the inquest it transpired that the condition of Shane's abdomen was changeable. Shane's learning disability also meant that he was reluctant to report whether he was in any discomfort thus hiding the true picture. The cause of the variable abdomen condition was due to the osmotic laxative treatment filling the abdomen with fluid thus making it distended. Shane was prescribed three sachets of laxative in the morning and three in the evening. On the 15th of August there also appeared to be an instruction for an additional 8 sachets to be administered. The nursing notes state that these were not given due to a maximum of 8 sachets being allowed over a 24 hour period, but the PRN prescription chart appear to be signed as being given. It was not clear therefore whether additional sachets were administered. In any event Professor Colin Johnson acting as an independent expert witness stated that it was not the dosage that was relevant but at what frequency it was given, whether all together or staggered over 24 hours. It was found at inquest that the conservative method of treating the constipation was appropriate and there was insufficient evidence to state that excessive laxatives had been administered, however the combination of a longstanding constipation caused the abdomen to become distended and lose muscle mass meaning that it was inefficient at moving material along the gastro-intestinal tract. A further consequence of longstanding distention was that it was continually pressing against the diaphragm causing Shane to suffer reduced lung function. The additional distention from the colon filling with fluid as a result of the laxative treatment placed additional and unrecoverable strain upon Shane's respiratory effort. I am concerned that in cases involving patients with learning disabilities (who commonly suffer from chronic constipation) the management of laxative treatment was not monitored closely enough to ensure a safe dose of laxatives. 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. There was a contradiction between the nursing notes and the prescription charts as to the amount of laxatives administered on the 15th and 16th of August 2018. 2. Shane was known to hide his physical condition on questioning due to his learning disabilities and saying what he thought people wanted to hear. As such it was difficult for staff to get a true picture of Shane's condition.. 3. Shane had ongoing respiratory compromise due to his abdominal distension pressing against his diaphragm therefore further distention posed a risk of further loss of respiratory function. 4. It was not clear whether medical professionals appreciated this risk and whether the administering of the laxatives ought to be staggered to allow Shane to receive the prescribed dose but not to the extent of overloading his already

	distended abdomen with fluid
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 13 September 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 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	**19 July 2023** ..... **[SIGNED BY CORONER]**