M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

15 November 2023 [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Health** **2. University Hospitals Bristol & Weston NHS Foundation Trust** **3. [redacted], daughter of the Deceased** **4. The Royal College of Physicians** **5. Chief Coroner**
1	**CORONER** I am Debbie Rookes, Assistant Coroner for the Coroner Area of Avon
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 13th December 2022 an investigation was commenced into the death of Calogero Di Blasi. The investigation concluded at the end of the inquest on 15th November 2023. The conclusion of the inquest was: **The deceased died as a result of a recognised complication of an investigative medical procedure in circumstances where underlying cirrhosis and resultant varices were unknown, and not recognised as a possibility, by the Endoscopist** The cause of death was recorded as: 1a) Haemorrhagic shock 1b) Perforated gastric varix (post surgical procedure) 1c) Portal hypertension due to chronic alcoholic liver disease

4	**CIRCUMSTANCES OF THE DEATH** On 10 August 2022, Calogero Di Blasi was referred by his GP to the Upper Gastro-intestinal team at the Bristol Royal Infirmary for possible stomach cancer. He underwent an endoscopy on 18 August 2022 where biopsies were taken. The results showed abnormal cells. On 15 September, Mr Di Blasi was referred by a GP to the Lower Gastro-intestinal team for possible bowel cancer and had a CT scan on 4 November 2022. The CT scan revealed cirrhosis with portal hypertension and gastric varices, which were new incidental findings. The Lower GI team had been made aware of the investigations ongoing by the Upper GI team, but the upper GI team were unaware of the Lower GI team's involvement. Both referrals were made on the 2 week cancer referral pathway. The CT Scan was reported on 14 November, and double reported on 16 November 2022. However, the referring clinician did not review the report until the day after Mr Di Blasi's death, on 2 December 2022. The incidental findings were not considered to be 'significant' by the Radiologists and were not therefore warrant an alert being sent to the referring clinician, leaving the report to be reviewed when they were able to. My investigation revealed that the timeframe for seeing patients on the cancer referral pathway is the date of the first appointment and there are no other target dates in respect of investigations of subsequent treatment. Mr Di Blasi underwent a further endoscopy on 30 November 2022. The Endoscopist was unaware of these incidental findings. A biopsy was taken from an area which looked abnormal but was actually a gastric varix. As a result of this, Mr Di Blasi suffered a massive bleed and despite maximal supportive measures, he died on 1 December 2022 at the Bristol Royal Infirmary, Upper Maudlin Street, Bristol, BS2 8HW.
5	**<u>CORONER'S CONCERNS</u>** 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) That one of the teams caring for Mr Di Blasi was completely unaware of the input from another specialty team, despite both referrals being made under the 2-week urgent referral pathway. The lack of communication between these teams meant that timely sharing of results did not occur. Even the very knowledge of the fact that a CT scan had taken place would have alerted the endoscopist to check those results, and it is likely that the second endoscopy would not have gone ahead. I understand this to be a national issue and is likely to apply to other investigations being carried out. (2) That the reporting timeframes on the 2-week urgent cancer pathway referral does not take into account timeframes for reporting investigative procedures or subsequent review by the referring clinicians. (3) The current training for Endoscopists for JAG certification requires the performance of 200 endoscopies. However, these tend to focus on the clinician's area of specialty

	and therefore there is a danger that lesion recognition will be limited and insufficient to ensure that endoscopists are able to recognise less frequently occurring lesions. With the need for an increasing number of endoscopists, action should be taken.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, the Secretary of State for Health, have the power to take such action, and that University Hospitals Bristol & Weston also have the power to take such action on a local level.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 10 January 2024. 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 [redacted] the daughter of the Deceased, and to the Chief Coroner. I have also sent a copy to The Royal College of Physicians who I understand are involved in the training of Endoscopists. 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	15th November 2023 Debbie Rookes Assistant Coroner

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The Coroner's Court, Old Weston Road, Flax Bourton, BS48 1UL