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) [redacted], CEO at Oxford University Hospitals NHS Foundation Trust.
1	**CORONER** I am HEIDI J CONNOR, Senior Coroner for Berkshire for the coroner area of Berkshire.
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. It is important to note the case of *R (Dr Siddiqui and Dr Paeprer-Rohricht) v Assistant Coroner for East London*. This case clarifies that the issuing and receipt of a Regulation 28 report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature and engages no civil or criminal right or obligation on the part of the recipient, other than the obligation to respond to the report in writing within 56 days. This has been reinforced recently in a report from the Independent Advisory Panel on Deaths in Custody with support from the Chief Coroner's Office.
3	**INVESTIGATION and INQUEST** I have on occasion referred to the deceased as Barney. This is in order to reflect the family's wishes. I conducted an inquest into the death of Francis Osborne Barnes, which concluded on 19th October 2023. I recorded a narrative conclusion as follows: Mr Barnes suffered a rare and significant complication of surgery. This was likely to have been the biggest factor contributing to Barney's death. If Barney had been transferred to Oxford University Hospital, consideration would have been given to thrombectomy and/or amputation. It is likely that, if amputation had been needed, this would have happened sooner. This delay contributed to Mr Barnes' death. His cause of death was: 1a) Multiple Organ Failure 1b) Femoral Artery Injury during Elective Inguinal Hernia Repair 2) Ischaemic Heart Disease
4	**CIRCUMSTANCES OF THE DEATH** Mr Barnes underwent an elective hernia repair surgery at Spire Dunedin Hospital in Reading, on 12th of March 2022. During this procedure, his external iliac artery was transected, resulting in a major haemorrhage. An off-duty vascular surgeon attended and was able to place a graft to bypass the damage to the artery. Mr Barnes was transferred to Royal Berkshire Hospital that afternoon.

	His vascular condition had deteriorated by the time he reached the Royal Berkshire Hospital, and this was evidenced in ultrasound and CT angiogram reports, available from around 10pm that night. Contact was made with the on-call consultant vascular surgeon at the John Radcliffe Hospital in Oxford. He advised that Mr Barnes should not be transferred to the John Radcliffe Hospital. It was clear that Mr Barnes' left leg was deteriorating, and that an amputation was likely to be needed. Most elective amputations are performed at a vascular centre, with the relevant expertise available there. Mr Barnes underwent amputation at the Royal Berkshire Hospital on the 14th of March, but died there on the 16th of March 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) The focus of my concerns relates to the approach of your Trust to learning from deaths. Although Mr Barnes was not treated at the John Radcliffe Hospital, I concluded that he should have been transferred there, and that the delay in carrying out vascular surgery there contributed to his death. The Oxford Trust has been involved in this investigation almost from the start, and other Interested Persons involved in the investigation have attempted to work with your Trust to investigate the circumstances of Mr Barnes' death. I have been assisted by investigation reports and statements from the Spire Dunedin Hospital, and Royal Berkshire Hospital. This, I am afraid, sits in stark contrast to the response and approach by the Oxford Trust. The Oxford Trust has carried out no investigation. They did not co-operate with the offer to conduct a joint investigation with Royal Berkshire Hospital. There is no recorded morbidity and mortality meeting minute, although we were told at inquest that the case was discussed. There is no recorded MDT meeting minute, although we were told at inquest that the case was discussed. There is no evidence of proposed changes beyond evidence in court during the inquest that "we are looking into this". Whilst I accept entirely that a knee-jerk response, even following a tragic death, is not appropriate, it is now some 18 months since Mr Barnes' death. Evidence from RBH and Spire Dunedin was consistent, namely that attempts to liaise with your trust and learn from this event jointly have been universally ignored. It was also difficult for my office to obtain evidence for the inquest. We were provided with a joint statement, from three consultant vascular surgeons (only two of whom were clinically involved). It transpired that this statement was written by a clinical governance manager, and each of the witnesses who gave evidence was careful to tell the court that they did not agree with the wording of that statement. We subsequently received a statement from the consultant vascular surgeon in this case on the 29th of September, and from the clinical lead of vascular surgery some 5 days before the inquest started. We were also informed 11 days before the inquest started that the key vascular surgery witness would be on holiday abroad. This witness was summonsed in May 2023. He ultimately gave evidence by video link, but this was difficult technically, and arrangements would have been made for him to attend in person, had we been made aware of this holiday arrangement, even aside from the fact that he had been formally summonsed.

	Multiple attempts have been made by the other Interested Persons in this case (notably Royal Berkshire Hospital and Spire Dunedin Hospital) to discuss the issues arising, but each of these offers has been ignored. The key clinical issues in this respect have been clarification of vascular surgery pathways, and use of an OARS system (or similar). No records were made by the vascular surgery consultant involved, despite being consulted several times about the same patient in a short space of time, and the fact that there was a clinical difference of opinion about where the patient should best be managed. We heard no evidence of a reason for the failure to engage with processes specifically aimed at learning from deaths – whether resourcing or any other reason. The matters of concern can be summarised as follows: 1. Clarification of vascular surgery pathways - i.e. working with others in the Thames Valley network to consider how patients should be efficiently referred to the vascular team, wherever that patient is physically based (including in the private sector). 2. Consideration of an electronic referral system (such as OARS). I note that OARS was set up by the Oxford Trust itself, and is already in operation in a neurosurgery context, and indeed even for some vascular surgery patients. 3. Consideration of how the Oxford Trust responds to and learns from deaths.
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 Friday 22nd December. 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 Mr Barnes' family. I have also sent this report to the following recipients, who have an interest in this matter: 1. Royal Berkshire Hospitals NHS Trust (via their legal representative). 2. Spire Dunedin Hospital (via their legal representative). 3. The senior coroner for Oxfordshire, Mr Darren Salter. 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: 27th October 2023**

	 **HEIDI J CONNOR** **Senior Coroner for Berkshire for Berkshire**