Regulation 28: Prevention of Future Deaths report

Jennifer Ruth Whinney (died 2 November 2022)

	THIS REPORT IS BEING SENT TO: **1. Queens Hospital**
1	**CORONER** I am: Melanie Sarah Lee Assistant Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 17 November 2022 an investigation was commenced into the death of Jennifer Ruth Whinney aged 68. The investigation concluded at the end of the inquest on 17 November 2023. I made a determination at inquest that Jennifer died of multi-organ failure following septicaemia from infective PICC lines and following successful surgery to repair a bowel fistula. The medical cause of death was 1a. multi-organ failure, 1b. septicaemia, 1c. recurrent line sepsis, enterocutaneous fistula repair, 2. ischaemic heart disease, hypertensive heart disease.
4	**CIRCUMSTANCES OF THE DEATH** In 2017 Jennifer underwent an emergency resection of her left colon and a stoma formation at Queens Hospital due to an ischaemic bowel. A small area of the wound failed to heal and she was reviewed at Queens Hospital on several occasions in 2021 and 2022. She then presented to Queens Hospital as an emergency on 19 April 2022 when a large wound had opened up and was discharging fluid and bowel contents. A scan revealed a fistula. She was managed conservatively to see if the fistula would heal by itself and this included inserting a PICC line to administer

	nutrition so that the bowel could be rested. She had no problems with her PICC line whilst at Queens Hospital. She referred to the Colorectal Specialist Team at the Royal London Hospital and seen in late May. At her initial appointment, her medical records were not sent with her and the surgeon reviewing her only had a referral letter. Jennifer was admitted to the Royal London Hospital on 12 July 2022 in preparation for surgery. She developed numerous infections to her PICC lines which led to sepsis. Jennifer underwent surgery to repair her bowel on 7 October 2022. The operation was uneventful and she recovered well. She then developed a further infection to her PICC line and died from multi-organ failure caused by septicaemia.
5	**CORONER'S CONCERNS** 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. Jennifer was referred to the colorectal specialist team at the Royal London Hospital and seen in late May. The witnesses were unable to give me the exact date of the appointment. Jennifer's notes were not sent to the appointment with her. I heard that patient records at Queens Hospital are not electronic. Ward staff compile the notes which are sent physically with the patient if they attend any external appointment. I heard that no one person has responsibility for ensuring that the notes are sent. Jennifer was articulate and understood her health problems well and so was able to provide the colorectal surgeon with her medical background. I am concerned that another patient may not be able to provide such a full and accurate history and that critical information may not be passed on.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that your organisation has 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 22 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 the following interested persons: • [redacted] (Jennifer's daughter) • Royal London Hospital And to: • CQC • HHJ Thomas Teague QC, the Chief Coroner of England & Wales 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 other 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.
9	**DATE** **SIGNED BY ASSISTANT CORONER** 27 November 2023