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:** **Chief Executive, Kettering General Hospitals NHS Trust via their legal representatives.**
1	**CORONER** I am Miss Isobel Thistlethwaite His Majesty's Assistant Coroner for the coroner area of Leicester City and South Leicestershire
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 21 October 2021 I commenced an investigation into the death of Lindy Lyanne ASTON aged 67. The investigation concluded at the end of the inquest which took place on 9, 10, 11 and 24 November 2023. The conclusion of the inquest was that: <u>Narrative Conclusion</u> *Mrs Aston was a 67 year old female who appropriately underwent a successful total gastrectomy for stomach cancer at the University Hospitals of Leicester NHS Trust on 29 September 2021. Post operatively, whilst at home on 15 October 2021, Mrs Aston suffered a ruptured spleen which requires surgical treatment. Mrs Aston was taken to Kettering General Hospital where, for reasons we don't understand, surgery did not take place, instead she was kept on the ICU and transferred to the Leicester Royal Infirmary on 16 October 2021 where she underwent surgery but died on 18 October 2021 at 12:40hrs.* The cause of death was established as: I a Multi Organ Failure I b Ruptured spleen following a total gastrectomy I c II
4	**CIRCUMSTANCES OF THE DEATH** Mrs Aston was a 67 year old female who underwent a total gastrectomy for stomach cancer at the University Hospitals of Leicester NHS Trust on 29 September 2021. On 15 October 2021 Mrs Aston began to experience pain in her abdomen, this became progressively worse. EMAS attended and Mrs Aston was transported by emergency ambulance to Kettering General

	Hospital. Mrs Aston was initially treated in the Accident and Emergency Department at Kettering General Hospital before being placed on the ICU. She remained at Kettering for almost 24 hours until she was transferred to the University Hospitals of Leicester NHS Trust. On 16 October 2021 Mrs Aston arrived at the Leicester Royal Infirmary at 16:00hrs, she was taken to theatre at 16:10hrs and underwent a splenectomy operation. Mrs Aston remained very unwell post-operatively and died on the 18 October 2021 at 12:40hrs.
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: **<u>Pre-amble</u>** The inquest heard evidence to confirm that Mrs Aston appropriately underwent a total gastrectomy at the University Hospitals of Leicester NHS Trust on 29 September 2021. There are no concerns about the surgery, care provided at or discharge from the University Hospitals of Leicester NHS Trust. The inquest heard that on 15 October 2021, whilst at her home, Mrs Aston began to experience pain in her abdomen. The pain became progressively worse and 999 was called. East Midlands Ambulance Service attended. The court heard evidence that, on the balance of probabilities, the worsening pain was likely to be the start of a splenic rupture. On 15 October 2021 at 15:31hrs Mrs Aston arrived at Kettering General Hospital, having been transported there by emergency ambulance. The inquest heard that Mrs Aston was "*in extremis"* on arrival at Kettering General Hospital which is perhaps the most unwell anyone can be. Mrs Aston needed life-saving surgery to stop her bleeding internally. The inquest heard that Mrs Aston should have been categorised as a high-risk "life or limb" Category 1 patient when she arrived at Kettering. As a Category 1 patient Mrs Aston should have been operated on within an hour of her arrival to stop the bleeding, however, instead of undergoing surgery she was placed on the ICU at Kettering where she remained for almost 24 hours, until the afternoon of 16 October 2023, when she was transferred to the University Hospitals of Leicester NHS Trust. On 16 October 2021 at 16:00hrs Mrs Aston arrived at the Leicester Royal Infirmary. Ten minutes later, at 16:10hrs Mrs Aston was in theatre undergoing a splenectomy. Mrs Aston remained very unwell post-operatively and on 18 October 2021, after discussions with her family, the decision to palliate her was taken, Mrs Aston died at 12:40hrs at the Leicester Royal Infirmary. <u>The decision making at Kettering</u>

The inquest heard evidence to confirm that the decision making as to whether a patient is operated on or not is entirely the remit of the surgical team at Kettering General Hospitals NHS Trust.

The evidence around why the decision not to operate on Mrs Aston at Kettering was taken that night is confused. Lack of theatre capacity at Kettering was often cited as one of the reasons and the possible complexity of the surgery required being cited as another.

The On Call Consultant Surgeon who made the decisions relating to Mrs Aston at Kettering General Hospital NHS Trust on 15 and 16 October 2021 did not attend the inquest as he now lives abroad so was unable to provide clarity around his decision making.

The inquest heard the following evidence about the splenectomy surgery that Mrs Aston needed that night:

- It is possible to undertake a splenectomy at Kettering General Hospital;
- Undertaking a splenectomy was something that the On Call General Surgeon at Kettering General Hospital that night was capable of (further, even if the surgeon had reservations about the possible complexity of the surgery a highly experienced surgeon from the University Hospitals of Leicester NHS Trust had offered to drive to Kettering to perform the surgery or assist with it, unfortunately despite his repeated offers of assistance he was told there was no theatre space available at Kettering);
- No emergency surgeries were undertaken at Kettering General Hospital on the night in question and therefore there was theatre capacity at Kettering General Hospital on 15 October 2021 into 16 October 2021 for Mrs Aston to have had her surgery.

Concerns

1) **Surgical decision making** - I am concerned about the fact that the decision about whether to operate on a patient or not lies with one single surgeon with seemingly no checks or balances around their decision making. It concerns me that all of the witnesses at the inquest agreed that Mrs Aston needed immediate life-saving surgery when she presented to Kettering General Hospital yet there was no challenge to the decisions made by the on-call surgeon not to operate.

2) **Trust investigations into Mrs Aston's care** – I am gravely concerned about the seeming inadequacies in the investigation and/or incident reporting processes at Kettering General Hospitals NHS Trust. The inquest was advised that a DATIX incident report was not raised in relation to Mrs Aston's care or death.

   I am concerned about the fact that Kettering General Hospitals NHS Trust did not look into the care provided to Mrs Aston until such time as the University Hospitals of Leicester NHS Trust contacted them about the inquest.

   I am further concerned about the fact that when Kettering General Hospitals NHS Trust did look into the care provided to Mrs Aston they did so on the assumption that the clinical decision making had been appropriate, this makes the exploration of the care provided somewhat otiose.

   The Trust's exploration of the care provided to Mrs Aston failed to identify the fact

	that surgery should have been undertaken within an hour and the fact that, despite some of the assertions to the contrary, it would have been appropriate and possible to undertake that life-saving surgery at Kettering General Hospital. The failure to properly investigate led to the wholly untenable situation where the Kettering General Hospital NHS Trust were alerted for the first time to the questionable clinical decision making and the potential errors in care at the inquest, which took place some 24 months after death (due to witness availability). I am concerned that the lack of robust critical analysis and investigation of the clinical decision making and care provided to Mrs Aston at Kettering General Hospitals NHS Trust before her death has caused a delay to, and led to missed opportunities to learn lessons that are vital to patient safety. My concerns relating to the inadequacy of the Trust's exploration of the care provided to Mrs Aston and the risks related to that go far beyond just the care provided by the Surgical Team at Kettering General Hospital NHS Trust. The risks have the ability to prevent learning, therefore negatively impact upon patient safety, across the entire Trust.
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 1st February 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 Chief Coroner and to the following Interested Persons **The Aston Family** **The University Hospitals of Leicester NHS Trust** I have also sent it to **The CQC** [redacted] 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: 08/12/2023**  **Miss I THISTLETHWAITE** **His Majesty's Assistant Coroner for Leicester City and South Leicestershire**