Regulation 28: Prevention of Future Deaths report

Sarah CHAPPELL (died 23.06.23)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Medical Director** **Medicine Board** **University College London Hospitals NHS Trust (UCLH)** **University College Hospital** **2nd Floor Central** **250 Euston Road** **London NW1 2PG**
1	**CORONER** I am: Coroner ME Hassell Senior 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 4 July 2023 I commenced an investigation into the death of Sarah Chappell, aged 43 years. The investigation concluded at the end of the inquest earlier today. I made a determination as follows. Sarah Chappell died from the recognised long term complications of necessary medical treatment. However, in addition to these, during her last admission to hospital her care was suboptimal because the appropriate team did not take charge. Placement of her nasogastric tube was not managed appropriately over her final weeks. If it had been, she would have survived this episode. I recorded the medical cause of death as:

	1a aspiration of gastric contents 1b adhesional small bowel obstruction 1c status post multiple complex surgeries flowing from an Arnold Chiari type II malformation with spina bifida & complicating hydrocephalus 2 metastatic adenocarcinoma of the rectum
4	**CIRCUMSTANCES OF THE DEATH** Sarah Chappell was transferred to University College London Hospital from the Princess Royal University Hospital in Orpington on 31 May 2023. She remained at UCLH until her death on 23 June 2023.
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. 1. There was a ten day delay in Ms Chappell's transfer from the Princess Royal Hospital to UCLH. I was told that this might have been because of a lack of beds, but it might also have been because of confusion about which UCLH site was the accepting surgeon's preferred destination, a confusion that was understood at the time by the Princess Royal to be a rejection of the transfer. 2. From at least 16 June 2023, the consultant urology surgeon in charge of Ms Chappell's care was very firmly of the view that he was not the best clinician to fulfil this role. He had long since correctly determined that she had not sustained a ruptured bladder, and thus considered that her care belonged with the gastroenterologists or the general surgeons. Despite the agreement on 16 June of the gastroenterology clinical director that Ms Chappell's care should be led by the gastroenterologists, they had not taken over her care by the time of her death, and there had not even been a conversation between the gastroenterology and general surgery consultants about the transfer of care. 3. There was a frequent misunderstanding among the medical staff that Ms Chappell's issues were all chronic. Her acute situation was often not properly handed over or understood by her consultants.

	4. Whilst at UCLH, the pain relief offered to Ms Chappell (principally simply paracetamol) was completely inadequate. At night, her buzzer was taken away from her and her door was shut. 5. The management of the nasogastric tube that was crucial in attempting to avoid a fatal aspiration was inappropriate. The tube in situ that was operating effectively was removed approximately ten days before her death. Her abdomen became extremely distended. A further tube placement was not attempted until the day before she died. When this proved beyond the nurses' skillset, a doctor was not called to assist until the following afternoon. By then, two experienced doctors were unable to insert a tube and, as they were attending her (with her mother present), their patient suffered a massive aspiration and died shortly afterwards. I was told at inquest that if the nasogastric tube had been passed at an earlier point, this would have been done successfully and the fatal cardiac arrest would have been avoided. 6. This death occurred almost six months ago, but no proper trust investigation has taken place, no change in policies or procedures has been agreed, and the systems at UCLH remain largely what they were on the day that Sarah Chappell died.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 5 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 following.

	• [redacted], Sarah Chappell's parents • [redacted], UCLH urology surgeon • [redacted], UCLH colorectal surgeon • [redacted], UCLH general and endocrine surgeon • [redacted], UCLH neurogastroenterologist • Princess Royal University Hospital • 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 SENIOR CORONER** 07.12.23 *ME Hassell*