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:** [redacted], Acting Chief Executive Officer, James Cook University Hospital, Marton Road, Middlesbrough TS4 3BW [redacted]
1	**CORONER** I am Clare Bailey Senior Coroner for the Coroner's area of Teesside & Hartlepool
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** Kate Elizabeth O'Donnell died at James Cook University Hospital, Middlesbrough on 23.03.22. I commenced an investigation into her death. On 17th and 18th January 2024, I held the inquest into her passing. The Medical Cause of her death is: 1a. Multi organ failure 1b. Systemic sepsis II. Hypopituitarism following chemoradiation for intracranial germ cell tumour. I left a narrative conclusion as follows- Kate Elizabeth O'Donnell underwent surgery at James Cook University Hospital on 16.03.22. She was discharged home on 17.03.22. She developed sepsis from the surgery and died at James Cook University Hospital on 23.03.22. The sepsis originated in her gut. The failure to administer prophylactic anti-biotics for the gastro-intestinal surgery contributed to her death.
4	**CIRCUMSTANCES OF THE DEATH** Miss O'Donnell's past medical history included a Germ Cell brain tumour which reoccurred at ages 4,7 & 9. She was treated with chemotherapy and radiotherapy. Aged 9 she received high dose chemotherapy and was consequently paralysed from just below the waist. She endured resulting chronic nerve pain/damage and was prescribed high daily doses of pain relief medications. Miss O'Donnell was doubly incontinent. Treatment moved from intermittent catheterisation to a suprapubic catheter.

Age 11 she underwent an ACE procedure. This was used for a few years until it was changed to a colostomy. Miss O'Donnell sustained regular infections from the redundant ACE. The infections had a significant impact on her overall health and exacerbated her pain.

It was therefore determined that the ace stoma would be excised.
This procedure, along with a cystoscopy, bladder washout & injection of 200 units of Botox took place on 16.03.22. Miss O'Donnell and her family encountered several problems in the immediate run up to the operation, to include the hospital notes being mislaid, not meeting the anaesthetist ahead of the operation, uncertainty about the colorectal surgeon's involvement, the possibility that the ACE stoma would not be reversed and subsequent confirmation that it would be and on the day of the procedure apparent uncertainty from the urologist as to how the operation would proceed. I accepted that all these points caused the family concern and frustration. I found that the operation was not well planned.

On 11 March 2022 Miss O'Donnell attended the hospital and gave a urine sample. The results showed a resistance to Ciprofloxacin. The consultant gave evidence that he checked the results on the morning of the operation by consulting WebIce. An audit of WebIce was provided which showed that no one accessed WebIce on the day of the operation. I held that the Consultant urologist was not aware of the results of the urine sample before the operation. I determined that on the day of the operation he acted in accordance with his usual practice, rather than to tailor the anti-biotics to the urine test results. He administered prophylactic Gentamicin at the start of the procedure and provided Ciprofloxacin post procedure both for the urological aspects of the surgery. The latter was ineffective as she was resistant to that medication. I found that the Consultant overlooked the provision of prophylactic anti biotics for the gastro-intestinal operation.

I determined that the surgeon was unaware of the classification of surgeries and didn't know that surgery could be clean-contaminated. He did not know of the SIGN guidelines and that prophylactic anti biotics were highly recommended for that type of gastro-intestinal surgery. I held that a member of the colorectal team should have assisted with the operation.

Post surgery Miss O'Donnell vomited a large amount on a single occasion and was suffering from ongoing pain. Mrs O'Donnell was her daughter's full-time Carer and was an expert in caring for her daughter. I accepted her evidence that on a good day Kate's pain would be 7/10. I found that the pain charts detailing Kate's pain post -surgery were grossly understated. Nurses were informed of her pain but took no action to alleviate the same. The episode of vomiting was not recorded in the notes.

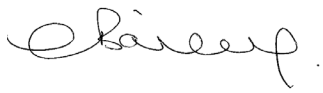
I accepted that generally one-off vomiting and pain may not be enough to prevent discharge with most patients. However, Kate's vulnerabilities, comorbidities, and extensive involvement with the medical teams, should have ensured extra vigilance and recognition should have been given to her reactions, with medical attention being sought.

I determined that Kate was not physically assessed by a doctor prior to discharge.
Kate should not have been discharged without a thorough further medical assessment which had been prompted by accurate medical recordings. The family should not have left hospital without information on sepsis or what to do if Kate was to deteriorate.

In the days following discharge Kate vomited daily, most days suffering several bouts of vomiting. I accepted that the Ciprofloxacin probably supressed the sepsis that Kate was battling post-surgery.

Kate deteriorated and ultimately was taken to James Cook University Hospital on the morning of 23.03.22. She passed away shortly after her arrival.

	The Trust undertook an internal investigation and produced a Patient Safety Incident Investigation Report. This report was presented at the inquest by one of the Trust's Clinical Directors. He confirmed that the hospital did not investigate the issue of prescription of prophylactic antibiotics for the gastrointestinal surgery. He accepted that more should have been done to check Kate's sodium before she was discharged and that a nurse should have contacted a doctor about the pain scores (even on the understated values). I instructed an independent expert to assist in determining whether any provision or omission in care contributed to Kate's death. I was informed that the provision of Ciprofloxacin contributed to Kate's death as it suppressed the sepsis she was fighting. I was also told that the omission of a prophylactic antibiotic for the gastrointestinal surgery contributed to Kate's death. The expert confirmed that the sepsis from which Kate died developed directly from the surgery undertaken on 16.03.22 and that the sepsis originated in her gut.
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, 1. Planning for the operation was poor and resulted in the non-attendance of a colorectal surgeon at the surgery. 2. The consultant urologist did not know the results of pre-surgery urine test results and subsequently prescribed incorrect prophylactic antibiotics post urology surgery. 3. The consultant urologist was not aware of the classification of surgeries and didn't know that surgery could be clean-contaminated. He did not know of the SIGN guidelines and that prophylactic antibiotics were highly recommended for this type of gastro-intestinal surgery. 4. The consultant urologist overlooked the provision of prophylactic antibiotics for the gastro-intestinal surgery. 5. There was insufficient vigilance and recognition given to Kate's post-operative presentation, considering Kate's vulnerabilities, comorbidities, and extensive past involvement with the medical teams. 6. Kate was not physically assessed by a doctor prior to discharge. 7. The nursing notes did not include relevant information, to include Kate vomiting and that she was in pain. The pain scores were under stated. 8. Case notes included details of a meeting on 14.03.22 which did not taken place and was a telephone call. 9. The nursing team did not respond to repeated statements that Kate was in pain-she was not offered pain relief nor was medical help sought. 10. The family were not provided with information upon discharge as to what signs to look out for and what steps to take if Kate was to deteriorate.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [redacted] Acting Chief Executive Officer, James Cook University Hospital, Marton Road, Middlesbrough TS4 3BW (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 March 16, 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] 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: 22 January 2024**  **Clare Bailey** **Senior Coroner for Teesside & Hartlepool Coroner's Service**