Regulation 28: Prevention of Future Deaths report

Alan Andrew SOANE (died 26 June 2023)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted]** **NHS England** **133-135 Waterloo Road** **London** **SE1 8UG** **2. The Rt Hon Victoria Atkins MP** **Secretary of State for Health and Social Care** **39 Victoria Street** **London** **SW1H 0EU**
1	**CORONER** I am Ian Potter, assistant coroner, for the coroner area of Inner North London.
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 30 June 2023, an investigation was commenced into the death of ALAN ANDREW SOANE, then aged 84 years. The investigation concluded at the end of an inquest, heard by me, on 18 March 2024. The inquest concluded with a short narrative conclusion. The medical cause of death was: 1a intra abdominal sepsis and haemorrhagic shock 1b anastomotic leak following pancreatico-duodenectomy (performed 05/06/2023).
4	**CIRCUMSTANCES OF DEATH** Mr Soane was an otherwise fit and healthy 84 year old man. The circumstances of his death are recorded in the short narrative conclusion that I reached at the inquest, which was:

	"Mr Soane underwent an endoscopy and biopsies at his local hospital in Essex in March 2023, which included a duodenal biopsy. The result of the duodenal biopsy was reported as, 'Findings are highly suspicious for malignancy, most likely differentiated adenocarcinoma. Immunohistochemical study is requested, and a supplementary report will follow.' As a result, Mr Soane was referred to the Royal London Hospital on a cancer pathway. A multidisciplinary team (MDT) meeting at the Royal London Hospital on 3 May 2023, concluded, among other things, 'diagnosis: duodenal cancer (biopsy-proven).' That meeting was undertaken without further biopsy or tests being undertaken. It transpires that the conclusion was not correct. Based on the outcome of the MDT meeting, Mr Soane was given a cancer diagnosis and agreed to complex surgery known as a 'Whipples' procedure, which was undertaken on 5 June 2023. Mr Soane died on 26 June 2023, as a direct result of known complications of the Whipples procedure. Mr Soane's surgeon would not have offered him the Whipples surgery had it not been for the incorrect diagnosis provided."
5	**<u>CORONER'S CONCERN</u>** During the course of the inquest the evidence 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 **MATTER OF CONCERN** is as follows:- (1) The NHS Trust in this case was, and remains, unable to provide for the presence of a Consultant Histopathologist at Hepato-pancreato-biliary MDT meetings. It was acknowledged that this was a factor that led to Mr Soane being given a cancer diagnosis that was incorrect. This inability to provide a Consultant Histopathologist is something that has been on the Trust's risk register for over five years and recruitment exercises have taken place, to no avail. I was told in evidence that this is attributed to the fact that nationally, 25% of Consultant Histopathologist roles remain vacant; in short, there is a national shortage of Consultant Histopathologists. The concern here is that a national shortage of Consultant Histopathologists puts a widespread proportion of the patient population at a significant risk. I was reassured that the individual NHS Trust had made continued efforts to reduce the risks they identified, by attempting to recruit to the vacant post. However, I was not reassured that action has been taken at a national level to address the shortage generally.
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 the report, namely by 28 May 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: (a) [redacted] (Mr Soane's wife) (b) [redacted], Chief Executive, Royal College of Pathologists, 6 Alie Street, London, E1 8QT I am also under a duty to send the Chief Coroner a copy of your response. 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 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	**Ian Potter** **HM Assistant Coroner, Inner North London** **2 April 2024**