	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) University Hospitals Birmingham NHS Foundation Trust** **2) NHS Birmingham and Solihull Integrated Care Board** **3) NHS England** **4) Ms Victoria Atkins - Secretary of State for Health and Social Care**
1	**CORONER** I am Mr Adam Hodson, Assistant Coroner for Birmingham and Solihull
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 14 December 2023 I commenced an investigation into the death of Ronald Henry SPENCER. The investigation concluded at the end of the inquest. The conclusion of the inquest was that he died from a recognised complication of a medical procedure
4	**CIRCUMSTANCES OF THE DEATH** **On 13 November 2023, Ronald had an oesophageal stent placed at the Queen Elizabeth Hospital to treat a symptomatic and reoccurring benign oesophageal stricture. He previously suffered an oesophageal perforation in March 2023 following dilatation procedure, but this had healed. Following the stent procedure, he subsequently became ill with a suspected bowel perforation caused by the stent migrating from his oesophagus into the mid jejunum, which is a recognised risk. He underwent laparotomy on 27 November where the stent was removed and the bowel repaired. Initially, he recovered well but began to deteriorate on 1 December, and he sadly died at 07:48 on 2 December 2023.** Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Gastro-intestinal ischaemia** **1b Oesophageal stent migration to small bowel (operated)** **1c** **II Oesophageal stricture, Iatrogenic - Presented with this 3/2023 to Sandwell hospital due to dysphagia and impassable scope ; Atrial Fibrillation**
5	**<u>CORONER'S CONCERNS</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 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. I heard evidence that there were significant staffing issues during the Ronald's period of in-patient care that caused delays to his treatment. Whilst there was no direct evidence at the

	inquest that these delays caused or contributed to death, any delays in patients receiving medical care due to a lack of staff clearly presents a risk of future deaths occurring. 2. It is recognised that the reasons for delay can be multifactorial, with so called "winter pressures" causing an influx of ill patients and heightened staff absences. "Winter pressures" are now a regular annual event and put significant strain on the NHS. There can be no doubt that patients have died, and will continue to die, from avoidable deaths due to delays caused by these staffing inadequacies. 3. It is understood that the matter of staffing issues is not solely isolated to University Hospitals Birmingham NHS Foundation Trust, hence this report being sent to those organisations involved in its impact across the Health Board area. 4. The challenges are also national in nature. They are too big for a single doctor, nurse or paramedic to fix. They are too big for the hospital Trust to fix on its own, hence this report is also being sent to NHS England and the current Secretary of State for Health and Social Care in order for a cohesive and national approach to be co-ordinated and implemented. 5. I remain significantly concerned not only that delays are continuing and that deaths will continue to occur into the future, but also that there is inadequate cohesive forward thinking or planning either in relation short term pressures (eg. "winter pressures") or with a view to finding longer term solutions. 6. It is for you and your organisation(s) to take the action that is required to resolve the issues and to prevent future patients from dying avoidable deaths. It is not for me as Coroner to make recommendations on how you do that, therefore I leave matters in your hands.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 19 June 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 1) The family of Ronald Spencer. I have also sent it to the Medical Examiner who may find it useful or of interest. 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 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	**23 April 2024**

	Signature:  **Adam Hodson** **Assistant Coroner for Birmingham and Solihull**