MR G IRVINE
SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted], **Chief Executive Officer, Barts Health NHS Foundation Trust** [redacted] • **RT Honorable Stephen Barclay, Secretary of State for Health & Social Care** [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 7th December 2022 this Court commenced an investigation into the death of Elvon Paul Randolph Morton aged 38 years. The investigation concluded at the end of the inquest on 9th May 2024. The conclusion of the inquest was a narrative conclusion; *"Elvon Paul Randolph Morton died in hospital on 7th December 2022 whilst awaiting a CT scan under sedation. His death was caused by the combined effect of septic shock, oxycodone - administered for pain relief, and lorazepam - used as a sedative."* Mr Morton's's medical cause of death was determined as;

	1a Septic shock (treated) II Chronic Kidney Disease, Hypertensive and Ischaemic Heart Disease
4	**CIRCUMSTANCES OF THE DEATH** Elvon Morton was a 38-year-old black man with extensive co-morbidity, including hypertension, kidney disease, Class 3 Obesity and angina. Mr Morton previously presented to hospital on four occasions in four years with upper right abdominal pain diagnosed as gall stones. On 6/12/22 Mr Morton called 999, he experienced upper right abdominal pain, vomiting, diarrhoea, dizzy spells and shortness of breath. He was taken to hospital by ambulance. Mr Morton had elevated inflammatory markers, tachycardia, tachypnoea, low blood pressure, acidosis and high lactate levels. Elvon was profoundly dehydrated; creatinine levels indicated an acute kidney injury. Elvon reported severe pain abdomen guarding was observed. Differential, queried diagnoses of perforated gall bladder & ischaemic bowel were arrived at. The on-call surgical and ICU team were called upon to assist. Treatment commenced of; fluid resuscitation, wide spectrum anti-biotics pain relief (paracetamol and oxycodone). Elvon was catheterised. An abdominal CT scan (without contrast - for fear of renal toxicity) demonstrated no clear abdominal cause for his symptoms, pulmonary atelectasis and a pleural effusion were observed. Elvon's respiratory function deteriorated, air sounds in the base of his lungs were diminished, he was started on oxygen therapy. Elevated blood troponin levels and concern regarding cardiac output meant serial ECGs were ordered. A further CT scan, this time utilising contrast was arranged. Mr Morton continued to deteriorate, his metabolic acidosis becoming more profound. Mr Morton became agitated and began to take steps to self-discharge. A decision was made that he did not have capacity and a best-interests decision was made to sedate him to facilitate a CT scan and further treatment. A second dose of oxycodone was administered to relieve pain and 4 mgs of Lorazepam were administered as sedation. Mr Morton was taken to the CT suite where it was observed that his oxygen saturations became erratic, it was noted that he had gone into cardiac arrest. CPR began, a crash team was called, advanced life support continued for over an hour before death was declared. The inquest determined that the combined effects of oxycodone and lorazepam upon Mr Morton's background co-morbidity and recent metabolic illness played a contributary factor on his cause of death. It was accepted by the trust that the safer course for Elvon would have been to anaesthetise and intubate him at an earlier stage in treatment.
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 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. –

	1. Documentation of key stages in Mr Morton's care was poor or non-existent. Critical decisions on; mental capacity, best interests, the choice of sedation, the amount of drug administered, the method of administration and the timing of administration were not clearly recorded. In multi-clinician treatment contemporary documentation is essential to preserve patient safety. In this case the lack of clear documentation meant that some clinicians were unaware that Elvon was sedated, whilst others were ignorant of the fact that he had declined treatment. 2. Witnesses blamed poor documentation on workload, specifically an influx of acute patients into the resuscitation bays. Despite this, no evidence was presented that any attempt was made to mitigate this pressure by, escalating the matter to the site manager, nor did the on-call ED consultant find it necessary to come in to the unit. These actions tend towards a "coping culture" inconsistent with patient safety. 3. The decision to sedate Mr Morton was flawed. The lack of contemporary documentation impeded an effective coronial investigation and review of that clinical decision. In the absence of clear and reasoned evidence of decision making, weight must be attached to evidence heard that Elvon's; size, sex and race triggered a heightened response by hospital staff to his agitation, leading to security officers being called. It was in this febrile atmosphere that the decision to utilise rapid tranquilisation, a simpler and faster process than anaesthesia and intubation, was made. 4. A failure in governance at the Trust meant that this case was not identified as a serious incident. This omission gives rise to a concern that future deaths may follow due to an inability on the part of the trust to identify, reflect upon, and remediate sub-optimal practice Elvon's relative youth, the unexpected nature of his death, the poor standard of documentation, the effect of patient acuity on the ability of staff to comply with regulatory duties and the Trust's acceptance (in Feb 2023) that intubation should have been undertaken earlier, should have resulted in this matter being properly reviewed. In this case the trust's Datix incident reporting system, morbidity and mortality meeting process and SIRMAP procedure were inadequate. Each structure was siloed from the other, leading to inconsistent findings. Additionally, despite preparing for an inquest, neither the Trust's legal team nor external lawyers seemed capable of identifying to the trust the absence of meaningful evidence of investigation, reflection and remediation of practice that was undoubtedly required in this case.
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 **16th July 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 family of Mr Morton, the Care Quality Commission and to the local Director of Public Health 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 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] 13th May 2024 [SIGNED BY CORONER]**