REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Officer East Suffolk & North Essex NHS Foundation Trust** **2. NHS England**
1	**CORONER** I am Sonia Hayes, Area Coroner, for the coroner area of Essex
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 22 March 2022 an investigation was commenced into the death of Chloe HUNT, aged 21 years. Chloe Hunt died on the 15 March 2022. The investigation concluded at the inquest on 29 May 2024. The conclusion of the inquest was Narrative: *'Chloe's death was avoidable. Had the pens in the stomach and duodenum been removed earlier, Chloe would not have died when she did.'* The medical cause of death of '1a Fatal Cardiac Arrhythmia Secondary to Metabolic Derangement due to Gastrointestinal Obstruction due to Pens in the Stomach and Duodenum
4	**CIRCUMSTANCES OF THE DEATH** Chloe Hunt died on 15 March 2022 at Colchester General Hospital due to Fatal Cardiac Arrhythmia Secondary to Metabolic Derangement due to Gastrointestinal Obstruction due to Pens in the Stomach and Duodenum. Chloe had a history of severe trauma and self-harm and engaging in care and treatment to cope with complex trauma, self-harm and overwhelming thoughts. Chloe swallowed 4 pens (initially thought to be 3) and was admitted to hospital on 11 March 2022 with abdominal pain. A CT scan found 1 of the pens was impacted in her duodenum. Being in hospital was hard to tolerate for Chloe due to her trauma and she informed the consultant. Chloe was not referred for removal of the pens. Chloe had to go outside on 12 March and represented after a number of hours with increased pain. Further tests were completed in the emergency department. Chloe was not given the option of

	general anaesthesia with a surgeon on referral for removal. Chloe underwent gastroscopy under sedation on 14 March and 2 pens were removed. It was not possible to remove the impacted pen. Chloe could not continue to tolerate the procedure with reintubation on each removal for the other pen. The procedure then could not be converted to general anaesthesia in the interventional radiology suite. Chloe was referred to the surgeons and was due to undergo a procedure on 15 March 2022. The remaining pen in Chloe's stomach also became impacted during the interval between the gastroscopy and her death. Chloe was last seen responsive around 03:45. Chloe had largely been tachycardic throughout her admission with low pressure and her oxygen saturations fell during the night requiring oxygen. Chloe had known previous overdoses and was found on post-mortem to have a thickened left ventricle in the absence of hypertension. Chloe was found in cardiac arrest at approximately 05:50 having suffered a cardiac arrhythmia secondary to metabolic derangement and resuscitation was not successful.
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. – a. Chloe explained on 11 March 2022 in Accident & Emergency to the doctor her background of complex trauma and how difficult she found it to be in hospital. This was not factored into a plan for treatment. a. Imaging established Chloe had swallowed 3 full-sized pens, 2 free in her stomach and 1 was impacted in her duodenum. There was a lack of consideration of the complexities of removal to guide whether the removal should be endoscopic or surgical. Endoscopy could not be converted into a procedure under anaesthetic in the interventional radiology suite. b. The requirement for reintubation after each pen removal and the difficulty for a patient to tolerate multiple procedures without anaesthetic was not considered for Chloe on referral for removal, or whether this might need to be converted to a procedure under anaesthetic. c. There was a lack of urgency in treating Chloe and lack of recognition of her deteriorating clinical condition. d. Chloe was tachycardic throughout her admission with low blood pressure and there was no investigation of the underlying cause in a young otherwise physically healthy woman. NEWS Scores should not replace consideration of the whole clinical picture for a patient.

	e. In the hours before Chloe's death, she required oxygen for the first-time that was administered for approximately 75 minutes and Chloe's heart rate reduced to normal for several hours for the first time in her admission. This reduction was not sustained, and her heart rated elevated later. These changes were not recognised as signs Chloe was a deteriorating patient. f. Chloe's low oxygen saturation level and the prescription of Oxygen was not documented on 14 March. g. From the timing of the recognition of Chloe's in-hospital cardiac arrest there was approximately 10 minutes before the first heart rhythm was recorded during the resuscitation.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 12 AUGUST 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: • Care Quality Commission 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	S. M. Hayes **19 June 2024** **HM Area Coroner for Essex Sonia Hayes**