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]**ner, Chief Executive Officer, Barking, Havering & Redbridge University Trust** [redacted] • **Secretary of State for Health & Social Care** [redacted] • [redacted]**, Medicines & Healthcare products Regulatory Agency** [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 17/05/2022, this Court commenced an investigation into the death of David John Morris aged 78 years. The investigation concluded at the end of the inquest on 3rd July 2024. The Court returned a narrative conclusion; "*David John Morris died in hospital on 16th May 2022 due to complications of*

	necessary surgery to treat the effects of oesophageal cancer. Mr Morris fell into septic shock due to peritonitis caused by a leak of enteral feed into his abdomen from a gastrostomy apparatus. It has not been possible to determine how the leak arose." Mr Morris's medical cause of death was determined as; 1.a. Intra-Abdominal Sepsis 1.b. Laparoscopic Gastrostomy 1.c. Oesophageal Cancer II Chronic Obstructive Pulmonary Disease, Ischaemic Heart Disease
4	**CIRCUMSTANCES OF THE DEATH** David Morris was a 78-year-old man who developed symptoms of abdominal pain and blood-stained vomiting in October 2021. Mr Morris was assessed by his GP who made a number of referrals to specialists under the two week wait pathway. Delays occurred in undertaking diagnostic tests of the deceased, which resulted in a finalised diagnosis of oesophageal cancer only being arrived at in late February 2022. The onset of cancer resulted in a stricture of the oesophagus which impeded oral intake of nutrition. On 2nd May 2022 Mr Morris underwent a surgical gastrostomy to facilitate enteral feeding through a tube directly into his stomach. On 3rd May 2022 Mr Morris began to deteriorate whilst treated on a surgical ward, he experienced difficulty in breathing and pain in his left upper quadrant. A leak was detected from his gastroscopy on two occasions during the day but enteral feeding was allowed to continue. Shortly before midnight, the leak re-occurred, Mr Morris was reviewed by a registrar and again, the enteral feed was allowed to continue. At approximately 07.00 hrs on 4th May 2022, the leak from the gastrostomy was observed to have increased and again a doctor was called for. Mr Morris's clinical observations were taken and it was noted that he had deteriorated, a mottled rash was observed on his abdomen. Despite these concerning signs, no clinical action was taken until after 10.30hr, over three hours later, when a surgical registrar reviewed Mr Morris. The surgeon identified septic shock with a likely abdominal cause and Mr Morris was prepared for emergency surgery. A laparotomy determined that the gastrostomy device had failed, Mr Morris had a gangrenous bowel, caused by peritonitis due to the spillage of stomach content and enteral feed into the abdomen. The ischaemic bowel was removed and re-look surgery was arranged for the following day. The gastrostomy device was removed and tested for 7 days thereafter, it appeared to be functional. The device was subsequently lost, negating the possibility of further investigation when it was returned to a manufacturer. Human error in the handling of the gastric ballon inflation port on the device remains a potential cause for the deflation and failure of the device. On the 8th May a final surgery was undertaken to repair the bowel and insert a feeding tube into the small intestine. Mr Morris declined post-operatively, passing away in hospital on 16th May 2022. Some time after the death of Mr Morris, the nurse in charge of the ward where the deceased was cared for on 3rd May 2022 was found collapsed and unresponsive at work. The nurse volunteered that they were under the effects of stolen controlled

	medication that belonged to the hospital. The nurse offered that they had been stealing and self-administering controlled medications during every shift they worked for approximately three years. At inquest, the nurse declined to answer questions on whether their drug misuse could have had a contributary effect of the failure of Mr Morris's gastrostomy.
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. Mr Morris's diagnosis and treatment for cancer was delayed due to poor organisation and communication at the Trust. 2. During the evening of 3rd May 2022 going into the early hours of 4th May 2022, Doctors and nurses failed to identify the extent of Mr Morris's gastrostomy leak and the onset of sepsis. After identifying symptoms of sepsis, staff failed to treat and escalate Mr Morris's care resulting in a delay of three and a half hours before a medical review commenced emergency treatment. 3. During Mr Morris's ward-based treatment on 3 & 4th May 2022 clinical records were either of a poor standard or were non-existent. The absence of clear records impeded the effective investigation of this death by the Trust's governance teams and the Coroner. 4. The initial serious investigation report into Mr Morris's death was unfit for purpose. The report to investigate or even identify the Registrar who reviewed Mr Morris on the evening of 3rd May 2022. Since then, no effective review has been undertaken by the Trust upon how this deficient report gained executive approval. 5. The Trust did not have effective controlled drug management systems in place to detect a prolonged and persistent course of conduct from an employed nurse who was stealing and self- administering controlled drugs in the workplace.
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 **30th 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 the family of Mr Morris and the Care Quality Commission. I have also sent it 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] 04/07/2024 [SIGNED BY CORONER]**