Lancashire & Blackburn with Darwen
Coroners Dr James Adeley
Senior Coroner

Date: **17 May 2024**
Our Ref: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO:

East Lancashire Hospitals Trust

1. Coroner

I am Dr James Adeley, Senior Coroner for the Coroner area of Lancashire & Blackburn with Darwen.

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/para

graph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

2. INVESTIGATION and INQUEST

On 29 June 2020 I commenced an investigation into the death of Antony Waring 70. The investigation concluded at the end of the inquest . The conclusion of the inquest was:

Antony WARING died on 24 June 2020 at Royal Blackburn Hospital following a highly inappropriate choice of urological surgical technique for the insertion of the suprapubic catheter causing perforation to the small bowel and resulting in a major laparotomy and admission to the Intensive Therapy Unit. Subsequent necessary feeding via a nasogastric tube in the oesophagus resulted in an aspiration

pneumonia. Mr Waring's death was contributed to by neglect.

1a Aspiration pneumonia following inadequate placement of

nasogastric tube;

1b Laparotomy for small bowel perforation and bladder repair;

1c Supra pubic catheter insertion.

II Multiple Sclerosis

3. Circumstances of the death

Antony Waring was 71 years of age on the date of his death of 24 June 2020 at Royal Blackburn Hospital operated by East Lancashire Hospitals Trust.

In 2002 Antony suffered from Multiple Sclerosis Waring had undergone a cystoplasty in which a loop of small bowel was brought down into the pelvis. There was a second laparotomy due to adhesions a week later.

On 20 March 2020 Antony Waring attended an Urology outpatient appointment for the insertion of a suprapubic catheter insertion, which was necessary due to complications caused by an indwelling catheter. For the insertion of a suprapubic catheter, Consultant 1 described Antony Waring's insertion of a suprapubic catheter as a "*difficult and risky*" procedure due to the previous surgery. As a result, to manage this risk, Antony Waring was listed for a catheter insertion with ultrasound guidance. The only guidance available in Europe and North America concerning the insertion of suprapubic catheters published by the British Association of Urological Surgeons guidance. This is a document by a committee that is subsequently peer-reviewed and consulted upon before being published in a journal. There is no NICE guidance for the insertion of suprapubic catheters. The 2010 BAUS guidance relevant at the time states as follows:

> *"In the patient with either a history of lower abdominal surgery or a bladder that cannot be adequately distended, the SPC should either be inserted using an open technique or with the adjunct of imaging that can reliably exclude the presence of bowel loops on the intended catheter track. An open procedure must be performed in a manner that will reliably identify the bladder and allow mobilisation of any interposing intestine away from the catheter track."*

Consultant 1 informed Antony Waring that an open procedure was not in his best interests. Consultant 1 made no request for Antony Waring

to be allocated to a urological consultant who use CT scanning, nor made any arrangements for the presence of an interventional radiologist to provide ultrasound guidance and allocated Antony Waring to a Core List where it was a matter of chance if ultrasound guidance would be used. The Trust has at least two consultant urological surgeons who routinely use ultrasound.

On 12 June 2020 Antony Waring attended hospital for the insertion of a suprapubic catheter. Consultant 2 was aware of consultant 1's views that ultrasound guidance was necessary. Consultant 2 made no attempt to manage the increased risk of interposing bowel on the suprapubic catheter insertion track by arranging either ultrasound or undertaking an open procedure. Consultant 2 inflated Antony Waring's bladder and inserted the suprapubic catheter perforating two loops of small bowel during the introduction. Antony Waring was admitted to intensive care unit with peritonitis and died 12 days later.

The adequacy of the Trust's Maintaining Health Professional Standards investigation and adequacy of the consent process have been dealt with by separate correspondence.

4. Coroner's Concerns

The **MATTERS OF CONCERN** are as follows:

(1) the Trust made no progress on the introduction of an SOP recommended in the internal review for almost 4 years. A draft SOP had been proposed in the weeks leading up to the inquest.
(2) The expert evidence at the inquest was that the Trust's proposed action plan using CT scanning at an unspecified time before a suprapubic catheter insertion was sub optimal and inferior to ultrasound as bowel may move between the date of the CT scan and the catheter insertion;
(3) in the four years since Antony Waring's death, the Trust has not provided a single ultrasound teaching session provided by the Trust to any consultant who is not capable of using ultrasound.
(4) the allocation of high-risk patients to Core Lists where a specific ancillary prophylactic measure such as ultrasound is left to either chance or to an administrator;
(5) The expert evidence at the inquest was that the research provided on the risk of complications after insertion of a suprapubic catheter into patients with lower abdominal surgery is inappropriate the patient such as Antony Waring and provides false reassurance as to the level of risk posed to these patients.

5. 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.

6. Your response

You are under a duty to respond to this report within 56 days of the date of this report, namely by **12 July 2024**. I, the coroner, may extend the period, but after the extensive inquest, he interval between the inquest and the service of this Report and that you have been on notice during this period, only with exceptional reasons.

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.

7. Copies and publication

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

1. Antony Waring's family

2. CQC

3. Relevant ICB

4. British Association of Urological Surgeons

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.

Yours sincerely

James Adeley

HM Senior Coroner

Lancashire & Blackburn with Darwen