MR G IRVINE
SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted] **Chief Executive Officer, Barking, Havering & Redbridge University Trust** Sent via email: [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 11th July 2023, this court commenced an investigation into the death of Gordon Long aged 73 years. The investigation concluded at the end of the inquest on 18th September 2024. The court returned a narrative conclusion, "*George Richard Long died in hospital on 8th July 2023 the day after necessary surgery to amputate his left leg. Mr Long died due to complications of surgery along with the effects of multiple, pre-existing, serious medical conditions."* Mr Gordon's medical cause of death was determined as; *1a: Infective Exacerbation Of Chronic Obstructive Pulmonary Disease And Congestive Cardiac Failure* *1b: Septic/Gangrenous Left Foot Treated With Left Above Knee Amputation,*

	Ischaemic Heart Disease And Extensive Metastatic Carcinoma To The Liver *1c.Peripheral Vascular Disease* *II. Type 2 Diabetes Mellitus, Atherosclerosis, Dyslipidaemia, Cirrhosis Of The Liver, Depression And Previous Left Sided Cerebrovascular Accident*
4	**CIRCUMSTANCES OF THE DEATH** Mr Long was admitted to hospital by ambulance on 1/7/23. A preliminary diagnosis of dry gangrene of the left foot was arrived at in the ED. A care plan was arrived at that involved amongst other things, admission onto a ward and referral to the vascular team for assessment. Mr Long was not assessed by a vascular specialist until 6th July 2023, by which time he had suffered a significant clinical decline. Surgery to amputate the effected limb was undertaken on 7th July 2023, he died on 8th July 2023.
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. Despite undertaking a patient safety incident investigation ("PSII") the Trust was unable to explain why Mr Long was not referred to the vascular team after he was admitted from ED into the medical receiving unit ("MRU") on the morning of 2nd July 2023. The Trust struggled to identify the consultant in charge of Mr Long's treatment when on the MRU and could not demonstrate that the consultant was spoken to as part of the PSII investigation. The inadequate standard of the investigation makes the court doubt the effectiveness of the Trust to identify and reflect upon future risks to patients. 2. Although an action plan had been agreed by the Trust to remediate the failures in care that led to the delayed referral, no clear evidence of change was demonstrated to the court.
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.**15th November 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 Long 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] 19/09/2024 [SIGNED BY CORONER]**