REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. East Kent Hospitals University NHS Foundation Trust (EKHT)** **2. National Institute for health and Care Excellence (NICE)** **3. NHS England**
1	**CORONER** I am James Dillon, Assistant Coroner, for the coroner area of **Central and South East Kent.**
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 26th September 2022 I commenced an investigation into the death of Megan Williams. The investigation concluded at the end of the inquest on the 20th June 2023 although I delivered the conclusion on 24th October 2023. The conclusion of the inquest was that the deceased Megan Ceris Williams died as a result of (set out in a narrative conclusion) an undiagnosed small bowel obstruction, apparently caused by band adhesions from previous intraabdominal surgery. She had attended hospital twice, on both occasions via ambulance, on 2nd May (when she was discharged with suspected gastritis) and 4th May 2022 (when she self-discharged in the early hours of the following morning and returned home where she died). The cause of death having been determined as: 1a Aspiration Pneumonia 1b Small bowel obstruction 1c Strangulated internal hernia due to band adhesions from prior intraabdominal surgery 2

4	**CIRCUMSTANCES OF THE DEATH** The deceased Megan Ceris Williams had had surgery for a previous burst appendix and that appears to have led to some band adhesions. More specifically Megan had had an appendicectomy in 2009. Adhesions identified on post mortem appeared to be in the same region as the appendix. The deceased had developed some discomfort late in the evening on 1st May 2022 and by 3am the following morning (2nd May 2022) suffered violent vomiting. The 111 service was called, and the deceased was taken by ambulance to William Harvey Hospital. The deceased was discharged, on 2nd May 2022 and sent home with a diagnosis of gastritis. At around 4pm the deceased had telephoned her family asking them not to collect her from hospital because she had vomited (which was not captured in any medical records). On 4th May 2022 the deceased was once again in severe pain and brought back to William Harvey Hospital by ambulance, after a long wait to be seen she left hospital at 1am, on 5th May 2022 and discharged herself (no signed documentary record of that self-discharge has been located). At around 3am on 5th May the deceased vomited again, by 7.30am she became breathless and at around 8am,she sat up saying that she was going to vomit but abruptly lost consciousness Emergency services were called, family members attempted resuscitation which was taken over by the ambulance service when they arrived. Resuscitation attempts continued for around two hours but were ultimately unsuccessful. The deceased died at her home address [redacted] on 5th May 2022.

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. Independent expert evidence was heard that indicated that the deceased likely had band adhesions - a known complication of her past abdominal surgery. It was the expert's opinion that a small loop of bowel had become trapped in the adhesions causing pain and obstruction. The expert stated that this loop of bowel may have slid in and out explaining why the deceased's symptoms were transient across the period of time that was examined (between 1st and 5th May 2022) and why clinicians suspected gastritis rather than a bowel obstruction. The inquest examined whether or not it would have been appropriate for a CT scan to have been done on the first hospital admission on 2nd May 2022. The lack of any record of a bout of vomiting by the deceased shortly before she left hospital on that date was relevant inasmuch as, had it been noted by hospital staff, may have lead to the deceased remaining in hospital with the potential for further investigations have been carried out which may have provided opportunities to intervene. The inquest also examined East Kent Hospital's Acute Abdominal Pain Pathway (AAPP) including knowledge of this pathway among clinicians and the clarity of the pathway as it was documented included about a patient being referred directly back to any specialist department (such as surgeons) if returning to hospital within 48 hours of having been discharged. The lack of any signed record of the deceased self-discharging from hospital on 5th May

	was concerning. The inquest also examined the EKHT SI process and heard from an emergency department consultant who spoke as to the process. It was suggested that the SI process had not taken account of information which had been provided by the deceased's family. The **MATTERS OF CONCERN** are as follows. – (a) That there was a lack of knowledge, among clinical staff, of the Acute Abdominal Pain Pathway (AAPP). (b) Given what was said about how clear the AAPP was, that EKHT should provide evidence of what further work has been done make it clearer and accessible to clinicians. (c) That the hospital SI process did not include information from family and other interested persons or parties as part its fact-finding exercise. (d) There was not a clearly documented and recorded process for patients who self-discharge from hospital.
6	**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.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 18th September 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 namely the family and EKHT. 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	**24th July 2024**  **James Dillon** **Assistant Coroner** **Mid Kent and Medway**