Prevention of Future Deaths Report

Sophie Ann Dean (date of death: 4 September 2023)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: 1. **Chief Executive Officer** **University College London Hospitals NHS Foundation Trust** **2nd Floor Central** **250 Euston Road** **London** **NW1 2 PG** [redacted]
1	**CORONER** I am Ian Potter, assistant coroner, for the coroner area of Inner North 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.
3	**INVESTIGATION and INQUEST** On 22 September 2023, an investigation was commenced into the death of Sophie Ann Dean, then aged 18 years. The investigation concluded at the end of an inquest heard by me on 11 June, 16 September and 20 September 2024. The inquest concluded with a short narrative conclusion in the following terms, "complications following recent surgical procedures". The medical cause of death was: 1a disseminated intravascular coagulation and septicaemia 1b pneumonia II laparotomy (24 August 2023), re-closure of abdomen (4 September 2023), microcephaly, bilateral frontal polygyria
4	**CIRCUMSTANCES OF DEATH** Miss Dean had an extensive past medical history and significant underlying co-morbidities. She was admitted to University College Hospital (UCH) on 23 August 2023, when air had been evidenced on a follow-up x-ray in relation to previous spinal surgery undertaken elsewhere.

	Miss Dean underwent a CT scan of the abdomen and pelvis at UCH, which showed 'free air' in the abdomen. There were three possible causes of this: 1) a duodenal ulcer; 2) a perforated bowel; and 3) a leak from Miss Dean's feeding tube. The view of the non-UCH radiology team who reported the scan overnight was that the most likely cause was Miss Dean's feeding tube. The consultant surgeon on call discussed the scan with the UCH radiology team, who were not sure of the underlying cause. The surgeon considered that the cause was unlikely to be a leak from the feeding tube and was more likely due to bowel perforation, which had a much greater potential to become a medical emergency. On 24 August 2023, Miss Dean underwent a laparotomy; there was no bowel perforation and the issue related to a leak from Miss Dean's feeding tube. A gastroscopy showed that the PEG-J feeding tube was loose. The tube was removed, and an alternative feeding tube was placed into the jejunum. The operation itself was uneventful and relatively straightforward; Miss Dean was expected to make a full recovery. Miss Dean was at higher risk from any surgical procedure due to her co-morbidities. In the days that followed the laparotomy, Miss Dean developed a chest infection was prescribed antibiotics. The operation did make a contribution to Miss Dean having developed the chest infection. Miss Dean's operation wound site then developed signs of dehiscing; she was taken back to theatre on 4 September 2023, due to complete separation of the wound edges. The risk of complications was increased by virtue of this being the second general anaesthetic within a short period of time. Following Miss Dean's return to the intensive care unit after the operation on 4 September 2023, she experienced a sudden deterioration and went into cardiac arrest shortly after 17:00. There were extensive efforts at resuscitation, but these were ceased shortly after 18:10.
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) Consultant's undertaking ward rounds allowed very junior doctors to make the entry from these consultations in the patient records. While there is no concern about this per se, there were numerous key factors missing from these notes. I am concerned that the notes did not fully represent the discussions and assessments that took place, which creates risk. 2) There were other omissions from the medical records for Miss Dean's admission.

	3) The on-call surgeon used language such as having “pushed the family” into agreeing to surgery on 24 August 2023. There was also evidence that not all options/possibilities were discussed with Miss Dean’s parents prior to their consenting to surgery. The evidence was that Miss Dean’s parents may not have fully understood the rationale for surgery or the possibility of conservative management of the issue, prior to the laparotomy on 24 August 2023.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that 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 the report, namely 25 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 the following: [redacted] – Sophie Ann Dean’s mother and father 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. She may send a copy of this report to any person who she 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	**Ian Potter** **HM Assistant Coroner, Inner North London** **30 September 2024**