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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 24251104

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], **CEO, Barking, Havering & Redbridge NHS Foundation Trust** **Sent via email:** [redacted] SM-INQUESTS (BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST) [redacted] 2. **RT Honorable** [redacted], **Secretary of State for Dept. Health & Social Care** **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 17th November 2023, this court commenced an investigation into the death of Chloe Every, aged 27. The investigation concluded at the end of the inquest on 21st October 2024. The court returned a narrative conclusion. *Chloe Every died in hospital on 14th May 2019. Chloe's death was caused by complications of a cardiac arrest sustained on 8th May 2019 whilst in hospital.* *The cardiac arrest on 8th May was probably contributed to by treatment given to Chloe*

	to manage symptoms of bowel cancer. *It is possible that medical procedures undertaken to facilitate diagnosis of Chloe's cancer contributed to her death.* *The inquest concluded that multiple actions and omissions of hospital staff during Chloe's inpatient admission did not comply with local and national guidance. Some of those omissions were actions that would have resulted in contemporary evidence being created relevant to this inquest.* *I find that there is insufficient contemporary evidence to allow me to undertake proper assessment of all of the factors that are likely to have contributed to Chloe's death."* Ms Every's medical cause of death was determined as; *1a Multi organ failure* *1b Hypoxic Cardiac arrest, subsequent cardiogenic shock* *1c Advanced Bowel Cancer (treated with Morphine)* *II Myotonic Dystrophy*
4	**CIRCUMSTANCES OF THE DEATH** Chloe suffered from a genetic condition, Myotonic Dystrophy. She was also diagnosed with a learning disability. In late 2018 Chloe was investigated for symptoms indicative of cancer. In Late April 2029 she was admitted to hospital with upper right abdominal pain and an interrupted toilet habit. After diagnostic imaging, a preliminary diagnosis of colon cancer with metastases in the liver was arrived at. Chloe was admitted into hospital awaiting a flexible sigmoidoscopy, planned for 8th May 2019. Chloe's pain increased; she was prescribed morphine. No recorded justification for the use of this powerful drug can be found in hospital records. The identity of one of the prescribing doctors cannot be made out due to the absence of clear records. On the morning of 8th May 2019, she underwent an enema. Before and during this process, Chloe was observed to be unresponsive. It is Moments after the procedure a crash call was raised as Chloe had sustained a hypoxic cardiac arrest, contributed to by the use of morphine. It is possible that the un-consented enema process contributed to the cardiac arrest. Chloe was successfully resuscitated and was admitted to the ITU for supportive treatment. After 5 days her care was stepped down to a respiratory ward, within a matter of hours of transfer, she was found unresponsive and declared deceased.
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. The Trust does not provide nursing cover during weekends and holiday periods of staff with relevant learning disability training. 2. The investigation of this inquest was prejudiced by the absence of contemporary nursing and medical notes from various stages of Chloe's treatment. The extent

	of these lapses meant staff who made important treatment decisions could not be identified, and where staff could be identified, no contemporary account of their rationale for making treatment decisions could be located. 3. The regularity of Chloe's clinical observations fell well below the expected level. The lapses included a period of over 10 hours in which no observations were undertaken. 4. Chloe underwent an enema on 8th May 2019 without informed consent being taken. The court found that Chloe was unconscious, before, during, and after the procedure, it is possible this procedure contributed to her death. 5. Nursing staff were incapable of explaining to the court the appropriate criteria that would have to exist before commencing CPR on an unresponsive patient. 6. Governance processes at the Trust failed to identify that Chloe's death constituted a patient safety incident until months after her death. A mortality review authored by the Associate Medical Director on 17th May 2019 assessed Chloe's care as good or excellent. 7. A Serious Incident report completed by the trust in the second half of 2019 failed to identify a series of healthcare failings in Chloe's treatment. Management failings at the Trust meant that Chloe's death was not reported to a Coroner until August 2023, by which time Chloe's body had been cremated denying the court an opportunity to gather relevant evidence through autopsy.
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 **23rd December 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 Ms Every, the Care Quality Commission and 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 25/10/2024 [SIGNED BY CORONER]**