REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	[redacted], Secretary of State for Health and Social Care, Department of Health and Social Care, 39, Victoria Street, London. SW1H 0EU.
1	**CORONER** I am Professor Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West 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 the 26th and 27th November 2024, evidence was heard touching the death of Mr Junior George Powell, who died on 6th September 2021 at St George's Hospital aged 57 years. **Medical Cause of Death** 1 a. Intestinal Ischaemia b. Aortic Dissection with arterial branch occlusion **How, when, where the deceased came by his death:** Mr Powell presented at approximately 22:00 to St George's Hospital on 3rd September of 2021 with acute onset of abdominal pain and vomiting. Initial CT scanning did not find nay surgical cause for his symptoms. He was reviewed at 05:15 on the 4th September 2021 by the medical registrar who was concerned about his pain and worsening clinical condition. She discussed the CT scan results with the radiologist and surgical team. In retrospective analysis of the CT scan images subtle changes were noted that prompted further imaging if his vascular system. This showed an abdominal aortic dissection, reduced blow flow to the coeliac axis, the superior mesenteric artery and renal arteries and evidence of intestinal ischaemia. He was reviewed by the general surgeons, vascular surgeons and interventional radiologists, by which time he deteriorated further. He underwent resection of his bowel midmorning on 4th September 2021 but received no surgical treatment to restore blood flow to the abdominal arteries or treat the dissection in the aorta. He was heparinised only. As a result, his condition continued to deteriorate and he developed increasing ischaemic damage to his abdominal organs. Despite further resection of his by now necrotic gall bladder and damaged bowel on 5th September 2021, he died at 15:49 on 6th September 2021 on GITU.

If mechanical restoration of blood flow to the abdominal arteries had occurred on the morning of 4th September 2021 or by late afternoon of 4th September 2021, on the balance of probabilities he would not have died at this time.

As such the lack of treatment to reduced flow to the arteries via mechanical means contributed to his death.

Conclusion of the Coroner as to the death:

Natural Causes contributed to by lack of definitive treatment of the aortic dissection.

4 **Evidence relevant to the matters of concern.**

Extensive evidence was taken and exhibited and some potential Regulation 28 matters explored. Of relevance to this report:

> They was a more than five hour delay before Mr Powell was reviewed by the medical registrar and he should have been in a bed in the medical ward by 01:15. This delay was caused by shortage of staff during that night and he was eventually seen by the medical registrar who should have been based on the ward, not seeing patients in accident and emergency.
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> Evidence was taken that confirmed that such delays are usual, not just in St George’s Hospital, and delays in admission to the wards are caused largely by the inability to discharge patients who are fit for discharge due to lack of suitable social support in the community.
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> In this case, treatment for Mr Powell was time critical and as such this delay probably contributed to his death.

5 **Matters of Concern**

> That delay in discharge for patients ready to be discharged due to lack of suitable social care in the community is causing congestion in the hospital admission process, delaying medical assessment and thus diagnosis of conditions that need urgent treatment and increasing the likelihood of death for such patients.

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. It is for each addressee to respond to matters relevant to them.

7 **YOUR RESPONSE**

You are under a duty to respond to this report within 56 days of the date of this report. 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: Wife of Mr Powell: Chief Executive Officer, St George's Hospital, Blackshaw Road, London. SW17 OQT. 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	**2nd December 2024** **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Inner West London Coroner's Court,** **33, Tachbrook Street,** **London.** **SW1V 2JR**