Prevention of Future Deaths Report

Mnayea ZMF Al Basman (date of death: 25 March 2024)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: **1. Chief Executive Officer** **Royal Free London NHS Foundation Trust** **Pond Street** **Rosslyn Hill** **London** **NW3 2QG**
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 3 April 2024, an investigation was commenced into the death of Mnayea ZMF Al Basman, aged 72 years at the time of his death. The investigation concluded at the end of an inquest heard by me on 6 November and 3 December 2024. The inquest concluded with a short narrative conclusion in the following terms. 'known complication of necessary surgical procedure'. The medical cause of death was: 1a intra-abdominal sepsis / peritonitis 1b anastomotic leak at site of right hemicolectomy 1c caecal adenocarcinoma (operated) II end-stage renal failure, atherosclerosis, congestive cardiac failure
4	**CIRCUMSTANCES OF DEATH** Mr Al Basman had an extensive past medical history and significant underlying co-morbidities. He was admitted to the private patient unit at the Royal Free Hospital on 11 March 2024, to undergo a right hemicolectomy to excise a caecal adenocarcinoma, planned for the following day.

	Mr Al Basman's co-morbidities increased his general and specific surgical risks, but he was found to be fit to undergo the surgery. The surgical procedure itself was 'technically challenging' but otherwise uneventful. Mr Al Basman showed signs of reasonable post-operative recovery until the weekend of 23/24 March 2024. From 24 March 2024, he deteriorated suddenly. Some aspects of his condition and clinical presentation that weekend should have been escalated to the consultant surgeon in charge of his care but were not; however, it is not possible to say that earlier escalation would have altered the outcome. On Monday 25 March 2024, Mr Al Basman deteriorated further and died in hospital. Mr Al Basman's death was the direct result of sepsis/peritonitis caused by an anastomotic leak at the site of the right hemicolectomy. Anastomotic leak is a known complication of this surgical procedure.
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 consultant colorectal surgeon was not in the hospital over the weekend of 23/24 March 2024; however, he was able to be contacted if the need arose. The consultant surgeon noted the following matters in relation to the care provided to Mr Al Basman over that weekend: • a further CT scan could have been indicated, particularly given issues with Mr Al Basman's drain, albeit there was nothing to indicate that any scan was needed on an urgent basis; • some entries in the clinical notes may have been 'falsely reassuring'; • the physiotherapist who saw Mr Al Basman on the morning of 24 March 2024, noted that he appeared to be 'declining' but there was no evidence that this was escalated this to someone within the healthcare team; • there was a degree of insufficient professional curiosity on the part of some clinicians who saw Mr Al Basman; and • there should have been a plan in place to closely observe Mr Al Basman overnight on 24/25 March 2024. 2) Based on the above, the consultant surgeon formed the view that Mr Al Basman's clinical presentation should have led to the consultant being informed and consulted, but it did not. 3) A number of the notes/records in relation to the care provided to Mr Al Basman, particularly over the weekend of 23/24 March 2024, lacked detail.

	Given that the events preceding Mr Al Basman's death have not been the subject of an internal investigation, I received little, if any, reassurance that these matters have been addressed.
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 28 January 2025. 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: • Mr Al Basman's family 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** **3 December 2024**