Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Portsmouth Hospital NHS Trust**
1	**CORONER** I am Sally OLSEN, Assistant Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 15 August 2023 I commenced an investigation into the death of Susan EVANS aged 55. The investigation concluded at the end of the inquest on 22 November 2024. The conclusion of the inquest was that: "On 11 July 2023, Susan Evans underwent elective Roux-en-Y gastric bypass surgery. The surgery went to plan and appropriate measures were taken to avoid the possibility of an anastomotic leak, a rare but recognised complication of gastric bypass surgery. Initially, Ms Evans recovered well, but she experienced abdominal pain in the early hours of 13 July 2023. It is likely that this was due to an anastomotic leak. 13 July 2023 was the first day of a junior doctors' strike. Unrelated to this, the hospital only had the equivalent of one full time specialist bariatric nurse, who was not on duty. Contrary to Queen Alexandra hospital's written policy for gastric bypass patients, Ms Evans was not seen by a member of the specialist bariatric team on 13 July 2023 and was not seen by a senior doctor after reporting pain in order to rule out the possibility of an anastomotic leak. The hospital at night nursing team, who administered pain relief, were unaware of the latter requirement. In addition, Ms Evans not seen by a member of the bariatric team or any doctor prior to her discharge from hospital on the morning of 13 July 2023. Ms Evans was still in a degree of pain when she left hospital. She was re-admitted to hospital on 15 July 2023. By this point she was extremely unwell with abdominal sepsis from an anastomotic leak. She underwent remedial surgery on 15 July 2023 and a further operation was required on 25 July 2023. Despite appropriate medical care following her re-admission, her condition deteriorated, and she died at Queen Alexandra Hospital on 12 August 2023. It is likely that, if she had been seen by a member of the bariatric team on 13 July 2023, she would have been kept in hospital and would have been operated upon sooner. The failures identified contributed more than minimally to her death."
4	**CIRCUMSTANCES OF THE DEATH** See Narrative Conclusion above

5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) Queen Alexandra's written post operative care pathway for patients who have undergone a gastric bypass operation states that: - There is to be a daily review by a bariatric specialist nurse, consultant or registrar. - A senior doctor is to review within 2 hours if there is increased abdominal pain in order to rule out anastomotic leak or bleed. In addition to this, the inquest heard evidence that patients should be seen by a member of the specialist bariatric team prior to discharge. This is not included in the written policy. Neither the written nor informal policy set out above were followed in Ms Evans' case. She was not reviewed by a member of the specialist bariatric team at any point on day 2 after surgery and the pain she experienced from the early hours of 13 July 2023 was not escalated to a senior doctor at all. The inquest heard evidence that medical staff who were not part of the specialist bariatric team were unlikely to appreciate the significance of pain. The failure to follow policy contributed more than minimally to Ms Evans death and is therefore a matter of concern.
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 February 07, 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 to the following Interested Persons [redacted] 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 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 by the Chief Coroner.
9	**Dated: 13/12/2024**  **Sally OLSEN** **Assistant Coroner for** **Hampshire, Portsmouth and Southampton**