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 [redacted] - The Chief Executive of East Suffolk and North Essex Foundation Trust**
1	**CORONER** I am Daniel SHARPSTONE, Assistant Coroner for the coroner area of Suffolk
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 26th February 2024 I opened an Inquest into the death of: **Denise Ellen Johnson** The conclusion of the Inquest on 10th December 2024 was: Dee died from acute small and large bowel infarction secondary to necrotising pancreatitis and intraabdominal sepsis, both recognised complications of severe post ERCP pancreatitis, on the background of obesity, recent treatment for breast Cancer and severe psychological stress The medical cause of death was confirmed as: 1a Multi-organ failure 1b Severe E.coli septicemia 1c Pancreatic necrosis and ischemic bowel perforation 1d CBD stones and post ERCP pancreatitis
4	**CIRCUMSTANCES OF THE DEATH** Dee was admitted to hospital as an emergency with abdominal pain and jaundice on 13th August 2022. Dee was 42 years of age with a history of obesity, ongoing treatment for breast cancer and depression. Investigations revealed a gallstone in the common bile duct as the cause of her jaundice. An endoscopic retrograde cholangiopancreatography (ERCP) was performed and a plastic stent inserted for drainage. Dee became acutely unwell post ERCP and was diagnosed with acute necrotising pancreatitis. Dee was admitted to ITU for 9 days for supportive care and antibiotics. The care of Dee's necrotising pancreatitis and associated peri-pancreatic collections via CT Scans, insertion of abdominal drains, treatment plans and clinical updates was managed at Ipswich General Hospital with ongoing advice and guidance from Addenbrooke's Hepato-Pancreato-Biliary multidisciplinary team. Subsequent CT scanning showed severe pancreatitis with fat necrosis and peripancreatic

	fluid collections. Dee's infected peri-pancreatic collections were drained by a series of drains. Dee had regular pain management, physiotherapy and dietician review. The peripancreatic collections were managed by ongoing abdominal drainage, flushing and antibiotics as guided by Microbiology. Despite ITU admission with intensive supportive care her condition deteriorated and Dee died on 24th November 2022.
5	**CORONER'S CONCERNS** During 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 these circumstances it is my statutory duty to report to you: **MATTERS OF CONCERN** <u>Timely notification to ERCP practitioners following serious complications, with formal case review</u> ERCP-based endoscopic complications should be presented in a formal setting in the presence of Endoscopy colleagues. There is a need for timely feedback to responsible ERCP practitioners in cases of procedure-based complications to ensure checks and learning on matters such as safety and adherence to guidelines and standard practice. <u>Regular discussions about management plans and treatment options with NOK/family by a responsible Surgical Consultant for inpatients with serious chronic surgical issues</u> Plans and management were discussed on the Surgical ward with Dee by the Consultant but there was a paucity of comprehensible and timely communication with the next of kin and rest of the family concerning management plans and treatment options. Two-way feedback in this situation plays a vital role in maintaining patient wellbeing and safety. <u>Lack of clarity around named Surgical Consultant cover for unexpected leave</u> It was unclear who was the Surgical Consultant responsible for Dee and her pancreatic disease management when her usual Consultant was off work due to unexpected leave. A clear handover process at Consultant Surgeon level for unexpected leave enables continuation of care between health care professionals and teams with continuity and oversight of treatment and management plans. Accordingly, I consider that: **Not having timely notification to ERCP practitioners following serious procedure-based complications, and timely associated formal ERCP case review with endoscopy colleagues** **Not having regular explanations and discussions with NOK/family by the responsible Consultant concerning ongoing management plans and treatment options for inpatients with serious surgical issues and,** **Lack of clarity over named Surgical Consultant cover with responsibility for surgical inpatients during periods of unexpected leave**

	All pose a significant risk to patient safety.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths as detailed above, and I believe you or your organisation have the power to take any such action you identify.
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 21, 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: 1. Dee's next of kin. I am 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Dated: 30/12/2024**  **Daniel SHARPSTONE** **Assistant Coroner for** **Suffolk**