## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**The Secretary of State for the Department of Health**<br>**Richmond House**<br>**79 Whitehall**<br>**London**<br>**SW1A 2NS** |
| 1 | **CORONER**<br><br>Donald Coutts-Wood assistant coroner for the coroner area of South Yorkshire (West). |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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. Schedule 5 to those Regulations provides:<br><br>(1) Where—<br>(a) a senior coroner has been conducting an investigation under this Part into a person's death,<br>(b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and<br>(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action.<br><br>(2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.<br><br>(3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner. |
| 3 | **INVESTIGATION and INQUEST**<br><br>On the 1st December 2011 I commenced an investigation into the death of Jude Augustus Gordon, who was born on the 26th May 1958. The investigation concluded at the end of the inquest on the 29th August 2013. The conclusion of the inquest was that Mr Gordon died from cardio respiratory failure, due to ileus of the small intestine, due to restoration of bowel continuity due to Crohn's Disease. Ankylosing Spondylitis was a significant contributory factor. Mr Gordon was in hospital and following a sudden deterioration in his condition, such deterioration being recognised, the level of treatment for Mr Gordon was not increased. |

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| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Gordon underwent successful surgery and anaesthesia on the 23rd November 2011 and initially his recovery was uncomplicated. However, at about 0730 hours on the 27th November his condition deteriorated and there were objective signs of respiratory failure. It was recognised by staff that there was a problem, but the need to attend to that problem was not acted upon. He was not referred to more specialist care such as critical care. He went for a CT scan later that day and on returning to the ward suffered a cardiac arrest and died very shortly afterwards.<br><br>One of the objective signs of his deterioration that morning was the Early Warning Score. In the Sheffield hospitals this is referred to as the SHEWS. It is not clear whether any referral to more specialist care would have led to a different outcome for Mr Gordon. (A copy of the SHEWS Guide is enclosed). |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) As stated the Early Warning Score in Sheffield is referred to as SHEWS. It was clear from the evidence that for a period of almost four and a half hours, prior to his final collapse, Mr Gordon's score had shown a marked increase. This in itself should have led to referral to consultant level which did not happen. It was also apparent that there had been a miscalculation of the Early Warning Score, by more than one individual. The court was informed, by expert evidence, that there are differences in the method of calculating an Early Warning Score, between different Trusts. Nursing staff, but in particular junior doctors, who are often the person to make the decision to increase the level of treatment, have either trained or worked in different Trusts. This may lead to confusion. It was not clear to me why there is not a single, National, Early Warning Score system.<br><br>(2) Evidence was given at the inquest, by a consultant, that if he had been called to see Mr Gordon at the time his condition deteriorated, as was indicated by the Early Warning Score system should have happened, then he would have referred to critical care. He was not contacted. I was informed at the inquest that a Trust in Birmingham has a computerised system, that leads to an automatic alert to the relevant senior doctor on each occasion that a Early Warning Score exceeds the relevant level, for contact to be required. Such a system would on the 27th November 2011, to the consultant attending on Mr Gordon. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. Is there an intention for a National scoring system to be introduced, and indeed is consideration being given to the introduction of computerised systems that lead to automatic referral to the relevant senior doctor? |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 18th November 2013. I, the coroner, may extend the period.<br><br>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. |

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| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons;<br><br>1. Mr Gordon's family<br>2. The Chief Executive, Sheffield NHS Foundation Trust<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **24th September 2013** |