REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

This report is made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

Recipients

This report is being set to:

- The Medical Director of East Cheshire NHS Trust
- [redacted] – Consultant Physician and Gastroenterologist

Coroner

I am Nigel Meadows, H. M. Senior Coroner for the area of Manchester City.

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.

Investigation and Inquest

On 31 May 2011 I commenced an investigation into the death of **Anthony Bernard Mcormick**, aged 79. The investigation concluded at the end of the inquest on 27 September 2013.

The cause of death was found to be:

1a Multi Organ failure due to sepsis
1b Multiple Liver Abscesses and Right Empyema
1c Acute Cholecystitis due to gallstones (operated)
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The conclusion of the inquest was a Narrative Conclusion as follows:

The Deceased's death was caused or contributed to by the following factors:

(1) The Deceased was born on the 30 May 1932 and suffered from other co-morbid conditions of clinical significance. When the results of the blood tests taken at Macclesfield Hospital on the 27 January 2011 were received this should have resulted in an urgent admission to hospital and further investigations undertaken to establish the source of the symptoms. This did not happen.
(2) There was a significant failure to appreciate the seriousness of the condition, the need for urgent treatment and associated raised mortality risks upon the receipt of the results of the CT scan on the 28 February 2011 showing the presence of multiple liver abscesses and gallstones.
(3) Upon receiving advice about the need for a Cholecystectomy after the HPB MDT on the 9 March 2011 there was a significant failure to ensure that a timely and appropriate referral was made to a specialist Hepato-Biliary surgeon. Requesting the GP to make a formal referral at that stage was inappropriate and caused significant further delay in appropriate treatment.
(4) Throughout the course of his clinical care at Macclesfield Hospital there was a failure to ensure that he consistently received appropriate antibiotic therapy without avoidable gaps in treatment.
(5) Had the deceased been referred in a timely and appropriate manner for the Cholecystectomy following the HPB MDT on the 9 March 2011 and/or been provided with appropriate antibiotic cover to ensure resolution of his liver abscesses it is probable that after any further necessary investigations and treatment he would have undergone that surgery in early April 2011 and he probably would have survived.

Circumstances of death

1. The Deceased was born on the on 30 May 1932 and suffered from other co morbid conditions of clinical significance. He had been referred for further investigations to Macclesfield Hospital by his GP after exhibiting gastrointestinal symptoms and on 27 January 2011 he had blood tests which were found to be abnormal. This should have triggered an urgent admission and investigations to establish the source of the symptoms. This did not happen. His clinical care was led by a Consultant Physician and Gastroenterologist at that Hospital. A CT of his chest and abdomen were requested subsequently but on 21 February 2011 he was admitted via A&E as an inpatient to the same hospital suffering from vomiting, lethargy, fever and rigors. He was commenced on antibiotics, probably on 23 February.

2. He had a CT scan on 28 February 2011, which showed multiple liver abscesses and a large gall stone. There was a significant failure to appreciate the seriousness of the condition, the need for urgent treatment and associated raised mortality risks upon the receipt of the results of the CT scan . He was discharged from hospital on 8 March 2011 and his case was discussed at the HPB MDT the following day. Advice was given by the specialist Hepato-

Biliary surgeon based at North Manchester General Hospital that he should have Cholecystectomy, continue his antibiotics to treat the infection caused by the liver abscesses and be re-scanned to ensure their resolution.

3. It was later decided that he should undergo an ERCP. This was undertaken at Wythenshawe Hospital on 7 April 2011 and one gall stone was removed from the bile duct and a stent was left in situ. His GP was expected to make a formal referral for the Cholecystectomy. He was reviewed at Macclesfield Hospital on 3 May 2011 and his case was subsequently discussed at a further HPB MDT meeting. He was re-admitted to Macclesfield Hospital via A&E on 9 May.

4. On 10 May 2011 he underwent an abdominal ultrasound, which confirmed the presence of gallbladder stones and liver abscesses that had increased in size and would require drainage. This was performed on 13 May 2011. His case was further discussed at the HPB MDT on 18 May 2011 and it was decided that he would require a Cholecystectomy and a table Cholangiogram and he was transferred to North Manchester General Hospital on 20 May 2011 but was not seen and reviewed by the specialist Hepato-Biliary Surgeon until 24 May 2011.

5. The following day a further CT scan was performed, which showed the presence of gallstones and that there was reactive fluid in the chest and abdomen. He underwent an open Cholecystectomy, exploration of the common bile duct and removal of the biliary stent on 27 May 2011. Post-operatively he developed Pneumonia and Sepsis. He required HDU care and his condition deteriorated and he was transferred to the ICU. Despite treatment his condition further deteriorated and he died on 31 May 2011. The Post Mortem examination demonstrated extensive Empyema and Sepsis. The court received and accepted detailed medical evidence from an expert witness about the issues of diagnosis and medical management of the deceased.

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 will 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. When the results of the blood tests taken at Macclesfield Hospital on 27 January 2011 were received this should have resulted in an urgent admission to hospital and further investigations undertaken to establish the source of the symptoms. This did not happen and suggests failures in communication and senior clinical review and appreciation of the significance of the presenting symptoms.

2. There was a significant failure to appreciate the seriousness of the condition, the need for urgent treatment and associated raised mortality risks upon the receipt of the results of the CT scan on 28 February 2011 showing the presence of multiple liver abscesses and gallstones. These are all factors which it would be reasonable to expect senior clinicians to appreciate and plan care accordingly.

3. Upon receiving advice about the need for a Cholecystectomy after the HPB MDT on 9 March 2011 there was a significant failure to ensure that a timely and appropriate referral was made to a specialist Hepato-Biliary surgeon.

4. Requesting the GP to make a formal referral at that stage was inappropriate and caused significant further delay in appropriate treatment. His care was being led by a senior and experienced Consultant.

5. Throughout the course of his clinical care at Macclesfield Hospital there was a failure to ensure that he consistently received appropriate antibiotic therapy without avoidable gaps in treatment.

6. The deceased had not been referred in a timely and appropriate manner for the Cholecystectomy following the HPB MDT on 9 March 2011 and was not provided with appropriate antibiotic cover to ensure resolution of his liver abscesses

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.

Your response

You are under a duty to respond to this report within 56 days of the date of this report, namely by 4th December 2013. 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.

Copies and publication

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

1. The family of the deceased
2. Pennine Acute Hospitals NHS Trust
3. [redacted] – Readesmoor Medical Group Practice

I have also sent it to [redacted] – Consultant Hepato Biliary Surgeon - who may find it useful or of interest.

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.

N S Meadows **8th October 2013**
H.M. Senior Coroner – Manchester City area