Regulation 28: Prevention of Future Deaths report

Gregg O'REILLY (died 21.01.14)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Medical Director** **Barts Health** **Royal London Hospital** **Whitechapel Road** **London E1 1BB**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 04.02.14 I commenced an investigation into the death of Gregg O'Reilly, aged 53. The investigation concluded at the end of the inquest on 15.05.14. I concluded that Mr O'Reilly died from two naturally occurring diseases, contributed to by the recognised complications of medical treatment for one of these. His medical cause of death was: 1a bronchopneumonia and urinary tract infection 1b diverticular disease (treated) and cirrhosis of the liver 2 hypertensive heart disease.

4	**CIRCUMSTANCES OF THE DEATH** Mr O'Reilly was admitted as an emergency to the Royal London Hospital on 31.12.13. He was dehydrated and in a poor nutritional state, with a high stoma output from his ileostomy, an acute kidney injury and a high white cell count. On 17.01.13, he deteriorated and went into multi organ failure. He then suffered a bleed from his abdominal wound. The following day, he suffered a further bleed and this had to be treated surgically, after which he was admitted to critical care. However, he did not recover, and died three days later.
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 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. I heard that an opportunity was missed by the medical, ward nursing and critical care nursing outreach teams, to refer Mr O'Reilly to critical care, certainly by 17.01.14. It is unclear whether that would have changed the outcome for him, but it meant that he was not offered optimal care. Given the number of staff who could have made such a referral, it seems that this issue goes further than individual error or lack of understanding. I appreciate that also makes it a big issue to tackle. Further, although he was on two hourly observations, no record of any observation could be found between midnight on 17.01.14 and 3am on 18.01.14, when Mr O'Reilly was found to have suffered a second bleed with very low blood pressure, and a cardiac arrest call was made.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that and your trust 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 15.07.14. 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • [redacted] wife of Gregg O'Reilly • [redacted] intensivist, Royal London Hospital 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 19.01.14