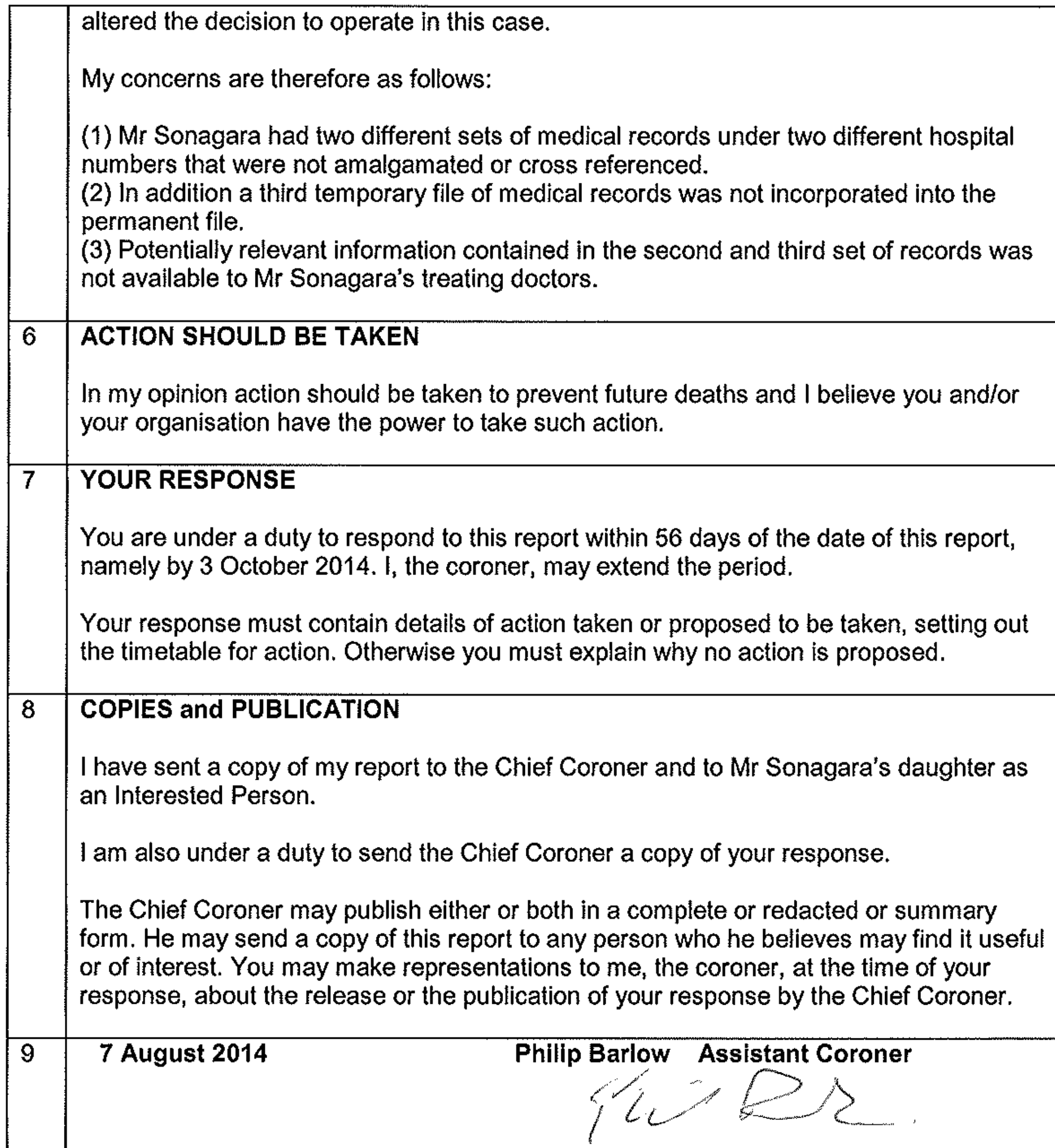
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Peter Morris, Chief Executive, Barts Health NHS Trust, c/o Legal Department, 3rd floor, 9 Prescot St, London E1 8PR**
1	**CORONER** I am Philip Barlow, assistant coroner, for the coroner area of Inner London South.
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 27 February 2013 I commenced an investigation into the death of Vijay Sonagara, age 54. The investigation concluded at the end of the inquest on 6 August 2014. The conclusion of the inquest was misadventure. The medical cause of death was 1a multi-organ failure; 1b alcoholic cirrhosis of the liver complicated by surgery for inguinal hernia repair (operated 8.2.13).
4	**CIRCUMSTANCES OF THE DEATH** Mr Sonagara had alcoholic liver disease and on 8 February 2013 underwent routine surgery for repair of inguinal hernia at Whipps Cross Hospital under the care of ███ ███ On 11 February 2013 Mr Sonagara's condition deteriorated rapidly. He was found to have decompensated alcoholic liver disease requiring intensive care treatment. He was transferred to St Thomas' Hospital where he died on 22 February 2013.
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. – The evidence at the inquest was that Mr Sonagara was being seen by the gastroenterologists at Whipps Cross Hospital at the same time as he was being considered for surgery by███ However, the gastroenterology treatment was recorded in a different set of hospital records using a different hospital number (but under the same name, same address, and same NHS number). In addition the evidence showed that there was a temporary file containing further medical records. These sets of medical records were not amalgamated or cross referenced.███ and his team were unaware of the other medical records and the information contained within them. As a result they were unaware that Mr Sonagara was being actively investigated at the same hospital. The information within the second and third set of records was potentially relevant to the decision making, although my final conclusion was that it would not have



	altered the decision to operate in this case. My concerns are therefore as follows: (1) Mr Sonagara had two different sets of medical records under two different hospital numbers that were not amalgamated or cross referenced. (2) In addition a third temporary file of medical records was not incorporated into the permanent file. (3) Potentially relevant information contained in the second and third set of records was not available to Mr Sonagara's treating doctors.
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 3 October 2014. 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 Mr Sonagara's daughter as an Interested Person. 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.
9	**7 August 2014** **Philip Barlow Assistant Coroner**