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.** Mr Jeremy Hunt MP, Secretary of State for Health **2.** Mr David Dalton, Chief Executive, Salford Royal NHS Foundation Trust.
1	**CORONER** I am Alan Peter Walsh, HM Area Coroner , for the Coroner Area of Manchester West
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 22nd August 2014 I commenced an Investigation into the death of Stanley Oliver, 85 years, born 6th October 1928. The Investigation concluded at the end of the Inquest on 6th July 2015. The medical cause of death was 1a) Multi Organ Failure 1b) Sepsis 1c) Perforated Gall Bladder 2) Neutropenia due to Tuberculosis of the Bone Marrow. The conclusion of the Inquest was Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** 1. Stanley Oliver died at the Salford Royal Hospital, Eccles Old Road, Salford on 14th August 2014. 2. Mr Oliver was admitted to the Salford Royal Hospital on Saturday 2nd August 2014 with abdominal pain and a CT scan revealed a perforated gall bladder. Mr Oliver was referred to the surgical team and the on call surgeon felt that surgical intervention represented too high a risk to Mr Oliver's life and that the better course of action would be intravenous fluids, antibiotics and the placement of a radiological drain. The Surgeon referred Mr Oliver to the on call Radiologist to consider the placement of a percutaneous cholecystostomy drain to drain the gall bladder over the weekend and Mr Oliver did not respond to the medical treatment. 3. The percutaneous cholecystostomy is an interventional radiology procedure to place a drainage tube into the lumen of a gall bladder using

	either ultrasound or CT guidance and a conscious sedation/local anaesthetic. The indication is usually to drain a distended, severely inflamed/pus containing gall bladder, which has not perforated. The Radiologist described the CT findings as indicating an already perforated gall bladder, which was therefore not very distended and would be difficult to drain. Furthermore the Radiologist told the Consultant Surgeon that he was unable to drain the gall bladder as he did not have the competence to perform the procedure. 4. The evidence at the Inquest was that all the gall bladder drainage was performed by gastro-intestinal (GI) Radiologists. There are four GI Radiologists at the Salford Royal Hospital but there is no on call rota in relation to the Radiologists, although it was accepted practice within the Radiology Department to request a clinical Consultant to contact one of the Radiologists direct with a view to performing the procedure out of hours. No contact was made with any of the GI Radiologists and a drain was not inserted until Monday 4th August 2014 when one of the GI Radiologists inserted a drain outside the gall bladder. 5. Mr Oliver continued to be treated with antibiotics and intravenous fluids and the drain was found to be operating successfully from the 4th August 2014 but Mr Oliver subsequently deteriorated and died on the 14th August 2014.
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: 1. During the Inquest evidence was heard that: i. There was no on call rota for a GI Radiologist to perform a percutaneous cholecystostomy out of hours and particularly over a weekend. The Hospital Trust indicated that a risk had been identified in relation to the unavailability of GI Radiologists out of hours and the Hospital that managed the risk by allowing the GI Radiologist to be contacted out of hours but the Trust accepted that there was no provision for the Radiologist to be available out of hours. ii. The Consultant Surgeon gave evidence at the Inquest that availability of a GI Radiologist to perform a percutaneous cholecystostomy was critical to the management of a patient and he raised concerns that there would be a risk to life if a percutaneous cholecystostomy could not be performed out of hours, either overnight or over a weekend.

iii. I accepted evidence at the Inquest that the Salford Royal NHS Foundation Trust were considering actions to make GI Radiologist available out of hours and to establish a system for any Radiologist to contact a GI Radiologist our of hours for procedures to be conducted out of hours. However there was no confirmation that an out of hours on call rota was being considered for GI Radiologists either within the Salford Royal NHS Foundation Trust or for a rota to relate to a wider area covering several other hospitals on the basis that an available Radiologist could travel to different hospitals to carry out a necessary procedure out of hours.

iv. Evidence was given at the Inquest that the unavailability of GI Radiologists was not limited to Salford but was a national problem in that there were very few out of hours on call rotas for GI Radiologists in hospitals in the United Kingdom.

It was accepted that a perforated gall bladder was a recognised condition, which occurred on a regular basis as an emergency presentation to hospital. In some cases surgical intervention would not be appropriate and an alternative treatment plan would involve the insertion of a percutaneous cholecystostomy drain or a drain to be inserted outside the gall bladder, both of which would require insertion by a GI Radiologist.

v. The evidence raised concerns that there is a risk of future deaths will occur unless action is taken to review the above issues.

2. I request you to consider the above concerns and to carry out a review with regards to the fact

i. The availability of GI Radiologists out of hours to perform procedures crucial to the management of the patient, including the provision of out of hour's rotas either within a single Hospital Trust or a rota as between hospitals in a group of Hospital Trusts.

ii. The provision of an out of hour's rota as referred to in 2.i. above within Salford Royal NHS Foundation Trust

iii. The provision of procedures and protocols in relation to the availability of GI Radiologists out of hours and a definitive line of communication whether it be as between Radiologists or by clinical Consultant direct to GI Radiologists to discuss and arrange a procedure out of hours.

iv. The training of health professionals in relation to the availability of GI Radiologists out of hours including training in relation to the procedures and protocols established in support of out of hours availability.

6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 10th September 2015. 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) [redacted] Mr Oliver's son 2) [redacted] Mr Oliver's son 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	**Dated** **16th July 2015**	**Signed** [redacted] **Alan Peter Walsh**