Karen Dilks
Senior Coroner for the City of Newcastle Upon Tyne

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Mr Jim Mackey, Chief Executive, North Tyneside General Hospital, Rake Lane, North Shields, NE29 8HN**
1	**CORONER** I am Karen Dilks, Senior Coroner for the City of Newcastle Upon Tyne
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 8th February 2012 Mr Eric Armstrong, Senior Coroner for North Tyneside and South East Northumberland opened and Inquest into the death of Patrick Joseph Carrick aged 54 years. The case was transferred to the Jurisdiction of Newcastle upon Tyne on the 1st May 2015 pursuant to the provisions of Section 2 of the Coroners & Justice Act 2009. The Conclusion of the Inquest was a Narrative conclusion: died due to a rare but recognised complication of a necessary surgical procedure. Mr Carrick was diagnosed with Colorectal Cancer and on the 23rd January 2012 underwent a Laparoscopic High Anterior Resection to treat this condition at North Tyneside General Hospital. Recognised complications of the surgery led to his death on the 5th February 2012.
4	**CIRCUMSTANCES OF THE DEATH** On the 23rd January 2012 at North Tyneside General Hospital Mr Carrick underwent Laparoscopic High Anterior Resection for Colorectal Carcinoma. The procedure was without event and there were no intra operative complications. In or around noon of the 24th January 2012 Mr Carrick's clinical condition deteriorated. His early warning score increased. Mr Carrick was reviewed by medical staff and an outreach nurse. The parameters for his management set at these reviews were not implemented (or there is no documented evidence of implementation) Blood analysis was undertaken and results available. No action in response was taken (or there is no documented evidence of any action taken) Mr Carrick received no intravenous fluids between 4pm and 10pm on the 24th January (or there is no documented evidence that he received such fluids) During output monitoring and observations were not conducted in accordance with the management plan (or there is no documented evidence of the same)

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	The directed administration of broad spectrum antibiotics at 5.25pm on the 24th January was not implemented until 7.10pm on the evening of the 24th January. There was no clinical consideration of the possibility of Acute Pancreatitis. The diagnosis of the same was made on the 25th January and thereafter appropriately treated. Acute Pancreatitis is a rare but recognised complication of the surgery Mr Carrick underwent. There was consensus between Independent experts that earlier diagnosis of Acute Pancreatitis was desirable, however it would not have affected the outcome in Mr Carrick's case.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) There was a significant departure from a patients management plan without explanation (2) The above was compounded as it occurred in a period of rapid deterioration (3) Crucial blood analysis results were not actioned (4) Inadequate completion of nursing and medical notes

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 . 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 [redacted] 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 09 October 2015 Signature_____ Senior Coroner for the City of Newcastle Upon Tyne