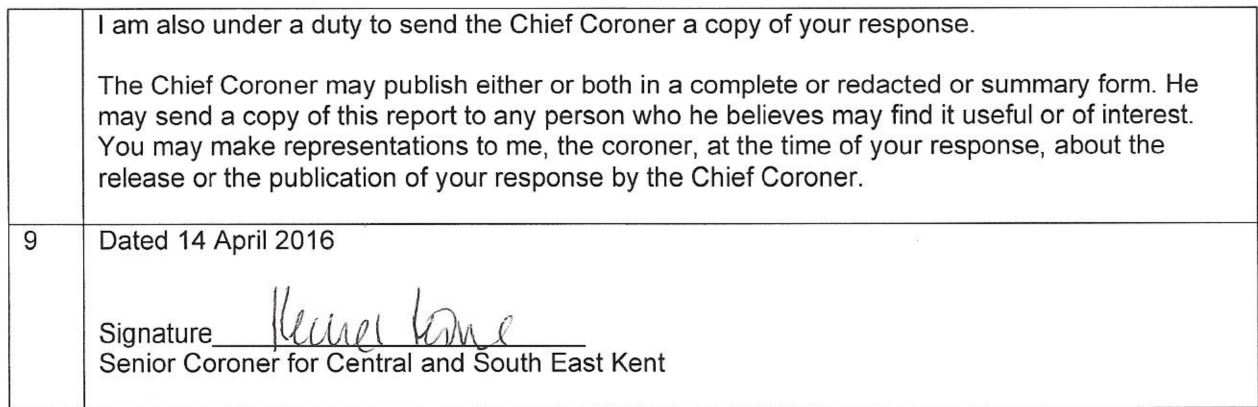
Helen Rachel Redman
Senior Coroner for Central and South East Kent

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Mr M Kershaw Chief Executive East Kent Hospitals University NHS Foundation Trust Kent & Canterbury Hospital Ethelbert Road CT1 3NG
1	**CORONER** I am Helen Rachel Redman, Senior Coroner for Central and South East Kent
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 21/05/2015 I commenced an investigation into the death of Helen Jennifer Turner. The investigation concluded at the end of the Inquest on 06.042016. The conclusion of the Inquest was: Mrs H J Turner was admitted to William Harvey Hospital on 08.04.15 complaining of symptoms of diarrhoea and vomiting which were diagnosed as a sigmoid colon obstruction on 12.04.15. On 20.04.15 Mrs Turner underwent surgery after developing peritonitis. There was a delay in reaching a correct diagnosis and a delay in operating on Mrs Turner which, on the balance of probability, has caused or contributed materially to her death on 17.05.15
4	**CIRCUMSTANCES OF THE DEATH** Helen Turner was admitted to William Harvey Hospital on 06.04.15 complaining of diarrhoea and vomiting. Initially it was thought that she had gastroenteritis but a CT of the abdomen confirmed a diagnosis of sigmoid colon obstruction. It was recommended that she undergo a stenting procedure at Kent & Canterbury Hospital but whilst waiting for transfer on 12.04.15 she deteriorated suffering from sepsis. She was transferred to the Intensive Care Unit where her condition further deteriorated. It was not until 20.04.15 that surgery was carried out which confirmed that she was now suffering from faecal peritonitis as a result of colonic perforation. A Hartmann's procedure was undertaken. Helen Turner was transferred to the Intensive Care Unit where she underwent further surgical procedures for abdominal wash out but deteriorated and died on 17.05.16. The cause of death was: 1a) Multiple organ failure 1b) Peritonitis owing to colonic perforation 1c) Large bowel obstruction owing to Adenocarcinoma of the sigmoid colon (operated)
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. – • There was a delay in confirming the diagnosis of sigmoid colon obstruction which did not take place until 12.04.15, some four days after her admission to William Harvey Hospital. • There was a delay in the decision for Mrs Turner to undergo a stenting of four days, by which time her condition had deteriorated thus rendering her unsuitable for this procedure. • There was a delay in operating on Mrs Turner to remove the bowel obstruction which did not take place until 20.04.15 by which stage her condition had deteriorated to a critical level. • The expert evidence heard at the Inquest found that Mrs Turner had a 90% chance of surviving the diagnosis of cancer and abdominal surgery to remove the tumour. Because of the delay in diagnosis and surgery, her chances of survival were diminished. •

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. • I have written two previous PFD Reports concerning the standard of [redacted] surgery at William Harvey Hospital. I attended an Individual Review on behalf of the Royal College of Surgeons of [redacted] in September 2015 at the Kent and Canterbury Hospital, Canterbury. • I am satisfied that as a result of the review steps have been taken to monitor [redacted] clinical practice and restrict him from undertaking emergency surgery. I understand that he is being mentored by a Consultant Surgeon at St Mark's Hospital, London and is being reviewed by his College. • I believe that these steps to safeguard [redacted] patients should continue until East Kent Hospitals University NHS Foundation Trust in conjunction with the Royal College of Surgeons are satisfied that he no longer poses a threat to his patients.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 09 June 2016. 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:- [redacted] Medical Director East Kent Hospitals University NHS Foundation Trust [redacted] Medical Director – Surgical Directorate East Kent Hospitals University NHS Foundation Trust President of Royal College of Surgeons 35-43 Lincoln's Inn Fields, Lincoln's Inn Fields, London WC2A 3PE [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 14 April 2016 Signature____________ Senior Coroner for Central and South East Kent

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