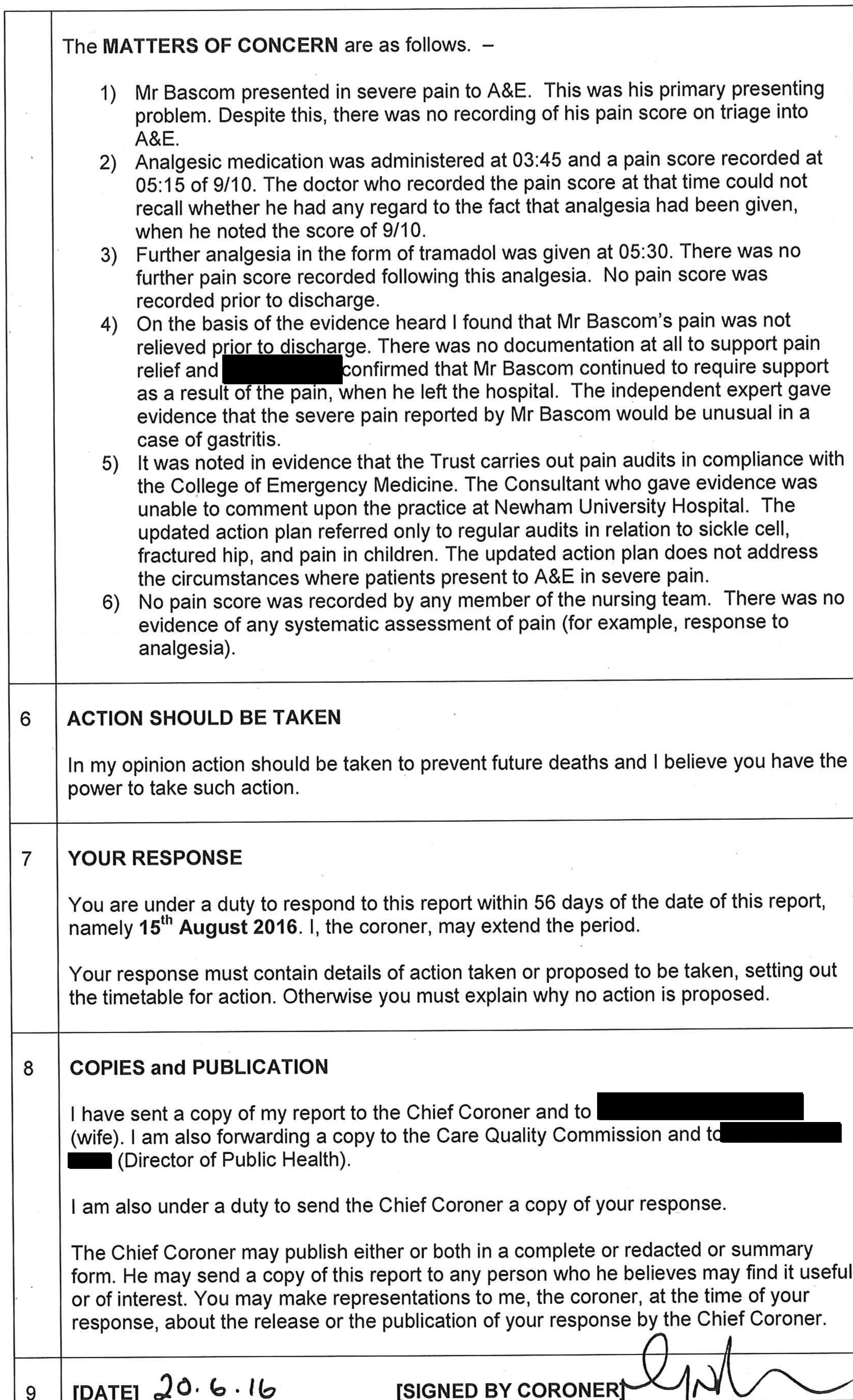
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Alwen Williams, Chief Executive, Barts Health NHS Trust, Royal London Hospital, Whitechapel Road, Whitechapel, London, E1 1BB**
1	**CORONER** I am Nadia Persaud, Senior Coroner for the Eastern Area of Greater London
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/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 8th September 2015 I opened an inquest into the death of Mr Zawdie Ogunseye Bascom. The investigation concluded at the end of the inquest on the 17th June 2016. The conclusion of the inquest was natural causes contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Mr Bascom was a 38 year old gentleman who suffered an onset of severe abdominal pain on Saturday 10th May 2014. He presented to A&E at Newham General Hospital with the primary presenting complaint of severe pain and was assessed by a triage nurse and then a locum SHO. The SHO carried out an abdominal examination which revealed a non-distended, hard and rigid abdomen. Observations were noted to be within normal limits, as was a full blood count. Venous blood gases however revealed a low pH (7.217) and a raised lactate (2.2). Only one pain score was recorded during the course of the 5 hour attendance to A&E, despite the reason for attendance being severe pain. Mr Bascom was discharged from hospital with a presumed diagnosis of gastritis. Mr Bascom remained in severe pain throughout the 11th May 2014 and presented to his GP on the 12th May 2014. The GP was provided with a discharge summary from A&E, which included reference to no raised inflammatory markers and a normal chest x-ray. The GP was not informed of the abnormal venous blood gas results. The GP changed the prescription of lansoprazole to omeprazole and recommended that Mr Bascom should return to A&E if the pain persisted or if he had no relief to the medication given. Mr Bascom collapsed at around 21:00 hours on the 12th May 2014 and in spite advance life support by paramedics and in hospital, he passed away on the evening of 12th May 2014 at Newham University Hospital. A post mortem examination confirmed a cause of death of 1a) Peritonitis 1b) Rupture of Inflamed Vermiform Appendix.
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) Mr Bascom presented in severe pain to A&E. This was his primary presenting problem. Despite this, there was no recording of his pain score on triage into A&E.
2) Analgesic medication was administered at 03:45 and a pain score recorded at 05:15 of 9/10. The doctor who recorded the pain score at that time could not recall whether he had any regard to the fact that analgesia had been given, when he noted the score of 9/10.
3) Further analgesia in the form of tramadol was given at 05:30. There was no further pain score recorded following this analgesia. No pain score was recorded prior to discharge.
4) On the basis of the evidence heard I found that Mr Bascom's pain was not relieved prior to discharge. There was no documentation at all to support pain relief and confirmed that Mr Bascom continued to require support as a result of the pain, when he left the hospital. The independent expert gave evidence that the severe pain reported by Mr Bascom would be unusual in a case of gastritis.
5) It was noted in evidence that the Trust carries out pain audits in compliance with the College of Emergency Medicine. The Consultant who gave evidence was unable to comment upon the practice at Newham University Hospital. The updated action plan referred only to regular audits in relation to sickle cell, fractured hip, and pain in children. The updated action plan does not address the circumstances where patients present to A&E in severe pain.
6) No pain score was recorded by any member of the nursing team. There was no evidence of any systematic assessment of pain (for example, response to analgesia).

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 **15th August 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 (wife). I am also forwarding a copy to the Care Quality Commission and to (Director of Public Health).

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 [DATE] 20.6.16 [SIGNED BY CORONER]