REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. **Mr Steve Jenkin, Chief Executive, Queen Victoria NHS Hospital Trust**
2. **[redacted], Medical Director, Queen Victoria NHS Hospital Trust**
3. **Mr Jeremy Hunt, Department of Health**
4. **Mr Simon Stevens, Chief Executive, NHS England**
5. **Sir David Behan, Chief Executive, Care Quality Commission**

CORONER

I am Karen HENDERSON, assistant coroner for the coroner area of West Sussex

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

INVESTIGATION and INQUEST

On 17th May 2017 I commenced an investigation into the death of Dennis Allen Teesdale, 83 years of age. The investigation concluded at the end of the inquest on 18th May 2017. The medical cause of death given was:

1a. Multi-organ failure
1b. Perforated large and small bowel (operated 19.10.16)
1c. Intra-operative percutaneous endoscopic gastrostomy (17/10/16)

2. Right squamous cell carcinoma and neck dissection (17/10/17), Left ventricular hypertrophy and ischaemic heart disease due to coronary artery atheroma, abdominal adhesions related to previous AAA repair and splenectomy, COPD

My narrative conclusion was:

Complications arising from the insertion of a percutaneous endoscopic gastrostomy in contravention of hospital guidelines. The recognition of these complications was delayed resulting in a lost opportunity to receive timely and optimal treatment

CIRCUMSTANCES OF THE DEATH

Mr Teesdale was a 83 year old man who underwent a hemiglossectomy, neck dissection and ALT free flap for a squamous cell carcinoma of the tongue on the 17th October 2016 at Queen Victoria Hospital, East Grinstead.

A Percutaneous Endoscopic Gastrostomy (PEG) was placed to allow enteral feeding post operatively. This involves placing a tube through the abdominal wall into the stomach guided by a light from an endoscope that had been placed in the stomach. Mr Teesdale was not a very fit man having ischaemic heart disease requiring coronary artery stents in the past and mild chronic obstructive pulmonary disease. He also had an abdominal aortic aneurysm repair and associated splenectomy in 2000.

In the morning of the 18th October, after being awoken from sedation Mr Teesdale complained of abdominal pain. This continued variably throughout the day. An abdominal ultrasound showed a small rectus sheath

haematoma which was regarded as the cause of the abdominal pain despite the pain appearing to be disproportionate to the size of the haematoma. Mr Teesdale also had a persistently raised lactate from 10.00 am which was not considered significant. By the early evening, Mr Teesdale had become distressed from severe abdominal pain and in the early hours 19th October 2016) he developed incipient multi-organ failure requiring blood pressure support with a noradrenaline infusion, amiodarone for fast atrial fibrillation and poor urine output.

No investigations were considered or undertaken for this deteriorating clinical picture and senior advice was not requested. At 0445 the on call surgical trainee reviewed Mr Teesdale and did not recognise a failing patient and did not request assistance from the on-call consultant surgeon. By 0600 a blood white cell count was documented to have fallen and the CRP had substantially risen indicative of septic shock, which was not recognised or commented upon as significant at the time or at any time subsequently.

Mr Teesdale was reviewed by the senior surgeons at or around 0900 on the 19th October and a decision was made to contact the surgeons at the Royal Sussex County Hospital (RSCH) for guidance without urgency or any documented recognition or understanding that Mr Teesdale was very unwell. An abdominal and chest x-ray was undertaken mid-morning. This showed air under the diaphragm indicative of a perforated abdominal viscus.

Several hours later Mr Teesdale was transferred to RSCH for a CT scan after which he had a laparotomy. This confirmed a considerable amount of adhesions from previous surgery, peritonitis from leakage of bowel contents from a PEG tube passing through the small and large bowel before entering the stomach. Mr Teesdale was transferred to the ITU at the RSCH but despite active resuscitation, he died on the 20th October 2016.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise for concern. In my opinion there is a risk that future death 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 Teesdale's care was compromised by the isolated position and associated lack of facilities and other sub-speciality medical and surgical clinical personnel able to assist in the investigation and management of Mr Teesdale at Queen Victoria Hospital, East Grinstead. More particularly:

2. There are no facilities or clinicians (radiologist or gastroenterologists who normally undertake such procedures) available to place a PEG prior to surgery, thereby requiring oral maxillo-facial surgeons of variable and unclear experience to undertake the procedure peri-operatively.

3. Written guidance by the surgeons for insertion of PEG's was not followed with little reflection as to whether this was an acceptable procedure given Mr Teesdale's previous extensive surgery at or around the point where the PEG was inserted with concomitant poor gastroscopic trans-illumination.

4. No risk assessment was undertaken as to whether a PEG insertion would have been appropriate, given that a non-invasive alternative of a feeding tube for enteral feeding was available.

5. No formal 'training' programme for the insertion of PEG or independent competency based assessment.

6. The post-operative management of Mr Teesdale did not follow the written guidance for the management of abdominal pain after PEG insertion. This resulted in a delay in seeking appropriate advice, timely intervention and optimal treatment of this complication.

7. Mr Teesdale's transfer was delayed because of a reluctance to transfer in the immediate post operative period complicated by the associated logistical difficulties of doing so given his major surgery.

8. As an isolated hospital, Queen Victoria Hospital has no 'on site' clinical specialist experience to assist when patients develop complications. As a consequence, there was no specialist available to assess Mr Teesdale's abdominal pain as detailed in guidance of post-operative pain following PEG insertion. No effort was made to seek such expert advice during 'daytime working hours'.

9. Mr Teesdale was cared for 'out of hours' by a trainee oral-maxillo-facial surgeon with unknown general surgical experience who did not recognise or manage the severity of a surgical complication.

10. There was no recognition of how unwell Mr Teesdale was on the consultant surgical ward round at or around 0900 on the 19th October 2016, despite considerable evidence present at the time that Mr Teesdale had developed multi-organ failure.

11. Poor communication between nursing staff, anaesthetic staff and surgical staff making it difficult to provide an overall consistent and systematic approach to the management of Mr Teesdale in a small High Dependency Unit with an inconsistent consultant presence during the day.

12. There are no haematology or biochemistry services at QVH. A courier service is required for emergency laboratory tests. This has the potential to either not request 'bloods' and/or a delay in obtaining results. Similarly, there is no 'out of hours' radiology service and there is no CT scanner on site to assist in a diagnosis (which was required as part of the management guidelines prepared by QVH).

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation: Queen Victoria Hospital NHS Trust, NHS England, Department of Health, CQC, have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd August 2017. I, the coroner, may extend this 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.

COPIES and PUBLICATION

1. I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] (wife), [redacted] (sons).

2. I have also sent it to: [redacted] (President Royal College of Surgeons), [redacted] (President, Royal College of Anaesthetists), [redacted] and [redacted] (Chief executive and executive Medical Director BSUH NHS Hospital Trust), [redacted] (Chief Executive Eastbourne Hospital NHS Trust), [redacted] (surgeon, QVH), [redacted] (anaesthetist QVH), who may find it useful or of interest.

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.

DATE: 7 June 2017 **SIGNED:** pp Jenny Fisher.