REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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<tr><td></td><td>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. Chief Executive, Walsall Manor Hospital Trust
2. Chief Coroner</td></tr>
<tr><td>1</td><td>CORONER

I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.</td></tr>
<tr><td>2</td><td>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.</td></tr>
<tr><td>3</td><td>INVESTIGATION and INQUEST

On the 15 May 2017, I commenced an investigation into the death of the late Mrs Dorothy Webb. The investigation concluded at the end of the inquest on 16 August 2017. The conclusion of the inquest was natural causes.

The cause of death was:

1a Haematemesis With Aspiration Of Gastric Contents
b Syndrome Of Inappropriate Antidiuretic Hormone Secretion (SIADH)
c Small Cell Carcinoma Of Right Lung With Liver Metastases
II Chronic Obstructive Pulmonary Disease</td></tr>
<tr><td>4</td><td>CIRCUMSTANCES OF THE DEATH

i) Around December 2016, Mrs Webb's health began to decline and she was experiencing dizziness and had lost consciousness. She was admitted to Walsall Manor Hospital with a suspected stroke and a diagnosis of hyponatraemia (low sodium levels) and syndrome of inappropriate secretion of antidiuretic hormone diagnosed. She was later discharged on the 27 January 2017.

ii) On 2 February 2017, she attended the same hospital after a fall. An x-ray was done and no fracture noted at the time.

iii) The next hospital admission came in April 2017, when she presented with a history of expressive dysphasia and a transient ischaemic attack (TIA) was suspected. She was treated and also commenced on antibiotics for a urinary tract infection before discharge.

iv) She was re-admitted back to hospital on the 25 April after a further fall and on this occasion a fracture (wedge fracture at T12) was identified. Two CT scans were done but only one scan was examined by the Radiologist and consequently a right para-vertebral soft tissue mass on the CT scan wasn't identified.</td></tr>
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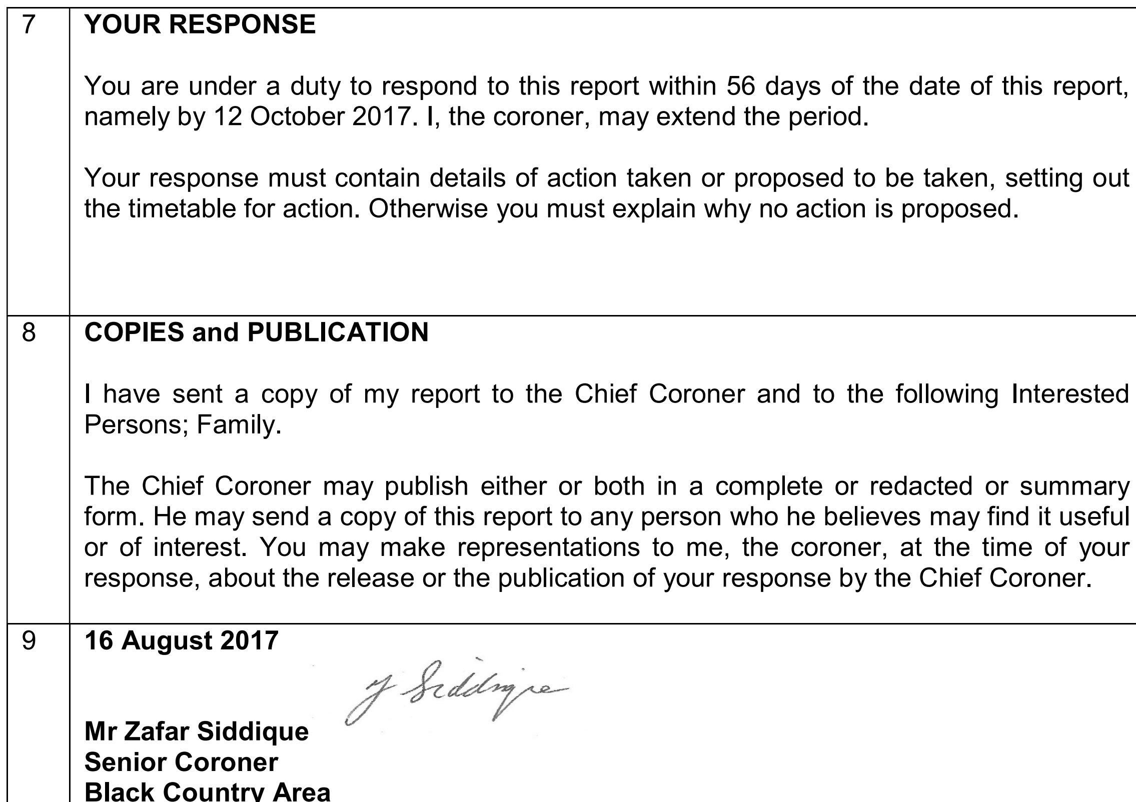
	v) On the 2 May she complained of chest pain and troponin levels were mildly elevated. She was found to be hypertensive and this was treated. vi) On the 4 and 5 May, she had several episodes of coffee ground vomit and at around 20:40 hrs. on the 5 May, she deteriorated rapidly and had vomited a round 500ml of coffee ground vomit which she immediately aspirated. vii) An emergency response was initiated and the suction machine used was ineffective but the Doctor treating her at the time does not believe she would have survived even if the suction machine had been effective because she was very frail and had very poor physiological reserves. viii) She sadly passed away a short time later. ix) After post-mortem, the tissue mass identified in the scan was confirmed as small cell carcinoma of Right Lung with Liver Metastases. This type of cancer is particularly aggressive and very difficult to treat and had spread from the lungs to the liver. x) The immediate cause of death was heametemisis (vomiting of blood) in conjunction with aspiration blood-stained vomit/gastric contents into the blood. There was evidence of a small distal oesophageal mucosal tear from episode of retching and vomiting. The low blood sodium levels and the development of inappropriate antidiuretic hormone secretion can be caused by the small cell carcinoma.
5	**<u>CORONER'S CONCERNS</u>** 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. Evidence emerged during the inquest that there was a missed opportunity and failure by the Radiologist to assess the scan which would have resulted in further investigation of the "mass" that was identified. Although this may not, on the balance of probability prevented the outcome, it may well have resulted in further medical investigation and treatment. 2. There was also a failure to note a fracture from the x-ray during the admission in February 2017 and consequently the patient and family were unaware of its existence until the re-admission in April 2017.
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. 1. In relation to the failure to note the scan results, you may consider re-visiting your procedures and systems to ensure that this is not replicated as part of your internal serious incident investigation.



7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12 October 2017. 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; Family. 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	**16 August 2017** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**

[IL1: PROTECT]