REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Re: Terrence Denis George, deceased

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]– Centre for Guidelines Director National Institute for Health and Care Excellence 10 Spring Gardens London SW1A 2B
1	**CORONER** I am Dr E Emma Carlyon Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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.
3	**INVESTIGATION and INQUEST** **Terrence Denis George (DOB 23.11.1943) died on 07.01.2016 at the Royal Cornwall Hospital, Treliske, Truro. The death was reported to the Coroner and a post mortem was undertaken and a cause of death established as 1a Acute Necrotising Haemorrhagic Pancreatitis 1b Cholelithiasis (Gallstones) II Ischaemic heart disease. An Inquest was opened on 20th January 2016. The inquest hearing took place between 14th- 15th June 2017 at Truro Municipal Buildings. The inquest concluded that "Terrence George died from severe gallstone pancreatitis without a date having been set for a necessary gallstone surgery within recommended timescale (2 weeks) following a previous pancreatitis episode on the 9th August 2015. There was an inadequate system in place to ensure the timeliness of the gallstone operation by the treating Hospital Trust.**
4	**CIRCUMSTANCES OF THE DEATH** Terrence George was admitted to the Royal Cornwall Hospital on the 9th August 2015 and was diagnosed with gallstone pancreatitis which settled. He was discharged on the 16th August with a plan for an outpatient appointment within 6 weeks. The Royal Cornwall Hospital trust treating Consultant was unaware of the discharge plan. Mr George was seen on the 6th October 2015 by a Consultant Surgeon who advised urgent admission to hospital for laparoscopic cholecystectomy and laparoscopic ultrasound. The consultant endeavoured to set a date for the surgery but the surgical booking clerk did not answer the telephone and there was no answerphone service available. The pre-operative assessment was conducted by telephone on the 19th November 2015 and a request was made by email to the GP on the same day for a series of tests to be undertaken. There was no time scale communicated for the tests. Mr George attended the GP surgery for the tests on the 25th November 2015 but for unidentified reason not all the tests were undertaken. The GP surgery pre-assessment team identified this between the 9-22nd December 2015 and an appointment as made with the GP surgery to complete the tests on the 4th January 2016. Despite arrangements being made for pre-assessment surgical tests, no surgery date was fixed prior to Mr George's

	emergency admission to the Royal Cornwall Hospital on the 3rd of January 2016 with a further episode of severe pancreatitis. Despite full intensive care treatment, Mr George deteriorated over the following day and died on the 7th January 2016. The International Association of Pancreatology (IAP) and the British Society of Gastroenterology (BSG) recommended a cholecystectomy to take place urgently after diagnosis of gallstone pancreatitis (within 2 weeks) and if performed, on balance would have avoided death at this time. The treating hospital did not have an adequate system for ensuring the timeliness of gallstone surgery or to identify that Mr George had not had his operation within the recommended Guidelines.
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. – At inquest the Coroner was reassured that the treating hospital (The Royal Cornwall Hospitals NHS Trust) had put in place measures to ensure an adequate system for ensuring the timeliness of gallstone surgery and to identify when patients had not had their operations within the recommended guidelines following the death of Mr George (see attached letter dated 26/07/2017). At the request of the Coroner, Royal Cornwall Hospital wrote to 12 acute NHS Trusts within the South West and only 2 of the 9 Trusts who had replied had any local guidance in place which sets out the pathway for surgery following diagnosis of gallstone pancreatitis. Although the treating doctors were aware of The International Association of Pancreatology (IAP) and the British Society of Gastroenterology (BSG) recommendation that a cholecystectomy should take place urgently after diagnosis of gallstone pancreatitis the Trust Management had not prioritised this due to other competing demands on Trust resources. It was considered that if there were NICE guidelines with regards to the timing of surgery after diagnosis of gallstone pancreatitis then Trusts would prioritise the timing of such surgery.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. We understand that your organisation is working on the production of NICE guidance in the areas of gallstone pancreatitis and that there is a timetable for the production of the guidance. In order to avoid further deaths it would be helpful if the current timetable was adhered to or brought forward.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 21st November 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 [redacted] of S J Edney solicitors (family); [redacted] (RCHT); [redacted] of

	BLM law (GP surgery). I have also sent it [redacted] and [redacted] (treating physicians) and Sarah Newton, MP 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.	
9	**[DATE]** **03/10/2017**	**[SIGNED BY CORONER]** Elizabeth Emma Carlyon