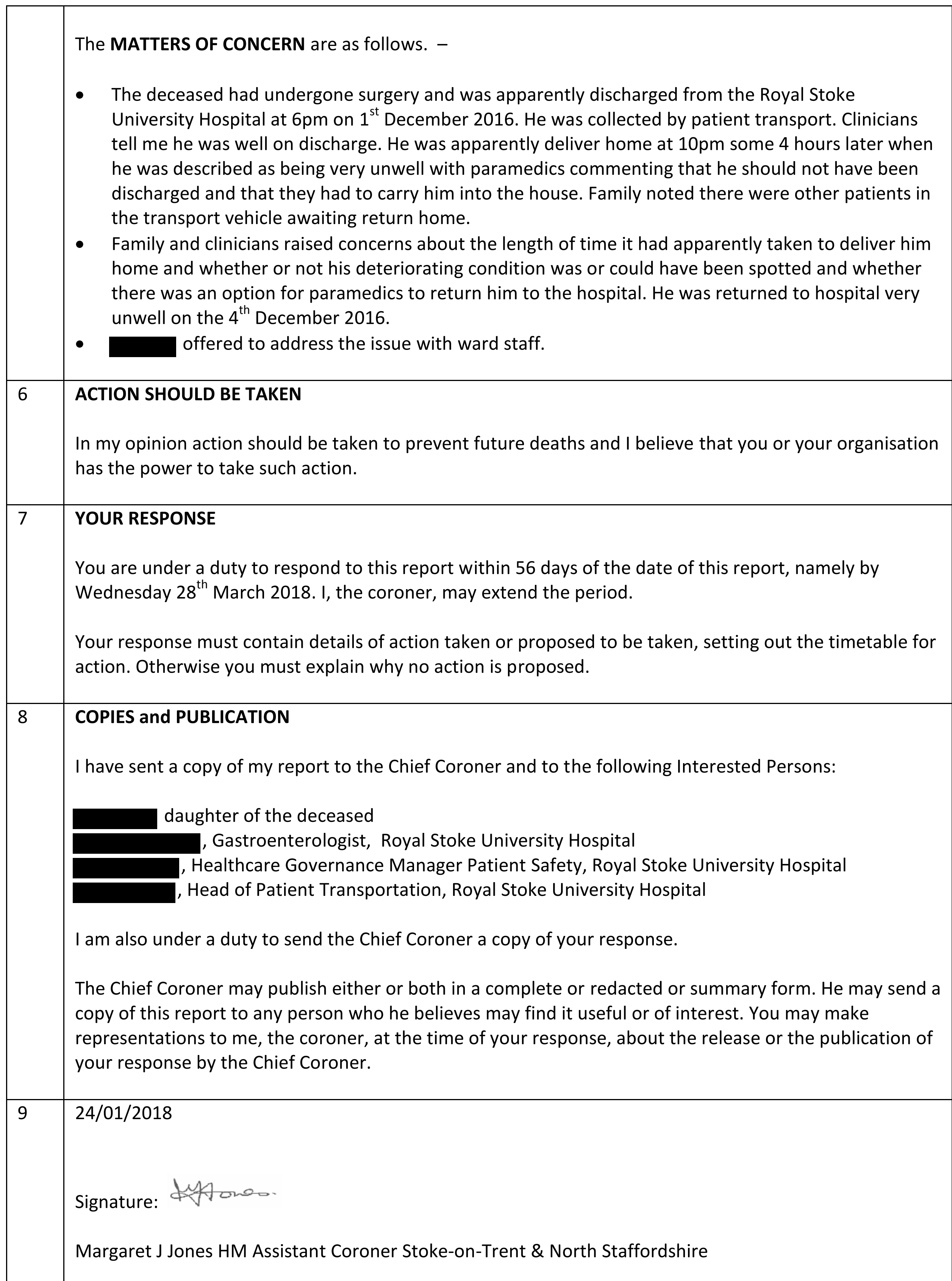
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Accountable Officer** **Staffordshire CCGs** **Place 2** **1st Floor** **Stafford** **ST16 2LP**
1	**CORONER** I am Margaret J Jones HM Assistant Coroner for
2	**CORONER'S LEGAL POWERS** I make this report under 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 15/12/2017 I commenced an investigation into the death of Reginald George KEY. The investigation concluded at the end of the inquest 24th January 2018. The conclusion of the inquest was that the deceased had a medical history which included diabetes mellitus, hypertension and gall stones. His gall stones had caused periodic problems and in 2016 he had lost weight. On 22nd November 2016 he was admitted to the Royal Stoke University Hospital. Stoke-on-Trent with severe right upper quadrant abdominal pain with vomiting. On 28th November he underwent a laparoscopic cholecystectomy during which an obstructing stone or sludge in the common bile duct could not be cleared. On 1st December he underwent an endoscopic retrograde cholangiopancreatography which failed to reveal a blockage and it was thought that any blockage had resolved naturally. He was discharged home the same day. He was readmitted on 4th December having been unwell ever since discharge. He appeared to be septic and there was evidence of a collection in the retroperitoneal gutter and there was a blood clot in the stomach. He underwent a number of procedures over the next few days including being taken to theatre for three laparotomies where a perforation of the duodenum was repaired (thought to have occurred during the endoscopic retrograde cholangiopancreatography) and the removal of large sections of ischaemic small and large bowel took place but his condition continued to decline and he died at 7.30 pm on 10th December 2016. The cause of death was:- 1a Multi organ failure. 1b Abdominal sepsis (treated). 1c Duodenal perforation following ERCP procedure.
4	**CIRCUMSTANCES OF THE DEATH** The death was reported due to surgery. He had been re-admitted 4/12/16 with septic shock. Had had colecystectomy 28/11/16 at RSUH. History: gallstone; hypertension; type II diabetes.
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. – • The deceased had undergone surgery and was apparently discharged from the Royal Stoke University Hospital at 6pm on 1st December 2016. He was collected by patient transport. Clinicians tell me he was well on discharge. He was apparently deliver home at 10pm some 4 hours later when he was described as being very unwell with paramedics commenting that he should not have been discharged and that they had to carry him into the house. Family noted there were other patients in the transport vehicle awaiting return home. • Family and clinicians raised concerns about the length of time it had apparently taken to deliver him home and whether or not his deteriorating condition was or could have been spotted and whether there was an option for paramedics to return him to the hospital. He was returned to hospital very unwell on the 4th December 2016. • offered to address the issue with ward staff.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that you or your organisation has 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 by Wednesday 28th March 2018. 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: daughter of the deceased , Gastroenterologist, Royal Stoke University Hospital , Healthcare Governance Manager Patient Safety, Royal Stoke University Hospital , Head of Patient Transportation, Royal Stoke University Hospital 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	24/01/2018 Signature: Margaret J Jones HM Assistant Coroner Stoke-on-Trent & North Staffordshire