REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS	
	THIS REPORT IS BEING SENT TO: 1. Dr Andrew Jones – CEO, Ramsay Healthcare UK, Level 18 Tower 42, 25 Old Broad Street, London EC2N 1HQ. 2. Mr David Hare - CEO, Independent Healthcare Providers Network, Floor 15, Portland House, Bressenden Place, London SW1E 5BH.
1.	**CORONER** I am Mrs Heidi J Connor, Senior Coroner for the coroner area of Berkshire.
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** I conducted an Inquest into the death of Simon Healey that was heard at Reading Town Hall between 3rd and 5th December 2018. I recorded a narrative conclusion as follows: *Simon Healey suffered a recognised complication of bowel surgery performed on the 1st August 2017. Opportunities for earlier detection of an anastomotic leak and subsequent sepsis were missed. If this had been detected at any point up to the 6th August 2017, it is likely that he would have survived. He died on the 10th August 2017.*
4.	**CIRCUMSTANCES OF THE DEATH** The family asked us to refer to the deceased as Simon at the inquest. I have reflected that request in this report.

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Simon Healey was born on the 29th January 1957. He underwent a right hemi-colectomy at Berkshire Independent Hospital on the 1st August 2017. The operation was performed by [redacted], consultant colorectal surgeon, who had performed numerous operations like this before, the vast majority of these in an NHS setting. The immediate post-operative period was uneventful.

By the night of 4th August 2017 however, Simon's NEWS score was 6 (at 10.30 hrs), and 7 (at 22.00 hrs). His CRP was 607. He had not passed urine. He was tachycardic with a raised respiration rate.

He was started on the sepsis pathway by nursing staff and [redacted] prescribed antibiotics. NEWS protocols were not followed in terms of frequency of reviews or considering escalation of care.

Simon's NEWS scores initially came down to 4 in the early hours of the 5th August but he was again scoring 7 at 04.50, 05.50 and 06.50 on that day. I heard no evidence of consideration of Simon's care being escalated at any point during his stay at the Berkshire Independent Hospital. The junior doctor (RMO) looking after Simon became concerned about his condition on the night of the 6th August. Nursing staff also considered that Simon was not making the progress that they expected after this operation. A decision was taken to carry out an x-ray on the morning of the 7th August 2017. This x-ray revealed free gas and fluid in the abdomen. [redacted] was called, and attended to review the patient at 16.50 hrs. Simon was transferred to the Royal Berkshire Hospital, arriving there at 19.45 hrs.

A CT scan revealed the presence of air and free fluid and Simon's clinical condition continued to deteriorate. He was taken back to theatre by [redacted] and a surgical registrar. A defect in the anastomosis was seen and a litre of fluid (including pus) was removed. The defect was sewn over with an omentum patch, the abdomen was washed out and an ileostomy was made.

Simon's condition on the ICU continued to deteriorate, with clear signs of organ failure. He suffered a myocardial infarction on the 9th August 2017.

Simon was taken to theatre for a final time on 10th August 2017, when the anastomosis was taken down. There was by then a more obvious defect in the anastomosis with faecal contamination. His bowel was noted to be dusky, because of the ongoing sepsis process and the Noradrenaline he had required because of his low blood pressure. The septic process continued after this third operation, and Simon died in the afternoon of 10th August 2017. A post mortem has revealed the cause of death to be:

1a E.coli Septicaemia
1b Faecal Peritonitis
1c Anastomotic Leak

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	1d Elective right hemi-colectomy for the management of colonic carcinoma 2 Hypertension. I had the benefit of independent expert advice, from a consultant colorectal surgeon, Professor Scholefield. The key points arising out of his opinion were: 1. He considered that anastomotic leak should have been suspected and detected by the 5th August 2017. He did not believe that it was reasonable to continue to treat the most likely cause of Simon's symptoms as ileus by the 5th August. It would have been preferable to investigate the possibility of the more serious complication of leak, particularly in view of Simon's observations, blood test results and the period of time that had by then elapsed since the original operation. 2. If an anastomotic leak had been detected at any point up to 6th August 2017, then on balance, Simon would have survived.
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 could occur unless this action is taken. In the circumstances it is my statutory duty to report to you. I have included the Independent Healthcare Providers Network in this report because it is likely that some of the issues raised in this case would be relevant to a number of private healthcare providers. As set out in the case of R (Dr Siddiqi and Dr Paeprer-Rohricht) v Assistant Coroner for East London, the issuing of a Regulation 28 Report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature. For the avoidance of doubt, a response is required from Ramsay Healthcare for each of the issues referred to below. The IHP Network need only respond to issues 1 and 2. The **MATTERS OF CONCERN** are as follows: (1) I believe that the NEWS policies in place at private hospitals should be reviewed. This relates not only to awareness of the policy and sepsis training generally, but also consideration of the arrangements for escalating care where a patient becomes critically unwell. Most private hospitals do not have a full critical care capacity (in terms of facilities and staff) and rely instead on a consultant's availability to attend and review the position. The Royal College of Physicians NEWS trigger thresholds

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	have been adopted almost verbatim by this hospital, save for the category relating to the sickest patients. Whilst the trigger thresholds in the RCP documents do need to be tailored to the organisation in question, it would appear, based on the information I have been provided with, that something well below an "emergency response" can be provided in this hospital, and perhaps also the wider private sector. RCP guidelines clearly require "emergency assessment by a team with critical care competencies". The escalation policy at Ramsay Healthcare hospitals currently (for a patient scoring 7 or above) is for the registered nurse "to immediately inform the RMO and named consultant. The named consultant to attend urgently and review the patient and agree action to be taken. Consider transfer of care to a level 2 or 3 clinical care facility i.e. HDU or ICU". This policy clearly anticipates initial review by a consultant, outside the hospital, who may well not be available to attend on an emergency basis. (2) We heard evidence that Berkshire Independent Hospital has performed 5 operations like this between 2016 and 2018, including Simon's operation. Whilst the surgeon had experience of the procedure in the NHS, post-operative management is carried out in a general ward, caring for patients from a range of specialities. Nursing staff in this context may well never have cared for a patient after this operation, and not be familiar with the signs and symptoms to be aware of and in particular, to alert clinical teams to signs which point towards leak and/or sepsis. I accept that private hospitals cannot realistically provide separate specialist wards for this. It does however raise the question of whether private hospitals should be carrying out procedures like this without specialised nurses and without facilities to escalate care without delay. (3) The final concern relates to Berkshire Independent Hospital only. The hospital investigation into these events was inadequate, particularly in relation to the decision-making of the key player in this matter, [redacted]. There are 2 sentences in the report regarding his involvement, and it would appear, a simple acceptance of his view that this was no more than a recognised complication of this procedure. This organisation will not learn from sad cases like this if their own investigations are inadequate. We heard some evidence of review of this procedure, but I suggest that this is considered very carefully, to ensure that the risk of future deaths is reduced by adequate and candid investigation.
6.	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe your organisation has the power to take such action.

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7.	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 31st January 2019. 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 Simon's family, and other Interested Persons form the Inquest. 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.	**6th December 2018** **Mrs Heidi J. Connor** **Senior Coroner for Berkshire**