REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive of Guys and St Thomas' NHS Foundation Trust
1	**CORONER** I am Briony Ballard, Assistant Coroner, for the coroner area of Inner London South
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** On 27 April 2018 this jurisdiction commenced an investigation into the death of Daniel Williams. The investigation concluded at the end of the inquest on 28 August 2019. The conclusion of the inquest was that Mr Williams died as a result of the unintended consequences of necessary surgical treatment.
4	**CIRCUMSTANCES OF THE DEATH** Mr Williams died at St Thomas' Hospital on 26 November 2017 as a result of developing recognised complications of gastrointestinal surgery (tumor removal) against a background of very significant medical complexity. The surgery which Mr Williams underwent resulted in a large wound and continuously oozing stoma. This was challenging to nurse and vulnerable to infection. The surgical joins formed following the tumor removal subsequently came partially undone leading to further infection. Mr Williams died as a result of the attendant consequences of this septic picture.
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. – 1) Following surgery Mr Williams was left with a wound which was challenging to nurse and vulnerable to infection. Having initially been nursed on ITU / HDU Mr Williams was stepped down to a general nursing ward. 2) The nursing care which Mr Williams received on this general gastrointestinal (GI) ward was found - by an internal Trust investigation which took place sometime after Mr Williams' death following a request by myself - to be "*deficient in delivering the fundamentals of care*". 3) Whilst still on this general GI ward Mr Williams deteriorated and was transferred back to the HDU unit. The day following that transfer a stool sample taken tested positive for clostridium difficile (c-diff).

	4) Although I found at inquest that the presence of c-diff was not relevant to how Mr Williams ultimately came by his death I have residual concerns with the potential under investigation of c-diff cases within the Trust from what I was told about the process which is triggered on discovering the presence of c-diff. 5) At Mr Williams' inquest I was told that c-diff infection is a potentially fatal infection. Consequently it is a regulatory requirement that hospital trusts carry out a clinical case review whenever c-diff is found in order to determine whether it was linked to any "*lapses of care*" in the care and treatment of the patients. 6) I was told that what should happen following the collection of a positive c-diff sample is that an alert is sent to the infection control nurse who then distributes the mandatory infection control data collection form to, inter alia, the ward on which the patient is currently. That ward – and that ward alone - then investigates focussed on identifying "*any significant deviations from best practice…*" including in the following categories: deficiency in environmental cleaning, deficiency in hand hygiene and / or deficiency in antimicrobial stewardship. What is not done however, is if the respective patient has recently been transferred from another ward, the investigation does not extend to the conditions on the transferring ward. 7) In this case it was the transferring ward where there were found to have been failings in delivering the fundamentals of care and about which the family had raised significant concerns at the time. The only reason these failures were highlighted was that an investigation was undertaken following a pre-inquest review on 26 September 2018 at which the family raised concerns that Mr Williams had died as a result of a c-diff infection contracted as a result of poor nursing care. The extent of the Trust's investigation was limited as it was conducted significantly after the event.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation have 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 13 November 2019. 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 Person [redacted] the deceased's father. 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 September 2019 Briony Ballard

[DATE]	[SIGNED BY CORONER]