## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **THIS REPORT IS BEING SENT TO:**<br><br>**Dr Alistair Chesser, Chief Medical Officer, Trust Executive Office, Barts Health NHS Trust, Ground Floor, Pathology Block, 80 Newark Street, London, E1 2ES** |
| 1 | **CORONER**<br><br>I am Nadia Persaud, Senior Coroner for the Coroner area of East London |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On the 16th July 2019 I commenced an investigation into the death of Mrs Ibiyemi Ereoah. The investigation concluded at the end of the Inquest on the 26th February 2020. The conclusion of the Inquest was that she died as a result of natural causes contributed to by neglect. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mrs Ereoah attended Newham Hospital on the 31st October 2017 with lower abdominal pain and anaemia. She underwent a number of investigations and concerns were raised in relation to a possible sarcoma. Her case was discussed at an MDT meeting where the concern of a possible sarcoma was downgraded to a likely benign fibroid. The consideration of the case at the MDT was inadequate. Her gynae-oncologist was not in attendance to present the case; there is no clear rationale as to why the concern was downgraded. A hysteroscopy performed on the 15th December 2017 was inadequate, as samples of the tumour and muscle wall should have been obtained. Inappropriate reliance was placed upon the biopsy result, to exclude the possibility of a sarcoma. In February 2018 Mrs Ereoah was booked for a total abdominal hysterectomy. She was inappropriately deemed unfit for surgery and did not undergo surgery at that time. There was 4 month delay in obtaining a consultant anaesthetic review of her operative fitness. Had Mrs Ereoah undergone surgery in February 2018, her death on the 17th September 2018 would have been avoided. Mrs Ereoah continued to present to hospital with severe anaemia between February 2018 to August 2018. She underwent a total abdominal hysterectomy on the 30th August 2018. Shortly after surgery she was diagnosed with a high-grade uterine sarcoma. She was discharged from Newham hospital and readmitted to Queens hospital on the 10th September 2018. She passed away as a result of a metastatic leiomyosarcoma on 17th September 2018. |
| 5 | **CORONER'S CONCERNS**<br><br>The **MATTERS OF CONCERN** are as follows:<br><br>1. Many of the concerns arising in this case were considered to be due to an insufficiency of gynae-oncology consultant cover at Newham University hospital. The lack of adequate Consultant cover was deemed to have contributed to the lack of advocacy at the MDT meeting; the inability to challenge the MDT |

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| | conclusion and the lack of Consultant overview of the recurrent admissions. In July 2019, the Trust agreed two key actions to address this deficiency:<br><br>• Clinical Leads at the RLH and NUH to review gynaecological oncology staffing and job planning, to ensure adequate administration time; cover when on leave/programmed for other duties, such as hot weeks.<br><br>• There should be an urgent organisational development/service level review of the NUH gynae-oncology team that is independent of the site.<br><br>As at the date of the Inquest, neither of these necessary actions had been completed.<br><br>2. Mrs Ereoah was deemed unfit for surgery by a clinical nurse specialist on the 16th February 2018. The nurse requested a consultant review which should have taken place within 3-5 weeks. It did not take place until 16 weeks later. The Inquest heard evidence that there was no system in place to ensure that all consultant reviews were carried out within a timely manner. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely **26th April 2020**. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the husband of the deceased. I am also forwarding a copy to the Care Quality Commission and Director of Public Health<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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]** 2. 3. 2020 **[SIGNED BY CORONER]** |