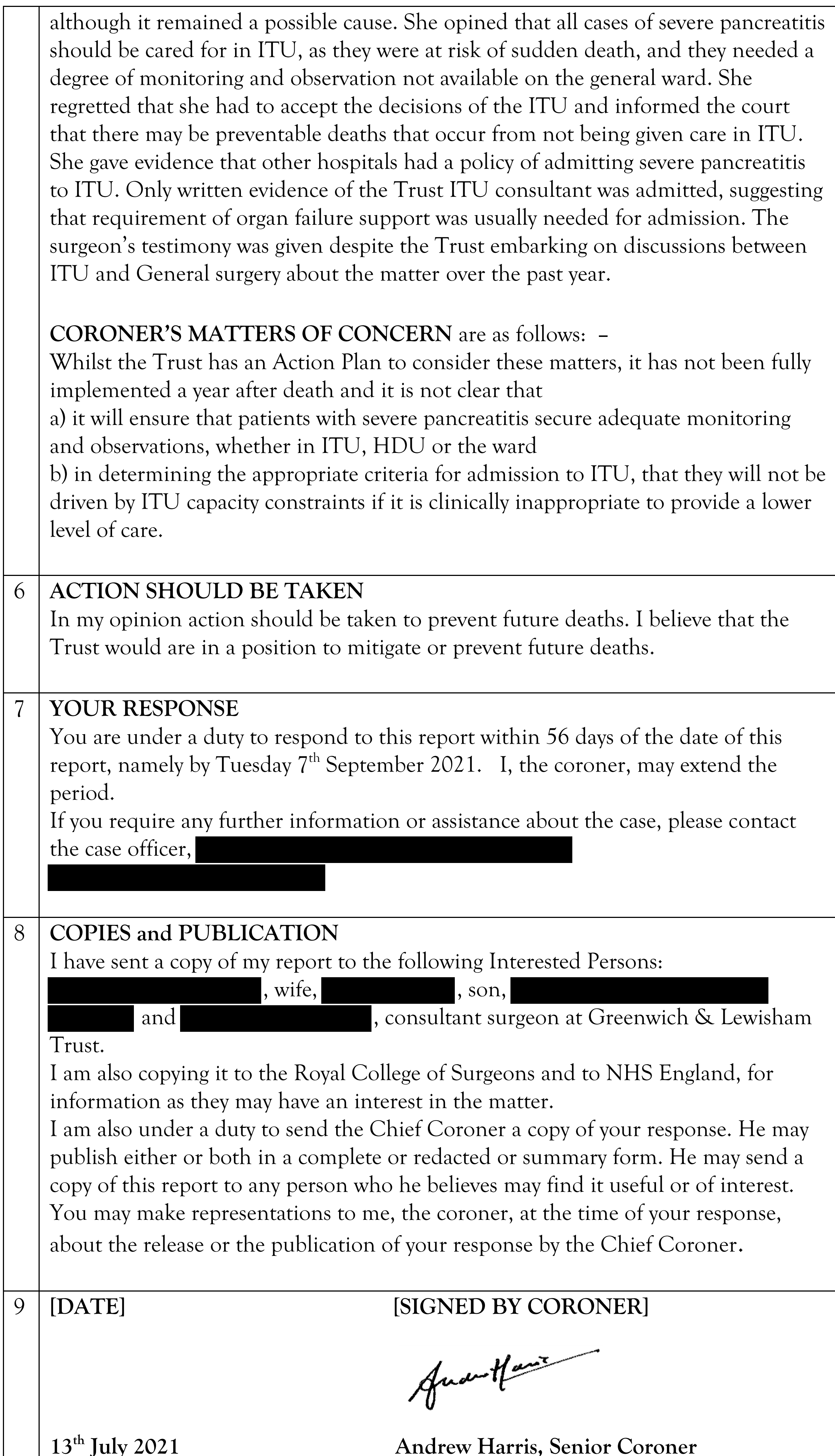
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [REDACTED], Greenwich & Lewisham NHS Trust, University Hospital Lewisham, High Street, Lewisham, London, SE13 6LH
1	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INQUEST** I opened an inquest on the 24 September 2020, into the death of Mr Abiodun Adisa ORITOGUN on 8th July 2021 in hospital ([REDACTED]) and concluded the inquest at Southwark Coroners Court on the 12 July 2021. The medical cause of death was: 1a Cardiac arrest 1b Aspiration pneumonia 1c Ileus and pancreatitis. The conclusion as to the death was complications of pancreatitis, Mr Oritogun died of complications of pancreatitis and ileus, contributed to by a failure to escalate review of his care plan the day before he died, which was a very busy one
4	**CIRCUMSTANCES OF THE DEATH** Mr Oritogun had severe acute pancreatitis for which he was admitted on 4th July 2020 and treated in the ward with analgesia, IV fluids and oxygen. He deteriorated and on the 7th had a peri arrest, with high CRP, tachycardia, high BP, pyrexia. His condition was not escalated for review and he became agitated and paranoid, He removed his NG tube and collapsed breathless whilst self-discharging in a corridor. Resuscitation was unsuccessful. He died of aspirational pneumonia.
5	**MATTERS OF CONCERN** The coroner found that there were two concerns about medical care, namely 1. He was considered to be in alcohol withdrawal, (which evidence was not concluded either way) but there was an inadequate care plan with regard to monitoring and observations following his MEWS score rising from 1 to 10 and having a peri-arrest, which should have triggered formal ITU referral (he was seen by outreach nurses) and should have led to finding a cause of his deterioration and subsequent agitation and implemented closer monitoring. The reviewing doctor has reflected and embraced learning. 2. The consultant surgeon gave evidence that Mr Oritogun had a significant risk of arrythmia related to electrolyte disturbances, although the evidence admitted was that these had been corrected prior to death. She nevertheless concluded that he died of a cardiac arrhythmia, which was not accepted as proven by the court,



although it remained a possible cause. She opined that all cases of severe pancreatitis should be cared for in ITU, as they were at risk of sudden death, and they needed a degree of monitoring and observation not available on the general ward. She regretted that she had to accept the decisions of the ITU and informed the court that there may be preventable deaths that occur from not being given care in ITU. She gave evidence that other hospitals had a policy of admitting severe pancreatitis to ITU. Only written evidence of the Trust ITU consultant was admitted, suggesting that requirement of organ failure support was usually needed for admission. The surgeon’s testimony was given despite the Trust embarking on discussions between ITU and General surgery about the matter over the past year.

CORONER’S MATTERS OF CONCERN are as follows: –
Whilst the Trust has an Action Plan to consider these matters, it has not been fully implemented a year after death and it is not clear that
a) it will ensure that patients with severe pancreatitis secure adequate monitoring and observations, whether in ITU, HDU or the ward
b) in determining the appropriate criteria for admission to ITU, that they will not be driven by ITU capacity constraints if it is clinically inappropriate to provide a lower level of care.

6 **ACTION SHOULD BE TAKEN**
In my opinion action should be taken to prevent future deaths. I believe that the Trust would are in a position to mitigate or prevent future deaths.

7 **YOUR RESPONSE**
You are under a duty to respond to this report within 56 days of the date of this report, namely by Tuesday 7th September 2021. I, the coroner, may extend the period.
If you require any further information or assistance about the case, please contact the case officer, ██████████
██████████

8 **COPIES and PUBLICATION**
I have sent a copy of my report to the following Interested Persons:
██████████, wife, ██████████, son, ██████████
██████ and ██████████, consultant surgeon at Greenwich & Lewisham Trust.
I am also copying it to the Royal College of Surgeons and to NHS England, for information as they may have an interest in the matter.
I am also under a duty to send the Chief Coroner a copy of your response. He 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]** **[SIGNED BY CORONER]**

13th July 2021 **Andrew Harris, Senior Coroner**