Regulation 28: Prevention of Future Deaths report

Stephen Francis WALKER (died 06.04.21)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Medical Director** **Royal Free Hospital** **Pond Street** **London NW3 2QG**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 21 April 2021, I commenced an investigation into the death of Stephen Walker, aged 79 years. The investigation concluded at the end of the inquest earlier today. Dr Walker's medical cause of death was: 1a aspiration pneumonia and acute pulmonary oedema 1b small bowel ileus and ischaemic small bowel 1c ileostomy reversal 2 aortic incompetence I made a determination at inquest that Stephen Walker died from the complications of medical treatment, being an ileus following an ileostomy reversal. Earlier placement of a nasogastric tube would have improved his chance of survival, because it would have reduced the risk of vomiting and so of aspiration.

4	**CIRCUMSTANCES OF THE DEATH** Dr Walker was admitted to the Royal Free Hospital for an ileostomy reversal on 1 April 2021. He began vomiting on the morning of 5 April and felt extremely unwell, but a nasogastric tube was not placed until that evening, at which point 2 litres was aspirated. He was then admitted to the intensive care unit, but died the following day.
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. Dr Walker's condition had deteriorated by the time of the morning ward round on Easter Monday, 5 April 2021. He said that he felt awful and had begun vomiting. Dr Walker wondered if this was secondary to opiate analgesia, and this was recorded as the clinical impression. However, no record was put before me at inquest indicating that the clinical fellow undertaking the ward round conducted an abdominal examination, no subsequent early medical review was fixed and no nasogastric tube was passed. 2. At the morbidity and mortality meeting on 24 June, the registrar said that Dr Walker was offered a nasogastric tube but declined. However, I was told at inquest that there was no record of this. 3. I was told at inquest that, at lunch time on 5 April, nurses twice bleeped for a medical review, but there was no record that a medical review was undertaken, or that this was chased. 4. At inquest, I asked the colorectal surgeon with care of Dr Walker to check matters in the online medical records before him. However, he said that he was in difficulty because they were so confusing in the way that they were laid out and completed. If the records are so confusing that a consultant cannot read them easily, then that is obviously sub optimal in terms of care. I am aware that the chair of the panel that has already considered the circumstances in which Dr Walker died, the consultant surgeon [redacted], intends to conduct a more in depth review of the medical records.

	I write this report partly in the hope that my concerns will feed into [redacted] review. As such, I should be grateful if a copy of my PFD report could be forwarded to him before he completes any such review.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 September 2021. 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 following. • [redacted], wife of Stephen Walker • HHJ Thomas Teague QC, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 12.07.21 *ME Hassell*