ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive of Bradford Teaching Hospitals NHS Trust 2. Chief Coroner 3. Family of Allison Louise Bird
1	**CORONER** I am Mary Burke, Assistant Coroner, for the Coroner Area of West Yorkshire – Western Division.
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** Inquest opened on the 26TH March 2018 into the death of Allison Louise Bird aged 38 years. Inquest concluded on 12th March 2020. Medical cause of death:- 1a. Multiple Organ Failure 1b. Systemic Sepsis 1c. Gastro Pulmonary Fistula Operated I recorded a narrative conclusion summarised as follows:- Allison Bird had undergone surgery on the 5th March 2018 to treat a gastropulmonary fistula, a recognised but rare complication of bariatric surgery which she underwent in April 2017. Post operatively Allison's condition began to deteriorate on the 12th March 2018 as a result she underwent further surgery on the 13th March 2018 but despite full intensive care support she died on the 16th March 2018 at Bradford Royal Infirmary(BRI) as a result of multi organ failure after developing overwhelming sepsis.
4	**CIRCUMSTANCES OF THE DEATH** Allison had undergone elective Bariatric surgery in April 2017. In October 2017, she developed a chest infection and was reviewed in the Accident and Emergency Department of BRI and diagnosed with pneumonia and prescribed antibiotics.

Subsequently she was prescribed further antibiotics by her General Practitioner, her symptoms persisted and she was referred once again to BRI, following which she was discharged without further treatment or follow up.

On 18th November she was admitted to BRI due to a worsening in her condition.

Following test and investigations she was diagnosed as suffering from a gastro pulmonary fistula (a connection between the remaining part of her stomach and her left lower lung) which had resulted in a very severe lung infection.

From the evidence presented the development of such a fistula is a rare but recognised complication of bariatric surgery.

Allison was under the care of [redacted] her original treating surgeon, he sought the assistance and input of [redacted] visiting thoracic surgeon.

A joint decision was taken by both doctors to treat the fistula with conservative treatment in the hope and expectation that the infection and fistula would resolve, and Allison remained in hospital until 14th December 2017.

Subsequent investigations revealed that although the fistula was reducing in size, it persisted.

Sometime in January 2018 a decision was taken between [redacted] and [redacted] that the fistula was unlikely to fully resolve without surgical intervention, and in addition a section of Allison's damaged left lung should also be removed. This required both their specialisms and a decision was taken that both surgical interventions would be performed at the same time.

None of the treating clinicians giving evidence at the inquest could identify any record being made of this, within Allison's medical notes.

[redacted] discussed his proposed part of the surgery with Allison in an outpatient appointment.

[redacted] did not discuss his proposed surgery with Allison until he saw Allison in the theatre area immediately before Allison underwent surgery on 5th March 2018.

Post operatively Allison spent an initial period in Intensive Care, she was then transferred to ward 21 surgical ward, however her condition gave rise for concern and she was transferred back to intensive care for a further period until 11th March 2018.

However on the morning of 12th March whilst on ward 21, Allison's vital signs began to deteriorate. It was unclear from the evidence presented to me whether despite this deterioration Allison's vital signs were not more frequently checked in the next 24 hour period in accordance with hospital guidelines.

Furthermore from the evidence presented to me it was unclear whether escalation measures to more senior clinicians were undertaken in the next 24 hour period by nursing staff in a timely manner once again in accordance with hospital guidelines.

What was clear from the evidence presented to me was that from approximately 11.00am the following day 13th March there was significant escalation in Allison's care.

Following review by senior clinicians at this time, a decision was taken that Allison required emergency surgery.
Even before surgery commenced, Allison suffered a cardiac arrest, which was successfully treated.

	Operative findings included a pneumothorax and infective pericarditis which were treated surgically. In addition treating surgeon [redacted], undertook further surgical intervention in an effort to repair the underlying fistula at the site of Allison's remaining stomach. Allison survived surgery, however her condition deteriorated post operatively and despite full intensive support she died on the 16th March 2018.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – 1. There was no discussion/explanation provided to Allison before she underwent planned major thoracic surgery on the 5th March 2018, the explanation given was immediately before she was asked to provide her written consent in the theatre area minutes before surgery commenced, a situation which if repeated causes me concern for a patient being able to appropriately consider the risks associated with proposed surgery and determine if they are willing to consent. 2. There did not appear to be an escalation of monitoring of Allison's vital signs by nursing staff in the 24 hour period commencing at 11.00am on 12th March 2018. 3. Nursing staff did not appear to be consistently seeking clinical review following non reassuring vital signs results actually taken in the same 24 hour period referred to in 2 above.
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by 4th June 2020. I, the Assistant Coroner, may extend this 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 Persons: [redacted] – Family Chief Executive of Bradford Teaching NHS Trust. 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	**[DATE]** **9th April 2020**	**[SIGNED BY CORONER]** (HM Asst. Coroner) Mr HMAC Mary Burke
