IN THE SURREY CORONER'S COURT

IN THE MATTER OF: ARTHUR FREDERICK HALL

The Inquest Touching the Death of Arthur Frederick Hall

A Regulation 28 Report – Action to Prevent Future Deaths

	• **Frimley Park Hospital NHS Trust**
1	**CORONER** J Russell-Mitra HM Assistant Coroner, for the County of Surrey
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** An inquest into the death of Arthur Frederick Hall was opened on 16th March 2018, resumed on the 29th January 2019 and concluded on 14th May 2021. I found that the cause of death was: I a 1a Multiple organ failure 1b Severe sepsis 1c Perforated viscus secondary to elective therapeutic colonoscopy with polypectomy 2 Hypertension and ischaemic heart disease I concluded with a narrative conclusion as follows: On 31st January 2018 Arthur Frederick Hall underwent an elective therapeutic colonoscopy polypectomy and was discharged the same day. Shortly thereafter he became unwell and about eight hours after the procedure presented to the Accident and Emergency Department of Frimley Park Hospital. There was a gross failure to recognise that an appropriate level of investigation of his condition was required and he was discharged in the early hours of 1st February 2018. He continued to be

	unwell. On 4th February 2018 he returned to the Accident and Emergency Department of Frimley Park Hospital, where he was found to have sepsis secondary to a perforation of the bowel which had taken place during the procedure on 31st January 2018. Arthur underwent a series of emergency surgeries but died as a consequence of overwhelming sepsis on 2nd March 2018. The delay in diagnosis, treatment and surgery caused by the failed discharge on the 31st January 2018 more than minimally contributed to his death. Arthur's death was as a result of a recognised complication of elective surgery, contributed to by neglect. I adjourned consideration of whether to write a report for the prevention of future deaths for further evidence to be provided.
4	**CIRCUMSTANCES OF THE DEATH** I. Arthur enjoyed reasonably good health throughout most of his life; was a keen cyclist and a lifelong bellringer. He suffered a heart attack and had been regaining his health and attending the gym in preparation for his return to cycling. On 24th July 2017 Arthur attended his GP due to rectal bleeding. He was referred to the colorectal team at Frimley Park Hospital. He underwent flexible sigmoidoscopy on 15th December 2017 which found the presence of two polyps. As a result of which he was booked for elective therapeutic colonoscopy with polypectomy to take place on 31st January 2018. He was provided with pre-operative informational literature which he read with care and discussed the potential risks in brief with his wife. II. Arthur attended Frimley Park Hospital Endoscopy Unit on 31st January 2018 and signed the consent form which gave the risks as "bleeding, perf". The risks of surgery are wider than this, however, the consultant who performed the procedure told me that he had a fuller conversation with Arthur about the full risks of surgery. III. The procedure involved the removal of a 6mm polyp removed in its entirety, the removal of a 25mm villous lesion. The larger polyp required due consideration of whether it could be safely removed as the procedure requires a greater level of skill and carries a greater risk. [redacted] told me that he had considered carefully whether it was possible to remove it and considered that it was possible. He went on to do so, resecting it piecemeal. He tattooed the site as expected practice in order to aid easy identification of the site in future procedures. One 8mm polyp was left in the distal sigmoid. The procedure was correctly and appropriately undertaken. IV. A perforation, which is a known and regular complication of such a procedure, occurred as a result of this procedure. The perforation either occurred during the procedure or shortly thereafter due to thermal damage to the wall which is a known complication of the removal of polyps of this type in this way but not immediately obvious.

	V.	Arthur was under sedation and was in the theatre between 12.09 and 13.11. He then remained in the recovery suite under observation of the nurses until 14.09. He was given advice about the procedure verbally and in writing. There were no immediate apparent issues whilst he was in the recovery room. He was considered fit for discharge.
	VI.	The advice Arthur was given about what to do if he had any problems or concerns was confusing. The document entitled Old version endoscopy discharge info 1 in the bundle at pp. 957-958 variously suggests attendance at the GP, attendance at A&E and telephone calls to either the Endoscopy Unit or the Surgical Assessment Line. No advice was given to clarify the order of such steps. There was some information about what kind of symptoms might require attention.
	VII.	Arthur returned home with his wife and rested all afternoon. He was in some discomfort. His wife provided him with a light dinner as he said that he did not want to eat much. Arthur became very sick: vomiting violently and he collapsed. His wife described her very understandable panic at this point. She rang a friend who was a GP and was advised to telephone 111. She did and sought assistance: she was told an OOH GP would call back. Shortly afterwards growing further concerned for Arthur's condition, she telephoned one of the Endoscopy Unit numbers. [redacted] cannot remember which number she rang but the call was answered by a nurse who took details and went to ask the Sister of the ward. The nurse returned the call and advised that Arthur was to attend A&E immediately. His wife telephoned 111 to advise them that the callback was no longer required. She then arranged transport for them and immediately took him to the A&E of FPH. They arrived at 21.43.
	VIII.	On arrival at A&E his wife made sure that all the members of staff who saw Arthur saw the colonscopy report he had been given on discharge.
	IX.	He was seen by A&E Treating clinician at some time in the early hours of 1st February 2018. Treating clinician conducted an examination of Arthur finding him to have a tender abdomen and right sided pain over the place where the colonoscopy had taken place. Bloods were taken for analysis. An upright chest Xray and a urine dipstick were taken. Arthur was discharged with a three-day course of antibiotics for a UTI.
	X.	Over the next few days Arthur was still not very well but was following the guidance he had been given and hoping that the three-day course of antibiotics would resolve his symptoms. Arthur's symptoms worsened; he did not have a bowel movement and he was in pain and hiccoughing, bloating and with a dull ache under the abdomen. His wife considered whether with the local GP surgery had an out of hours weekend clinic but they did not. She was concerned and suggested A&E to Arthur on a number of occasions over the weekend: he was eating very little, running hot and cold and in pain.
	XI.	By 4th February 2018 the course of antibiotics over and the symptoms worse her husband telephoned 111 and the operative spoke to Arthur and he was advised to wait for a callback from an OOH GP. No call was

	received, and his wife became more concerned. She arranged for a neighbour to take them to the hospital, and they attended the A&E department of FPH. XII. Arthur was quickly assessed as having suspected sepsis due to a perforation. The sepsis protocol was initiated. This was quickly confirmed by CTPA. Over the course of the next 3 weeks Arthur was on maximal support in ICU and underwent a series of emergency operations to treat the perforation and to excise the faecal contaminant from the abdomen as well as to try to save the ischaemic bowel affected as it was by the failure of blood supply caused by the septic shock. Arthur was seriously and gravely ill. He was not expected to survive the first damage control laparotomy on 5th February 2018. However, the sepsis had caused such damage to his bowel, his stomach and his other organs that in spite of all attempts to save him a decision was made on 1st March 2018 that no further intervention was possible, and he was placed into palliative care. He died on 2nd March 2018 at 15.51.
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 could 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. On the 1st February 2018 the differential diagnosis of bowel perforation was abandoned without full investigation. 2. The recognised first line of enquiry was an upright chest X-ray. What is known about upright chest Xray's is that they are known to miss a number of perforations. This was used to exclude the possibility of perforation when it is a known limited diagnostic tool that can miss from 20% of perforations to 50% of perforations (see literature). 3. Second line of enquiry (endoscopy or CTPA) was not undertaken. 4. Assumptions were made that pain was a result of surgery and therefore not considered an important indicator of a problem. The surgery is considered by practitioners to be painless, and that pain or sickness are signs of potentially serious complications. 5. Given the potential time-critical nature of Arthur's possible complaint, more detailed discharge advice should have been given. 6. No surgical opinion was sought when a surgical patient attended A&E with symptoms which were suspected to be related to surgery.

	7. No further examination of abdomen was undertaken prior to discharge. 8. Signs of sepsis were missed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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. 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 Persons; [redacted]. 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	**Signed:** **J. Russell-Mitra** **Dated this 7th March 2022.**