	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Mr Simon Stevens, Chief Executive Officer (CEO) of NHS England, NHS England, PO Box 16738, Redditch, B97 9PT 2. The Rt. Hon Matt Hancock, Secretary of State for Health and Social Care, Richmond House, 79 Whitehall, London SW1A 2NS 3. Dr Ian Abbs, Chief Executive and Chief Medical Officer, Guys & St Thomas NHS Foundation Trust, Great Maze Pond, London, SE1 9RT
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 On 4th June 2018 an investigation was opened into the death of **Mr Derek Weaver (died 31.05.18) case ref: 01562-18 (IF.** This followed a hospital death which there was reason to suspect was related treatment and/or a failure to secure treatment by transfer from the Sussex hospital where he was being treated to the local regional thoracic surgery centre. It took several months to secure medical records and statements from the referring hospital. The inquest was opened but the original listing was adjourned due to the hospitalization of the key medical witness. On 3rd October 2019, the inquest was concluded thus: The medical cause of death was 1a Multi-organ failure 1b Systemic Inflammatory response and sepsis (SIRS) I Hypertension and Diabetes The conclusion was recorded thus: *"Whilst he died from natural causes, his death was contributed to by a 14 day delay in transfer for surgery, which was related to exceptional pressures on bed capacity."*

4	CIRCUMSTANCES OF THE DEATH The circumstances were recorded thus: *"Mr Weaver was admitted to hospital in Sussex with a community acquired pneumonia on 8th May after a 3 week illness. He was found to have an empyema which was drained but it loculated. On 11th it was agreed with the Regional Thoracic Centre, that he needed surgery. His clinical condition improved on antibiotics. He was not transferred until 26th, having emergency surgery on 27th by which time he had become septic again. He had washouts on 27th and 29th which triggered a systemic inflammatory response, from which he died at 08.11 on 31st May."*
5	CORONER'S CONCERNS During the course of the inquest, the evidence revealed a matter giving rise to concern that in my opinion means that there is still a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTER OF CONCERN** is as follows. - A consultant thoracic surgeon who was involved in his care after transfer said that had a higher chance of death because surgery was at a time of SIRS. If he had been transferred earlier he would have had surgery when he was not septic. It would have been two stages, the first being key hole surgery, with mortality of only 1 in 100. That may have obviated the necessity of second stage decortication surgery, with mortality of 5%, but it was probably needed anyway. The delay in transfer related to a surge in referrals, limiting capacity. Most regional referrals of this sort needed to be treated at weekends to maintain treatment of cancer cases in the week. There had been pressure to secure greater resources. The risk of potentially preventable deaths will recur whenever there is such a surge in referrals and be mitigated by provision of more beds.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths. I believe that the following organizations would wish to learn of the circumstances of this death and are in a position to mitigate or prevent future deaths: **NHS England** **The Secretary of State for Health and Social Care** **Guys & St Thomas NHS Foundation Trust**
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday 11th December 2019. 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. 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) Non-Executive Director, East Sussex Health Care, Conquest Hospital I am also sending this report to the following, who may have an interest, or provide further information with regard to potential for prevention: The Royal College of Physicians The Royal College of Surgeons 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] 15-10-19 [SIGNED BY CORONER]