	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • **BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST**
1	**CORONER** I am Tim Holloway, Assistant Coroner for **Blackpool & Fylde**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 02/11/2018 I commenced an investigation into the death of James David FLETCHER ("the Deceased"). The investigation concluded at the end of the inquest on 29th April 2019. The conclusion of the inquest as to the medical cause of death was: 1a Peritonitis 1b Leak of gastric content 1c Feeding tube insertion (percutaneous endoscopic gastrostomy) 2 Cerebral palsy
4	**CIRCUMSTANCES OF THE DEATH** The Court reached a narrative conclusion as follows: James David Fletcher ("James") was admitted to Blackpool Victoria Hospital, Whinney Heys Road, Blackpool ("the Hospital") on 12th July 2018 for a percutaneous endoscopic gastrostomy ("PEG") to be performed. His neurological diagnoses were quadriplegic cerebral palsy and epilepsy. He had other complications of his severe disability including chronic dislocation of the right elbow, dislocation of the left elbow joint which had required reconstructive surgery, gastro-oesophageal reflux disease and reflux uropathy. He had a learning disability and was unable to communicate verbally. Whereas the surgery was uneventful, having been transferred to Ward 15b, a general surgical ward, his condition deteriorated post-operatively. That deterioration was probably occasioned by a leak of stomach and small bowel contents through the wall of the stomach into the peritoneal cavity at the site of the insertion of the PEG tube into the stomach due to slow healing of the wound. That, in turn, gave rise to the development of chemical peritonitis, a rare but known complication of such surgery, which was established no later than the morning of 13th July 2018. The peritonitis caused ileus of the small bowel which led to small bowel obstruction which, in turn, occasioned repeated vomiting. The vomiting exacerbated the leakage of gastric contents by causing distension of the operative perforation at the site of the insertion of the tube into the stomach, thereby, in turn, exacerbating the peritonitis. No consideration was given to the possible presence of peritonitis and no imaging capable of positively identifying that condition was undertaken and thus the peritonitis went undetected prior to James' death. On 14th July 2018, shortly after 11.08am, James died on Ward 15b of the Hospital on account of peritonitis due to leakage of gastric content. The PEG tube continued to be used in the period following the onset of the peritonitis. The use of the PEG tube was contraindicated. It is possible that this contributed more than minimally, negligibly or trivially to his death. Whereas broad spectrum antibiotics were not prescribed until 13th July 2018 it is not possible to conclude that this contributed more than minimally, negligibly or trivially to his death. Whereas there were admitted failures to carry out observations of vital signs in accordance with Trust protocol, to escalate James' condition and to make clinical provision for him in accordance with Trust protocol even when elevated Early Warning Scores were identified and whereas there was a further admitted failure to monitor his fluid balance in accordance with Trust protocol it is not possible to

	conclude that these failures more than minimally, negligibly or trivially contributed to his death.
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) I am concerned that, whilst there exist policies concerned with the provision of care to those patients with learning disabilities there may be a lack of disseminated guidance and protocols for the care of those patients who are unable to communicate verbally. It is of particular concern that, in such cases, measures should be identified by which a method of communication can be established and/or appropriate measures should be put in place to compensate for any lack of communication verbally, including but not necessarily limited to the use of objective observations. 2) There is a risk of future deaths because both patient care and the opportunity to learn valuable lessons following a death may be compromised by issues pertaining to the quality of record keeping and to the retention of records. Whilst it is understood that "NEWS 2" is being introduced and supersedes the early warning score system being used at the time of the Deceased's death and whilst the early warning score system in use at the time does not, therefore, form the subject matter of this report: a) I am concerned that the evidence revealed that substantial periods of time elapsed, at times measuring 9 or more hours, when no entry was made in the Deceased's History Sheet, notwithstanding the deteriorating nature of the Deceased's condition. This approach to record keeping carries the risk of material information concerning the condition and care of patients not being communicated between medical, nursing and other clinicians; b) Complete records were not provided to the Court in accordance with directions given prior to the inquest. It was understood from the Trust that complete records were unavailable and yet it transpired on the first day of the inquest that further records were available but had not been found and produced previously. I am concerned that the system of record keeping gives rise to a risk that patients' records which are material to their ongoing care will be lost or otherwise inaccessible. c) I am concerned that, without records of appropriate quality being made and retained, the opportunity to learn lessons through the process of internal investigations and, should it arise, the Coroner investigation and inquest process will be compromised. 3) I am concerned that communications between medical staff, between nursing staff and between medical and nursing staff should be accurate and that it should be ensured that they have been understood. By way of example, in this matter, there was either miscommunication or misunderstanding of the position concerning the taking of an abdominal x-ray and an apparent miscommunication or misunderstanding of the level of expertise being offered in the interpretation of a chest x-ray. 4) I am concerned that there is a lack of knowledge amongst medical and nursing staff who may come into contact with and have the responsibility for the care of patients who have undergone PEG surgery about the post-operative risks of such surgery, in particular the risk of peritonitis, of the signs and symptoms which may give rise to a differential diagnosis of peritonitis and of measures which would be or may be contraindicated in the circumstances that complications, including peritonitis develop. This is illustrated in the present case by an apparent lack of awareness that peritonitis may develop and that the use of the PEG tube in the circumstances concerned was contraindicated and by the omission to place a warning label in the Deceased's notes as provided for by the applicable protocol. The fact that the use of the PEG tube was contraindicated was not identified in the course of the internal serious incident investigation. 5) Related to 4) above I am concerned that the risk of peritonitis may have been shrouded by the identified risks of sepsis and of aspiration pneumonia and that the risk of peritonitis also needs to be identifiable by those providing care for patients following such surgery. 6) The evidence disclosed that certain essential medication had not been retained in close proximity to the Deceased, where it was required. I am concerned that, in such circumstances, essential medication may be required urgently to protect the life of a patient and that systems should be robust enough to ensure that it is available in the correct location.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you **BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST** 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 26TH June 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] ~~[and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)].~~ I have also sent it to the following who may find it useful or of interest: • **CARE QUALITY COMMISSION** • **NHS ENGLAND** 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	01/05/2019 Signature__ *T R Holloway* (signed electronically)_____ Tim Holloway Assistant Coroner **Blackpool & Fylde**