	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Wexham Park Hospital, Slough** **2. Chief Executive, St. Peter's Hospital, Chertsey, Surrey**
1	**CORONER** I am Peter James Bedford, senior coroner, for the coroner area of Berkshire
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** On 7th August 2013 I commenced an investigation into the death of Christine Nutbeam, then aged seventy six years. The investigation concluded at the end of the inquest on 16th January 2014. The conclusion of the inquest was a narrative verdict, the medical cause of death being Pneumonia and Adult Respiratory Distress Syndrome due to Aspiration during a Debridement Operation for an infected injury to the right leg. A copy of the Narrative Verdict is attached.
4	**CIRCUMSTANCES OF THE DEATH** 1. Mrs Nutbeam was struck by a car in the car park of Sainsbury's Supermarket in Cobham, Surrey on 28th June 2013 while a pedestrian. She suffered a degloving injury just above her right ankle but no broken bones. She was treated in St. Peter's Hospital with a follow up appointment with plastic surgeons at Wexham Park Hospital to treat the leg wound. 2. On 9th July, Mrs Nutbeam attended St. Peter's Hospital with abdominal discomfort and vomiting. Staff at St. Peter's rearranged an appointment that Mrs Nutbeam had for the same day, 9th July, at Wexham Park Hospital, the new appointment being two days later. 3. Mrs Nutbeam attended Wexham Park Hospital on 11th July and the following day was taken to theatre for a debridement procedure as the leg wound had become infected. Treating Clinicians at Wexham Park Hospital were not made aware of the recent vomiting episodes and treatment at St. Peter's Hospital on 9th July nor that, after admission to Wexham Park Hospital, she had continued to vomit. There was no record in the nursing notes. 4. During the surgery at Wexham Park Hospital on 12th July, Mrs Nutbeam vomited and aspirated. Despite subsequent treatment in Intensive Care, she passed away and a post mortem examination revealed pneumonia superimposed on Adult Respiratory Distress Syndrome which the Pathologist concluded was a direct consequence of the aspiration following the debridement procedure.
5	**<u>CORONER'S CONCERNS</u>** 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) Staff at St. Peter's Hospital did not contact Wexham Park Hospital to advise of the recent admission, treatment and symptoms even though they were on notice that Mrs Nutbeam had a follow up appointment at Wexham Park Hospital some two days later because they arranged that appointment. Concern is the apparent lack of any procedure to allow information to be transferred between different Trusts in different Counties. There was no letter given to Mrs Nutbeam to accompany her to the subsequent appointment. (2) Despite clear evidence from the family that Mrs Nutbeam was vomiting on the ward shortly before her debridement procedure, there is no reference in the nursing notes and this information was not made known to the Anaesthetist nor Surgeon. The fact that she was vomiting prior to a surgical procedure should have been a matter of serious concern. (3) The evidence given at the Inquest was that if the Anaesthetist/Surgeon had been aware of the vomiting symptoms, the procedure would have been deferred to investigate the cause of the vomiting. This may have prevented aspiration during the surgery. (4) It was also given in evidence at the Inquest that, when the Anaesthetist visited Mrs Nutbeam prior to the surgery and explained the procedure, the risks and took her consent, he did not ask her if she had vomited within the last twenty four hours. The evidence was that this is not a standard question to ask of patients ahead of surgery. The question is posed as to whether this should become a standard question that is asked of patients prior to going to procedure as, if it had been asked on this occasion, the lack of information from St. Peter's Hospital and the absence of any reference to vomiting in the nursing notes would still have come to the attention of the treating Clinicians. Should this become a training issue?
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, namely by Wednesday 19th March 2014. 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 Mrs Nutbeam's family. 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	**21st January 2014** **P.J. Bedford** **H.M. Senior Coroner for Berkshire**