REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** NHS England PO Box 16738 Redditch B97 9PT
1	**CORONER** I am Dr Fiona Wilcox, Senior Coroner, for the coroner area of Inner West London
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 Saturday 24th August 2013 I commenced an investigation into the death of Ms Desiree Harmony Falvo, aged 35 years. The investigation concluded at the end of the inquest on 26th March 2014. The conclusion of the inquest was: Medical Cause of Death 1 (a) **Hypoxic Brain Injury** (b) **Cardiorespiratory Arrest** (c) **Upper airway tract obstruction (treated August 2013).** How, when and where and in what circumstances the deceased came by her death: ***Ms Falvo had congenital laryngeal stridor due to immobile vocal cords which required multiple surgical procedures. On 20/8/2013 she had a relatively minor procedure to assess her suitability for reconstructive surgery at Charring Cross Hospital. This appeared to go well. Post operatively she did not feel right in herself, however was discharged objectively fit at approximately 13:30 on 22/8/2013.*** ***That evening she developed difficulty in breathing over a couple of hours, vomited then deteriorated rapidly. LAS was called and she was transferred to St George's Hospital. On arrival she was in extremis.*** ***The treating doctors had difficulty in securing her airway due to obstruction around the vocal cord area, scarring in her neck and her body habitus, during which she arrested.***

	By the time the ENT Registrar had arrived and completed a tracheostomy, she had suffered hypoxic brain injury. She died at 05:58 on ITU at St George's Hospital. ***The cause deterioration is unknown.*** Conclusion of the Coroner as to the death ***Narrative- see above.***
4	**CIRCUMSTANCES OF THE DEATH** It was clear from the evidence taken during the inquest that an expert team was attempting to resuscitate Ms Falvo in very difficult circumstances. A paediatric intensivist had almost got the tracheostomy in place just as the ENT Registrar had arrived and took over the surgical tracheostomy insertion. However a recurrent theme of the evidence was that the procedure required to secure Ms Falvo's airway was the expertise of the non resident ENT surgeon. I understand from discussion with the experts called to give evidence, that there are insufficient ENT Registrars to be resident in all A&E Departments and that whilst those working in A&E and expected to manage airways are trained in emergency surgical tracheostomy techniques, many of these clinicians feel uneasy and lack the confidence to perform such procedures.
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) That A&E departments have insufficient cover to ensure that they have on site clinicians able to secure airways via emergency surgical tracheotomy, (2) That the training planned and provided to those expected to manage and secure airways including the use as appropriate of surgical tracheotomy, is reviewed and upgraded such that those clinicians have both the skills and confidence to perform such procedures in an emergency situation.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 11th June 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 the following Interested Persons :

[redacted]

[redacted]

I have also sent it to the following persons or organisations who may find it useful or of interest:

[redacted]
Consultant ENT Surgeon,
Charing Cross Hospital,
Fulham Palace Road,
London.

[redacted]
Consultant in Emergency Medicine,
St George's Hospital,
Blackshaw Road,
London.
SW17 0QT.

[redacted]
St George's Hospital,
Blackshaw Road,
London.
SW17 0QT.

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 **15th April 2014**

Dr Fiona Wilcox,
HM Senior Coroner,
Inner West London,
Westminster Coroner's Court,
65, Horseferry Road,
London.
SW1P 2ED.