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HM Senior Coroner for Essex

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Southend University Hospital**
1	**CORONER** I am Eleanor McGann, Area Coroner, for the coroner area of Essex
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 30th June 2014I commenced an investigation into the death of Julie Ann Robertson, Date of Birth 2nd October 1963. The investigation concluded at the end of the inquest on 2nd July 2014. The conclusion of the inquest was:- **Narrative Verdict** On 8th May 2013 Julie Ann Robertson had an operation for an elective total abdominal hysterectomy and bilateral salpingo Oophorectomy. The operation was uncomplicated and in recovery she was fine. She was transferred back to the ward. At around 2.00 am on 9 May 2013 her blood pressure was low and her pulse rate was up. This is a known indicator for internal bleeding. A doctor was not contacted until 3.00 am and an SHO attended at 3.10 am followed by the Registrar at 3.40 am. Although there was difficulty in obtaining a blood sample the result of a bedside haemacue test was available by 4.40 am and this showed the haemoglobin level was 8. This case was not immediately escalated to a more senior doctor. A full blood test was not available until 5.45 am and only then was a consultant contacted and for the first time there was some recognition that this was an emergency. By the time Mrs Robertson was seen by a senior

	anaesthetist at 6.17 am she was unfit for immediate surgery. This was mainly due to blood for a transfusion still being unavailable despite the fact that the possible need for such blood had been recognised by 4.40 am. The blood eventually arrived at the ward by 6.55 am when the delayed blood transfusion was finally started. Despite the fact that 2 surgeons were in theatre ready to operate by 7.19 am the operation could not commence until around 8.00 am because Mrs Robertson was too unwell to be given a General Anaesthetic. When they were able to operate the surgeons did their best but it was too late. Mrs Robertson's chances of a successful recovery had been reduced by the earlier delays. Record keeping throughout was poor and timings were unclear. Julie Ann Robertson died on 11th May 2013 as a result of complications following the operation as set out above.
4	**CIRCUMSTANCES OF THE DEATH** See Narrative conclusion above.
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) The possible need for blood had been anticipated as early as 4:40am. If there had been a blood fridge on the ward then the matched blood could have been brought to the ward so that when a transfusion was called for it would have been instantly available on the ward. The blood eventually arrived at 6.55am by which time Mrs Robertson was unfit for surgery. 2) Record keeping was poor and this was acknowledged in the Root Cause Analysis report. Although I heard evidence that there had been some training instigated there is no formal training and indeed witnesses at the inquest still seemed unaware of good practice as to record keeping.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 10th September 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- Gadsby Wicks Solicitors for the 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	**16th July 2014** **Mrs Eleanor McGann, Area Coroner for Essex**
