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: 1. **Public Enquiries Unit** **Department of Health** **Richmond House** **79 Whitehall** **London** **SW1A 2NS** 2. **The British Thoracic Society** **17 Doughty Street** **London** **WC1N 2PL** 3. **The Royal College of Anaesthetists** **Churchill House** **35 Red Lion Square** **London** **WC1R 4SG** 4. **College of Emergency Medicine** **7-9 Bream's Building** **London** **EC4A 1DT**
1	CORONER I am M. E. Voisin, Senior Coroner, for the Area of Avon
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 24th April 2014 I commenced an investigation into the death of **Gerald Trevor WERRETT**, aged **67**. The investigation concluded at the end of the inquest on 25th July 2014. The conclusion of the inquest was that Mr Werrett died due to: Ia Bilateral bronchopneumonia Ib Chronic obstructive airways disease II Ischaemic heart disease His death was contributed to by a misplaced chest drain and the conclusion given was natural causes contributed to by neglect.
4	CIRCUMSTANCES OF THE DEATH Mr. Werrett was admitted to hospital on 28th February 2014 with infective exacerbation of his chronic obstructive airways disease together with a number of co-morbidities. During his admission he required a number of chest drains to be inserted to treat his condition. On 31st March 2014 he required a further drain to be inserted and two chest x-rays were taken. It was clear from the evidence and indeed not disputed that the chest x-rays were inverted and mislabelled which resulted in the registrar misinterpreting the one x-ray that she looked at (she did not look at both), this resulted in a chest drain being put in the left side when in fact the pneumothorax was on the right. Mr. Werrett subsequently required a chest drain to be inserted on the right as well.

	Mr. Werrett's treating consultant gave evidence and said that the chest drain was wrongly inserted, having two chest drains caused pain and made him less mobile with cough difficulties, the staff clearly tried desperately to rectify the situation but that the second unnecessary drain had an impact and a contributory factor to his death. The incident on 31st March 2014 resulted in a never event and the Trust have now rolled out a safety check list to be completed prior to the insertion of a chest drain together with guidelines for the insertion of chest drains.
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. – Chest drains are inserted by a number of medical disciplines and clearly this event has shown that basic failures can have catastrophic consequences, the areas identified during the inquest included: 1. A lead anatomical marker was not used when taking the chest x-ray 2. Both chest x-rays were incorrectly labelled, and this error was not identied by the clinician 3. The chest x-ray that was looked at was misinterpreted 4. Both chest x-rays were not considered. 5. The cardiac silhouette was not interpreted correctly 6. Mr. Werrett was not examined prior to the insertion of the chest drain. North Bristol NHS Trust have clearly learnt a valuable lesson following this incident and have devised a safety check list and guideline which could be of assistance to the wider medical community. North Bristol NHS Trust have indicated that they would be willing to share the check list and guideline which if implemented could avoid a similar event happening again.
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 Monday 29th 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 – the Family of Mr. Werrett and North Bristol NHS Trust. 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	**1st August 2014** **M. E. Voisin**