REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr S Bain** **Chief Executive** **East Kent Hospitals University NHS Foundation Trust** **Kent & Canterbury Hospital** **Ethelbert Road** **Canterbury CT1 3NG**
1	**CORONER** I am Rachel Redman, Senior Coroner, for the Coroner area of Central and South East Kent
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 1st November 2012 I commenced an investigation into the death of Betty SMITH. The investigation concluded at the end of the inquest on 2nd April and 10th September 2014. The conclusion of the inquest was that Betty SMITH died as the result of the unintended consequence of necessary surgical treatment.
4	**CIRCUMSTANCES OF THE DEATH** Betty SMITH required surgery for a large intrathoracic hiatus hernia. She had significant comorbidities. She was referred to the Anaesthetic Department who advised that surgery should proceed after six months of warfarin for treatment of a pulmonary embolus, from review of the medical records only and not after a consultation with her. There was no barium swallow or endoscopy which the expert opinion considered would have demonstrated evidence of volvulus or obstruction. On 22nd October 2012 she was admitted for laparoscopic Nissen Fundoplication with mesh which was uneventful. She was due to go to the High Dependency Unit post-operatively but remained in recovery for several hours before going to the ward with just a drain and no invasive support as there was no HDU bed available. She deteriorated the following day and began a heparin infusion for a pulmonary embolism. She was admitted to ITU on 24th October 2012 and died the following day. Cause of death was:- 1a) Intraabdominal and intrathoracic haemorrhage 1b) Repair of haitus herna

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:- • To return Betty SMITH to a ward post operatively and not secure an High Dependency Unit bed before surgery commenced falls well below accepted care. The expert opinion was concerned that such a high risk patient should have been referred to a Tertiary Centre for a second opinion and probably management. • The pre-assessment service offered by the Anaesthetic Department is far from adequate. To review such a high risk patient with significant comorbidity from the medical records is not in the patient's interest. Time should be afforded to the anaesthetists to review the patient at an out-patient clinic pre-operatively to assess the risks and discuss them. • Two ITU beds have been closed three months ago due to nursing shortages leaving William Harvey Hospital with just nine ITU beds. This is 4.5 beds per 100,000 population compared to the national average of 6.4 ITU beds. This is presenting the ITU Intensivists with significant difficulties and compromises the care of those patients requiring intensive therapy in a busy district general hospital.
6	**ACTION SHOULD BE TAKEN** • I consider that additional time should be afforded to the Anaesthetic Department to review patients not just from the records but in out-patient clinics before surgery. • I believe that such complex surgery should be referred to a Tertiary Centre for a second opinion and probable management. • I believe that this type of surgery should not proceed without securing an HDU/ITU bed in advance. • I consider that more ITU beds should be made available in the Intensive Care Unit.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 22 December 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. 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	27th October 2014 Rachel Redman – Senior Coroner