REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] East Kent Hospital University NHS Trust Kent & Canterbury Hospital Ethelbert Road Canterbury CT1 3NG
1	**CORONER** I am Rachel Redman Senior Coroner, for the Coroner area of Central & 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 30th January 2013 I commenced an investigation into the death of Herbert Chandler. The investigation concluded at the end of the inquest on 23rd July 2014 The conclusion of the inquest was that Mr Chandler suffered from chronic obstructive pulmonary disease and a left pneumothorax. He developed an acute right tension pneumothorax after erroneous aspiration which led to terminal respiratory failure.
4	**CIRCUMSTANCES OF THE DEATH** Mr Chandler was admitted as an in-patient to William Harvey Hospital on 17th January 2013 with a history of chronic obstructive pulmonary disease. Investigations show that he had a pneumothorax in the left lung. Mr Chandler was investigated and treated conservatively with antibiotics, nebulizers and steroids even though his respiratory rate was above 30 from 19.01.13 and above 32 from 20.01.13. On 22nd January, an attempt was made to aspirate the pneumothorax but an error was made and the right lung was aspirated instead of the left. The left lung was then aspirated but Mr Chandler died soon after both 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: A series of failings by the Trust have caused or contributed to the cause of death, namely:- • A conservative approach to managing the left pneumothorax with antibiotics,

	• Inappropriate prescribing of medication, namely gentamicin and aminophylline, • A failure to put in a chest drain when the patient was reviewed on 22nd January by a Consultant Respiratory Physician, • A failure to communicate findings after a Consultant's review on 22nd January to the medical on-call team, • The Medical Registrar's failure to request a chest x ray before attempting the aspiration procedure given that more than 48 hours had elapsed since the previous x ray, • The Medical Registrar's failure to check the radiology immediately prior to aspirating the right lung, The Medical Registrar's failure to examine Mr Chandler immediately prior to aspirating the right lung to confirm her findings concurred with the radiology, • A confusing format of medical records which prevented sequential recording of entries by health care professionals, • A failure to provide Consultant on call respiratory cover.
6	**ACTION SHOULD BE TAKEN:** I believe that the following action should be taken:- • That the BTS guidelines are reviewed when managing patients with a pneumothorax and raised respiratory rate. • That a protocol is followed before an invasive procedure is attempted by a member of staff which includes an examination of the patient, a reference to the medical records and a review of the radiology and results of all other investigations. • That the medical records are revised to provide for sequential recordings of entries by all healthcare professionals. • That provision is made for Consultant on-call respiratory cover.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 16 October 2104. 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: Messrs Clyde & Co, Morrisons Solicitors, Radcliffes Le Brassue Solicitors. 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	**21th August 2014** **Signed:** **Senior Coroner**