Karen Dilks
Senior Coroner for the City of Newcastle Upon Tyne

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Rt Hon Jeremy Hunt** Secretary Of State For Health Department For Health Richmond House 79 Whitehall London SW1A 2NS
1	**CORONER** I am Karen Dilks, Senior Coroner for the City of Newcastle Upon Tyne
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 30th October 2015 I commenced an Investigation into the death of Helen Elizabeth Patton age 76 years, born 9th October 1939, died 27th October 2015. The Investigation concluded at the end of the Inquest on the 19th April 2016. The conclusion of the Inquest was that Mrs Patton "died due to rare complications of a Mini Tracheostomy procedure".
4	**CIRCUMSTANCES OF THE DEATH** Mrs Patton suffered from breathlessness. Investigations to identify the cause of her symptoms were undertaken. Lung Nodules were identified suspicious of Malignancy. A multi disciplinary team of clinicians recommended that Mrs Patton undergo a Right Lobectomy Operation to treat her suspected cancer. The Operation was without complication. Mrs Patton made initial positive progress but then suffered infection, respiratory failure and fast heart rhythm. She was unable to clear secretions. In order to facilitate, removal of the secretions, a Mini Tracheostomy was inserted on the 22nd October 2015. The procedure was not undertaken in an operating theatre but on an Intensive Care Ward, nor was it guided by ultra sound scanning. The evidence of a senior and experienced consultant thoracic surgeon was that this is in common practice both regionally and nationally. During Mrs Patton's Tracheostomy Procedure the guiding needle damaged a small Thyroid Artery. This led to Catastrophic Bleeding and Rapid Exsanguination. This caused Mrs Patton's death. The risk of a similar all be it rare complication continues to exist in each Mini Tracheostomy Procedure carried out under the same conditions.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) The Continuing risk of mortality where Mini Tracheostomy Procedures are not undertaken within theatre conditions or ultrasound guided (2) That Mini Tracheostomy Procedures are undertaken regularly on a national level without ultrasound guidance or in theatre conditions (3) The absence of any national guidance in respect of Mini Tracheostomy Procedures to minimise the risks associated with them particularly the risks of conducting such procedures outside of an operating theatre and without ultrasound guidance

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Rt Hon Jeremy Hunt 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 20th April 2016. 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, Mrs Patton's family, [redacted] (Consultant Thoracic Surgeon) and the Medical Director at the Newcastle Health Trust who may find it useful or of interest. 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	Dated 20 April 2016 Signature_____ Senior Coroner for the City of Newcastle Upon Tyne