Thomas Ralph Osborne
Senior Coroner for Milton Keynes

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [redacted], Chief Executive NHS England**
1	**CORONER** I am Thomas Ralph Osborne, Senior Coroner for Milton Keynes.
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 10th January 2017 I commenced an investigation into the death of Patricia Lilian Parker, aged 89 . The investigation concluded at the end of the inquest on 11th July 2017. The conclusion of the inquest was a Narrative conclusion: *The deceased underwent an endoscopic procedure under sedation at Milton Keynes Hospital on 5th January 2017. She suffered a cardiac arrest following sedation and despite resuscitation she died at 04.15 on the 8th January 2017.* The medical cause of death was recorded as 1(a) Hypoxic brain injury following cardiac arrest during diagnostic endoscopy 2) Gallstones, Atrial Fibrillation
4	**CIRCUMSTANCES OF THE DEATH** On 5th Jan 2017 the deceased was prepared for an endoscopy. Her throat was sprayed with Xylocane she was then given Midazalem [redacted]) and Pethidine [redacted] and the procedure was started. Her saturations dropped suddenly and she became cyanosed, the procedure was immediately stopped but she went into cardiac arrest. CPR was started, she was intubated and admitted to Department of Critical Care for further management. Her family were informed of the situation and the possible cause of arrest was likely to be due to her sedation prior to endoscopy. She died on 8th January 2017. There was a failure to adhere to the Trust's Intravenous Sedation Policy for adults and BNF (British National Formulary) recommendations in relation to titrating of the sedation.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern namely that the clinicians involved in the care of the deceased were not aware of the clinical guidelines for sedation. 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)That the numerous guidelines relating to the use of sedation should be more widely brought to the attention of all clinicians undertaking sedation. (2) That NHS England should highlight the problems arising from the use of sedation particularly in the elderly and encourage all Hospitals to develop training locally for their clinical staff.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 18th September 2017. 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 Mrs Parker • Milton Keynes University Hospital 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 24th July 2017 Signature_____ Tom Osborne Senior Coroner for Milton Keynes