REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Royal Wolverhampton NHS Trust.** **2. Chief Coroner**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 4 April 2017, I commenced an investigation into the death of the late Mrs Sarah Poole. The investigation concluded at the end of the inquest on 16 May 2017. The conclusion of the inquest was a narrative conclusion: Natural causes contributed to by neglect. The cause of death was: 1a Cardiac Dysrhythmia (Ventricular Fibrillation) b Cerebral Anoxia/Brain Injury c Acute Aortic Dissection with Aortic Rupture and Cardiac Tamponade (Operated 29/10/2016) ll Hypertension
4	**CIRCUMSTANCES OF THE DEATH** i) Ms Poole was admitted to New Cross hospital after complaining of sudden onset of headache and back pain on the 28 October 2016 shortly after 11pm. ii) An ECG performed by ambulance staff was abnormal. She was then triaged by nursing staff and assessed at Level 4 before being given pain relief medication. iii) She was seen by a doctor at 1:50am who recorded a history of anxiety and panic attacks, headaches and pain in her back and chest. Her observations were normal and it was incorrectly concluded that her ECG was normal when the wrong ECG was examined relating to another patient. iv) She was later discharged home and no discharge papers were given to the family. v) Her condition continued to decline and she was readmitted back to hospital on the 29 October at around 1pm; a scan and further investigation revealed an aortic dissection. vi) She then had emergency surgery which was a complex operation with

	associated risks. vii) She developed further complications post operatively and by the 3 November a CT brain scan revealed minimal brain activity. She sadly passed away on the 5 November 2016.
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. – 1. Evidence emerged during the inquest that there were failures to record and endorse the name of the Doctor reviewing the ECG and a failure to take into account previous abnormal ECG results during the handover from the paramedic 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. 1. I understand that since this incident a number of measures have been introduced including reinforcing the requirement to sign all ECG's. However, a recent audit (May 2017) indicated that out of twenty cases examined there were still two failures by the clinician to endorse the ECG. 2. You may wish to consider setting up a review of the policy and training for the relevant staff concerned and a consideration of an escalation policy for those who continue to fail to adhere to policy and instructions.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 25 July 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; Family. 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	**30 May 2017** Z Siddique **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**