**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

*NOTE: This form is to be used **after** an inquest.*

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. The Chief Executive,**<br>**Blackpool Teaching Hospital NHS Foundation Trust** |
| 1 | **CORONER**<br><br>I am Alan Wilson, Senior Coroner, for the area of Blackpool & Fylde |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 3rd September 2013 an investigation commenced into the death of Mark Bentley Hudson aged 50 years. The investigation concluded at the end of the inquest heard on 8th October 2014.<br><br>The record of the inquest confirmed as follows:<br><br>The Medical cause of death was<br>Ia Myocardial Infarction<br>1b Severe Coronary Artery Disease and Thrombosis of the Right Coronary Artery Bypass Graft<br><br>11 Left Pulmonary Embolus and Diffuse Alveolar Damage<br><br>The conclusion of the Coroner as to the death was a Narrative conclusion as follows:<br><br>**Mark Bentley Hudson was admitted to hospital on 20th August 2013 following three days of intermittent chest pain. After assessment he underwent urgent coronary artery bypass graft surgery. Although he initially appeared stable he went into cardiac arrest at approximately 22.45 hours on 25th August 2014 necessitating cardiopulmonary resuscitation. At approximately 00.10 hours on 27th August 2014 he again suffered a cardiac arrest. Efforts were made to ventilate him. Oesophageal intubation went unrecognised until the arrival of an anaesthetist. Despite efforts to revive him, death was pronounced at 01.15 hours later that morning.** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>See the contents of section 3 above. |

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| | The inquest was informed that further to admission to hospital on 20th August 2013 and having undergone urgent and necessary cardiac surgery, the Deceased had suffered a cardiac arrest on 25th August 2013 but had been resuscitated and stabilised.<br><br>However just after midnight on 27th August 2014 he went into ventricular fibrillation. Evidence was heard that a telephone call was made by staff on the Cardiac Intensive Care Unit [CICU] that the on - call Anaesthetist be bleeped with a view to her attending to provide assistance for Mr. Hudson. Shortly afterwards, the Anaesthetist having failed to appear at the CICU, two further requests were made by CICU staff for the Anaesthetist to be contacted.<br><br>An Anaesthetist gave evidence to the effect that she does not recall receiving the first two of those requests to attend CICU.<br><br>When the Hospital Trust undertook a Sudden Untoward Incident Review, it could not be established that the requests made by CICU staff had been received and acted upon. Switchboard staff are not expected to maintain a contemporaneous record of the calls they receive which require switchboard staff to then contact the Anaesthetist. The author of the internal review did accept that she could not rule out the possibility that the Anaesthetist had not been contacted in response to the first two requests and that the CICU staff had effectively been trying to maintain the Deceased's airway whilst expecting the Anaesthetist to arrive imminently when she had not actually been notified.<br><br>At the inquest this appeared to be an issue that had not been fully appreciated during the Hospital Trust's internal review.<br><br>Ultimately, the Anaesthetist did attend CICU to learn that a Surgical Registrar had - given the non appearance of an Anaesthetist - decided to take over airway management and attempted to intubate the Patient but that his airway had been compromised given that intubation had been carried out incorrectly. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>At the conclusion of the inquest, I indicated to the Interested Persons that I proposed to write to the Trust by way of a report in accordance with the provisions of paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009.<br><br>Having concluded this inquest, I now write to the Trust to confirm that in my view the Trust should take action because:<br><br>Although encouraged by the steps that have been / are being taken internally at the Hospital further to this death, I remain concerned that there is a real risk that when the need arises for urgent provision of specialist care within the CICU department, such requests may go unanswered or be delayed. If CICU staff request such assistance via the Hospital Switchboard personnel at the hospital, I am concerned that the procedures in place are insufficiently robust to the extent that requests may not be followed up appropriately and to the potential detriment of the Patient requiring that urgent help.<br><br>I would therefore be obliged if the Trust would write to me in due course to confirm what steps if any the Trust proposes to take to address these areas of concern. |
| 6 | **ACTION SHOULD BE TAKEN** |

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| | In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 30thDecember 2014. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>The family of Mark Bentley Hudson<br>The Coroners Society<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | A.A.Wilson<br><br>**Alan Wilson**<br>**Senior Coroner for the area of Blackpool & Fylde**<br><br>**Dated: 4th November 2014** |