	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr J Sobieraj,Chief Executive, United Lincolnshire Hospitals NHS Trust**
1	**CORONER** I am Mrs Heidi Connor, assistant coroner for the coroner area of Nottinghamshire.
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 1 August 2017 I commenced an investigation into the death of Elaine Bradbrook.. The investigation concluded at the end of the inquest on 11 January 2018. The conclusion of the inquest was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** I was asked to refer to the deceased as Elaine during the inquest, and I reflect that request in this report. <u>Clinical background</u> Elaine Bradbrook suffered a severe stroke on 21.4.17. Onset of symptoms was around 10.30. She was admitted to Pilgrim Hospital, Boston, Lincolnshire at 11.48. She was quickly scanned and Alteplase was started at 12.18. Her condition was monitored in line with the trust's protocol for the first 24 hours after administration of the drug. At 12.30, her GCS was recorded as 13. This was the last recorded GCS. Her NEWS was 2. Her next observations were due at 16.30. In fact, a set of NEWS observations was recorded at 14.00. I found it likely that these were recorded before 16.30 because staff caring for her were concerned about her condition. Her NEWS at 14.00 was 6. This was partly because of a drop in blood pressure, but also because her level of consciousness dropped. She was recorded as being responsive only to pain at that time. The evidence of the neurosurgery witness was that it is likely that her GCS was around 9 or 10 at that time. The NEWS score alone should have triggered review by a doctor. There is no evidence that this happened. Neurosurgeons in Nottingham were contacted at around 2pm. I found it likely that this call was triggered by the finalised report of a routine head CT (done at 10.00, with final report available at 13.43, suggesting urgent neurosurgical review), rather than by the NEWS Score. This is because : • The GCS (and its exact EVM components) given to Nottingham matches that recorded at 12.30. It is unlikely that her GCS was 13 or 14 by 14.00. • There was no increased monitoring after 14.00, which is likely to have been suggested after a clinical review at that time. Indeed, there is no evidence of any further monitoring or review after 12.30 that day. The clear recollection of ambulance staff who arrived to transfer Elaine at 15.26 was that she was GCS 4 and remained so throughout the journey to Nottingham. Nursing staff at the hospital told ambulance crew that Elaine had been vomiting and had required

	suction. Despite this, Elaine was handed to ambulance staff for transfer in a very deep coma, without protection of her airway, without escort, and without review by an anaesthetist or indeed any other doctor, after her deterioration on the afternoon of 22 April. Hospital staff administered Ondansetron before she left. It is likely that they knew that the ambulance technician and trainee technician sent to transport her could not intubate her. Surgeons in Nottingham were surprised at Elaine's condition on arrival. A craniectomy procedure was nevertheless carried out. This showed massive brain swelling. She died at Queen's Medical Centre on 27 April 2017. Her cause of death (following PM) was : 1a Ischaemic stroke 1b Atherosclerosis I accepted the evidence that it was unlikely that Elaine would have survived even with different management, given the severity of her stroke. My focus in issuing this report is on the safety of other patients for whom these matters could make a difference. <u>Investigation and inquest management by the Lincolnshire Trust</u> Complications arose before the inquest, when the only witness who provided a statement [redacted], consultant stroke physician) booked a foreign trip a number of weeks after his summons was sent to the trust. The medical director was involved, and [redacted] kindly agreed to change his plans. Unfortunately, he booked a flight for the second day of the inquest, and asked to leave early that day, leaving no representative from the trust to hear the conclusions, which raised serious concerns about the management at Lincolnshire. In Dr Jergovic's defence, he had never attended an inquest in the UK before. The trust was aware that he was due to attend a 2 day inquest, but sent no representative or supporter from the trust to assist him. Witnesses from East Midlands Ambulance Service NHS Trust and Nottingham University Hospitals NHS Trust both attended with representatives from their respective legal services departments, despite the fact that the Lincolnshire trust was the only Interested Person (other than family). The trust legal team was asked repeatedly to send the witness (doctor) who had been responsible for the patient just before her transfer to Nottingham. We were told that was [redacted]. He gave evidence that he was not involved that day – he could only give evidence based on the records. [redacted] (consultant neurosurgeon from Nottingham) gave evidence that the Lincolnshire trust was made aware of concerns about her transfer to Nottingham. The trust has confirmed (when we asked them) that there has been no internal investigation of these matters. [redacted] said he was not aware of any investigation. The trust adduced no evidence of either an awareness of the issues arising from this inquest, nor any steps to reduce the risk for similar patients in future. It is suprising that [redacted] appears not to have had any support from the trust which employs him, and that the trust has not investigated the circumstances of this case before now. The trust has a duty of candour, which appears to have been overlooked.
5	**<u>CORONER'S CONCERNS</u>** 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. My concerns are :

	a. There was a failure to escalate and act on Elaine's deteriorating condition from at least 14.00 on 22 April 2017, when her NEWS was 6, and her GCS is also likely to have dropped. b. There was a failure to record a single GCS after 14.00, when her level of consciousness dropped. I found no evidence of any clinical or nursing review after this time. c. There was a failure to discuss Elaine's condition with neurosurgeons in Nottingham again before she was transferred to Nottingham, when it was clear that her condition had deteriorated significantly. d. There was a failure to reduce the risks during transfer – a patient with a GCS of 4 and a history of vomiting was handed over to ambulance staff with an unprotected airway and without clinical review, or escort. e. The trust appears not to have appreciated the significance of these issues. It has not carried out any internal investigation, nor contacted Elaine's family in line with its duty of candour. I am concerned that there has been no opportunity for learning within the trust, following these serious failures. f. The trust's procedure for carrying out High Level Investigations and Serious Untoward Incident Investigations should be reviewed. g. The trust legal services team did not send the witness (doctor) responsible for reviewing Elaine shortly before transfer, as requested. It sent no representative or supporter with [redacted], despite the trust being an Interested Person. There was no representative in attendance to hear the conclusions which raised serious concerns.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you / your organisation 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 11 April 2018. 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 : 1. Elaine's family 2. Legal services team at United Lincolnshire Hospitals NHS Trust 3. Legal services team for NUH 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	**14 February 2018** ***H.J.Connor***