REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Miles Scott, Chief Executive, St George's Hospital, Blackshaw Road, London. SW17 0QT Charlie Massey, Chief Executive, General Medical Council, Regents Place, 350 Euston Road, London. NWE1 3JN The Rt Hon Jeremy Hunt MP, Secretary of State for Health & Social Care, Department of Health, 39 Victoria Street, London. SW1H 0EU
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London
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 19th October 2017 and 21st February 2018, evidence was heard touching the death of **Ms Ivanika Olivari.** Ms Olivari had died on 3rd August 2017 in St George's Hospital following an out of hospital cardiac arrest at her home address on 29th July 2017. She was 68 years old at the time of her death. The findings of the court were as follows: **Medical Cause of Death** 1 (a) Hypoxic-ischaemic encephalopathy secondary to ventricular fibrillation cardiac arrest

	(b) Malfunction of implanted cardiac pacemaker (c) Atrial Fibrillation II Mitral valve replacement for mitral stenosis, pulmonary hypertension, systemic hypertension and rheumatic fever. **How, when and where the deceased came by her death:** Ms Olivari suffered with heart problems following rheumatic fever including an arrhythmia for which she had an implanted pacemaker. On 29th July 2017 a Holter recording found her pacemaker to be malfunctioning. This required urgent resetting to prevent the risk of her developing a life threatening arrhythmia. An unsuccessful attempt was made to contact her by telephone at approximately 13:25. Ms Olivari arrested at approximately 18:13 the same day as a result of the pacemaker malfunction. She was resuscitated at the scene, taken to St George's Hospital and her pacemaker reset. Sadly she died on 3/8/2017 as a result of neurological damage sustained at the time of the arrest. **Conclusion of the Coroner as to the death** Natural Causes
4	**Circumstances of the death.** Evidence was taken at the inquest that the problem identified on the Holter recording was that the pacemaker was not correctly capturing the heart beat of MS Olivari, such that she had pauses with no heart rhythm which made her susceptible to the development of escape ventricular fibrillation. This was found at the scene by the LAS when she collapsed at home. This was considered by the clinicians who gave evidence to be a real and significant and life threatening risk. However as she had not reported any physical symptoms during pauses on the Holter recording, this risk whilst real, was considered to be unlikely to imminently occur. As such Ms Olivari was classified as requiring urgent treatment, within the next few hours to reset her pacemaker, but not immediate emergency treatment. The results of the Holter were brought to the urgent attention of the Cardiology registrar on call who then pulled up her electronic records and made two attempts to call the number on the records given as Ms Olivari's mobile phone through the hospital switch board. One call lasted 17 seconds and one 25 seconds. This doctor could not recall the two calls connecting, but recalled getting through to the mobile's answerphone on one occasion. She stated that she did not leave a message on the phone, but intended to try and call her back later and if by the end of her shift, which was a very busy Saturday due to finish at 8 pm, she had made no contact, then she would arrange for an ambulance to be sent to Ms Olivari's home address to collect her and bring her to hospital to have her pacemaker re-set. No other numbers were used to try and contact Ms Olivari. In the event, this doctor did not attempt to contact Ms Olivari again and at approximately 19:30 Ms Olivarui was brought to St George's Hospital by the LAS who had resuscitated her at home following her collapse at around 18:13. A finding of fact was made that had Ms Olivari been contacted and attended hospital and had her pacemaker re-set prior to her arrest she would not have arrested and died at the time she did. The cardiology registrar stated that she did not leave a message as she had concerns about patient confidentiality and to leave a message was against what she understood to be hospital guidelines. The Court was informed that hospital guidelines on message taking were based on guidelines from the department of health and the GMC which concern possible breaching of patient confidentiality.

	Not even a very bland and non-contentious message was left, advising the patient to contact the cardiology registrar, whom had previously seen and been in communication with the patient and so was known to Ms Olivari.
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. It is for each addressee to respond to the matters that relate to their area of authority or control. The **MATTERS OF CONCERN** are as follows: 1. That doctors should leave messages on answerphones for patients to make contact with them in urgent and emergency situations. 2. That doctors should attempt to contact patients via all contact phone numbers that they have access to for patients in urgent and emergency situations. 3. That in urgent and emergency situations risk to life should be considered the priority. 4. That hospital guidelines and St George's hospital guidelines in particular, in relation to such matters, should be updated and amended to reflect the above where needed. 5. That hospitals and St George's Hospital in particular, should ensure that all relevant staff have their training updated in a prompt and auditable fashion to reflect the concerns raised above. 6. That the GMC considers its guidance for doctors and amend where necessary to ensure that it is clear that messages may be left for patients in urgent and emergency situations. 7. That the Department of Health also considers its guidance that it issues in relation to such matters, and amend where necessary to ensure that it is clear that messages may be left for patients in urgent and emergency situations. 8. That the GMC and Department of Health both take steps to ensure that the clarifications as outlined above are communicated to all doctors by the GMC and to all relevant staff employed by the NHS by the Department of Health.
6	**ACTION SHOULD BE TAKEN** 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. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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. [redacted] 2. [redacted] Consultant Cardiologist, St George's Hospital, Blackshaw Road, London. SW17 0QT. 3. [redacted] Cardiology Registrar, c/o the Legal Department, St Goerge's Hospital, Blackshaw Road, London. SW17 0QT. 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	**7th March 2018**  **Dr Fiona J Wilcox** **HM Senior Coroner** **Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED**