REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted] Clinical Director, Salford Royal NHS Foundation Trust, Eccles old road, Salford. M6 8HD.
1	**CORONER** I am Timothy William Brennand, Assistant Coroner, for the Coroner Area of Manchester West.
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 26th day of January 2016, I commenced an investigation into the death of James Sheffield, Aged 64 years. The investigation concluded at the end of the inquest on the 31st January 2018. The conclusion of the inquest was: A medical cause of death of: 1a. Global Cerebral Hypoxia 1b. Idiopathic Post-Operative Acute Respiratory Failure II. Disseminated High Grade Renal Carcinoma; Obesity Related Obstructive Sleep Apnoea The Narrative Conclusion was that James Sheffield died as a consequence of the combination of naturally occurring disease and the effects of recognised complications of post-operative recovery following necessary surgical intervention to treat injuries sustained in an accidental fall that had given rise to a susceptibility to respiratory failure on a background of pre-existing complex co-morbidities.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a history of neuro-ischaemic ulcer to the right foot, dyslipidaemia, angina, previous heart failure, previous stroke, hypertension, obesity hypoventilation syndrome and obstructive sleep apnoea. On the 1st June 2016, the deceased suffered an accidental fall at a shopping

	centre. He was taken to Salford Royal Hospital, Eccles Old Road, Salford and following a full evaluation was discharged with analgesia upon no significant findings being diagnosed. On the 13th July 2016, the deceased was recalled to the hospital upon a clinical review revealing potential abnormality and then diagnosed with a hairline femoral fracture and pelvic metastatic carcinoma which was deemed to be secondary to a carcinoma of the kidney. There was a delay between recall, diagnosis and active surgical intervention in the form of corrective hip replacement surgery that took place without complication on the 11th July 2016. That delay had no bearing upon the outcome. Post-operatively, the deceased received high dependence care within an Intensive Care Unit and made an initial recovery to the extent that that he was stood down to care on ward. Upon transfer to ward, the deceased's CPAP machine that was intended to accompany him went missing following x-ray procedures undertaken prior to admission on ward. The accepted omission to ensure an important item of medical equipment was transferred and in the possession of the deceased and available for use did not have a bearing on the outcome. At about 1.15pm on the 12th July 2016, suddenly and unexpectedly, for reasons that cannot be established, the deceased suffered a cardio-respiratory arrest. Resuscitation was undertaken promptly. Despite active management of his condition, the deceased failed to regain consciousness. His condition deteriorated until he died on the 17th July 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. The case involved evidence of the in-patient treatment and care in circumstances where that patient had brought into the hospital their own piece of important medical equipment – in this case a Continuous Positive Airway or "CPAP" machine (also known as an obstructive sleep apnoea machine); 2. Established medical practice, for good reasons, permitted patients to bring into the hospital and utilise their own "CPAP" machine with which the patient would be familiar; 3. However, the evidence that I heard revealed that there was no established system in place to ensure that such a piece of important medical equipment would remain with the patient in the event of transfer of that patient within the hospital from differing wards, units or departments; 4. Whilst I heard evidence that a comprehensive "Report following investigation" had been conducted by Salford Royal Hospital, facilitated by their Governance Manager, in which there was correctly identified the

	necessary potential root causes, conclusions and sharing of lessons, proposed monitoring mechanisms, ward to ward transfer documents and electronic record systems that had been put in place – nevertheless, the evidence that I received suggested that there were outstanding protocols and/or policies to be implemented to ensure that following an internal transfer, patient owned medical equipment such as the "CPAP" machine should not only be moved with that patient, but specific measures taken to ensure that it was both immediately available and ready for use to enable the patient to self-care upon completion of the transfer.
	ACTION SHOULD BE TAKEN In my opinion urgent 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 7th June 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: [redacted] – the sister of the deceased. [redacted] AVMA, Freedman House, Christopher Wren House, 117 High Street, Croydon. CR0 1QG. Hill Dickenson, No.1 St. Paul's Square, Liverpool. L3 9SJ – solicitors for Salford NHS Foundation Trust. 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** **12th April 2018**
	Signed **Timothy W.Brennand**