	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [redacted], Medical Director, Plymouth Hospitals NHS Trust**
1	**CORONER** I am Andrew James Cox, Assistant Coroner for Plymouth Torbay and South Devon.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 6 February 2017, I commenced an investigation into the death of Patricia Cragg, then aged 74. The Investigation concluded at the end of the Inquest on 23 August 2018. The conclusion of the Inquest was that Mrs Cragg died from a known but rare complication of a necessary medical procedure. The medical cause of death was given as:- 1a) Haemorrhage into Retro Peritoneum (Right Iliac Artery Haemocele Device appropriately placed) 1b) Angiogram/Angioplasty 1c) Unstable Angina from Severe Three Vessel Coronary Artery Atherosclerosis II)
4	**CIRCUMSTANCES OF THE DEATH** Mrs Cragg had known severe coronary artery disease. She was not felt to be a suitable candidate for surgery. On 26 January 2017 she underwent a high-risk percutaneous intervention guided by intravascular ultrasound carried out by [redacted]. At the end of the procedure, the patient reported pain and it was suspected that she was bleeding from the arterial point of entry. The decision was quickly made that she required a CT scan to confirm the diagnosis. Unfortunately, as a consequence of an unrelated road traffic collision, there were a number of other patients also awaiting a CT scan. It took five hours for Mrs Cragg's CT scan to be performed which revealed an extensive haemorrhage. Before she could be taken to theatre she deteriorated and died in the hospital on 27 January 2017. It was accepted at inquest that earlier surgical intervention may have prevented the outcome although in the context of a number of other significant comorbidities.
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) There was a lack of available CT resource to deal with the two simultaneous sets of emergencies. The inquest heard from [redacted] who accepted this had been a recognised

	weakness for a considerable period of time. I was advised that there were two potential courses of action that could be adopted to overcome this difficulty. First, there could be a second on-call consultant radiologist available to assist the first on-call consultant at times of particularly high demand. Secondly, there could be a facility to open up and run a second CT scanner. This would require the presence of the whole range of staff to include radiographers, porters, et cetera. I was told this was the second time in recent years where there had been simultaneous emergencies that inevitably meant there was a delay in reporting a patient's condition. It seems a decision is required as to whether it is appropriate to allocate additional resource to CT imaging and if so how that additional resource should be deployed in times of unexpected high demand. (2) I was told that the radiology department did not have its own internal major incident policy setting out how to respond to situations like that involving Mrs Cragg. [redacted] informed me that this was a piece of work he was trying to complete but that he would need input and assistance from his consultant colleagues before being able to do so.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 20 October 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] 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 23/8 2018 Signature_____ for Plymouth Torbay and South Devon