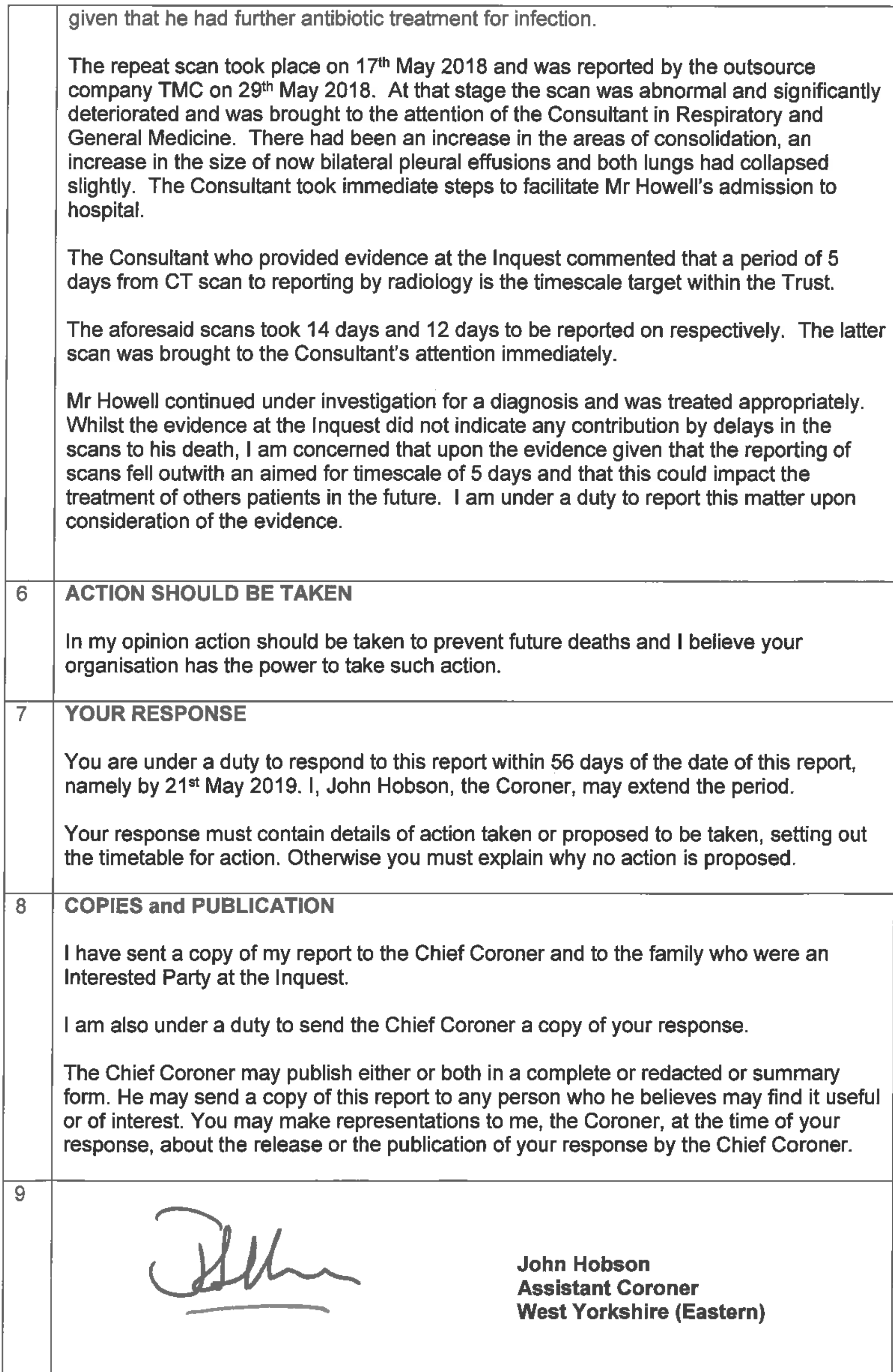
04 APR 2019

ANNEX A

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:** The Mid Yorkshire Hospitals NHS Trust
1	**CORONER** I am an Assistant Coroner, for the Coroner area of West Yorkshire (Eastern)
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 12th June 2018 an investigation was commenced into the death of Mr Alfred Howell (known as 'Alf'), aged 73. The investigation concluded at the end of the Inquest on 21st January 2019. The conclusion of the Inquest was that Mr Howell's cause of death was by way of Disseminated lung adenocarcinoma. The conclusion was that this was a natural cause of death.
4	**CIRCUMSTANCES OF THE DEATH** On 30th May 2018 Mr Alfred Howell, (known as 'Alf') was admitted to Pinderfields Hospital, Wakefield following respiratory investigation which indicated deterioration including the presence of now bilateral pleural effusions and the slight collapse of both lungs. Although he was stable on a review, on 1st June 2018 his condition then deteriorated. A further large collapse to the left lung was identified and although Mr Howell was treated accordingly he suffered a cardiac arrest and passed away on 5th June 2018, his death being confirmed at 0407 hours.
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 matter of concern is as follows:– During investigations into Mr Howell's medical condition, CT scans were taken on a number of occasions. Specifically, he underwent a CT scan on 24th March 2018 which was reported on by the radiology department on 7th April 2018. Upon review at an MDT on 17th April 2018, a deterioration of the changes previously seen in both lungs was noted. An MDT plan was then to perform an early follow up CT to assess whether the changes might improve



	given that he had further antibiotic treatment for infection. The repeat scan took place on 17th May 2018 and was reported by the outsource company TMC on 29th May 2018. At that stage the scan was abnormal and significantly deteriorated and was brought to the attention of the Consultant in Respiratory and General Medicine. There had been an increase in the areas of consolidation, an increase in the size of now bilateral pleural effusions and both lungs had collapsed slightly. The Consultant took immediate steps to facilitate Mr Howell's admission to hospital. The Consultant who provided evidence at the Inquest commented that a period of 5 days from CT scan to reporting by radiology is the timescale target within the Trust. The aforesaid scans took 14 days and 12 days to be reported on respectively. The latter scan was brought to the Consultant's attention immediately. Mr Howell continued under investigation for a diagnosis and was treated appropriately. Whilst the evidence at the Inquest did not indicate any contribution by delays in the scans to his death, I am concerned that upon the evidence given that the reporting of scans fell outwith an aimed for timescale of 5 days and that this could impact the treatment of others patients in the future. I am under a duty to report this matter upon consideration of the evidence.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 21st May 2019. I, John Hobson, 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 family who were an Interested Party at the Inquest. 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	**John Hobson** **Assistant Coroner** **West Yorkshire (Eastern)**