Regulation 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 The Chief Executive
Norfolk & Norwich University Hospital
Colney Lane
Norwich
NR4 7UY

1 CORONER

I am Yvonne BLAKE, Area Coroner for the area of Norfolk

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 15/01/2018 I commenced an investigation into the death of Brian Robert HAVARD aged 52. The investigation concluded at the end of the inquest on 12/03/2019. The conclusion of the inquest was:

1a Acute Aortic Dissection
1b
1c
II

2 CIRCUMSTANCES OF THE DEATH

Mr Havard presented to the Emergency Department (ED) of the NNUH on the evening of 8 January 2019 by ambulance with chest pain and vomiting. He arrived at the hospital but was cared for in the ambulance for several hours by paramedics. Eventually he was admitted just after 6am on 9 January and seen by the junior doctor nearly an hour later. He was discharged with a diagnosis of Musculoskeletal Pain and his partner came to fetch him, he collapsed in the car and an ambulance was called , he died en-route back to the hospital.

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 doctor had not read the ambulance electronic records and was not aware of a system in place to obtain these notes prior to his seeing the patient. These notes contained information about Mr Havard having hematemesis and two doses of morphine given to Mr Havard by the crew. He did examine Mr Havard and had differential diagnoses and went to speak to the locum consultant who was just coming on shift for advice. The consultant did not ask to see the notes from the crew or the hospital notes and was just shown the ECG. He evinced no professional curiosity about a**

patient needing three doses of morphine and being considered for discharge. The locum consultant did not seem to be aware of any system in place to access the ambulance electronic records. He did not give any convincing explanation for not seeing this patient or his apparent ignorance regarding obtaining ambulance notes. He did not give a convincing explanation for not reviewing the patient.

2. **There did not appear to be a system in place for junior doctors who have approached a senior to have their case reviewed with the responsibility for this being on the senior doctor.**
3. **Record keeping generally appeared to be poor and thus the doctors who attended at inquest had little documentation with which to refresh their memories and the ambulance notes do not appear to be routinely included in these notes and or read.**

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.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 May 2019. 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] (Wife)

[redacted] (EEAST)

who may find it useful or of interest.

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: 22/03/2019

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Yvonne BLAKE
Area Coroner for Norfolk
Norfolk Coroner Service
Carrow House
301 King Street
Norwich NR1 2TN