Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:
[redacted], Network Manager (Adult Critical Care) for Thames Valley & Wessex Operational Delivery Networks

1 CORONER

I am Tom OSBORNE, Senior Coroner for the area of Milton Keynes

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 31/07/2018 I commenced an investigation into the death of Mark Stephen Anthony Simon KUBIAK aged 61. The investigation concluded at the end of the inquest on 11th March 2019. The narrative conclusion of the inquest was:

> *The deceased suffered from acute necrotising pancreatitis and was cared for in the department of critical care at Milton Keynes University Hospital. On the 25th July 2018 it was decided to transfer him to the John Radcliffe Hospital in Oxford for surgical intervention. He was transferred to a portable ventilator and the oxygen supply was not connected properly and the lack of ventilation was not recognised. He suffered a cardiac arrest and died at 12:34 on 25th July 2018.*

4 CIRCUMSTANCES OF THE DEATH

The circumstances were that Mr Kubiak was being transferred from Critical Care at Milton Keynes Hospital to Intensive Care at the John Radcliffe Hospital. The Transfer network checklist was being followed but the checklist does not require the change of oxygen supply to be tested, or for a tug test to be carried out. When Mr Kubiak left the department the oxygen was not properly connected to the portable cylinder.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

That the Thames Valley Transfer Network Checklist does not require the oxygen supply to be checked, or for a tug test to be completed at the time that the oxygen is transferred from the ward supply in the hospital to the portable cylinder. If such a check and test had been carried out, the failure of the oxygen flow to the patient would immediately have been noticed and the situation rectified.

The checklist needs to be reviewed and updated to include the test suggested.

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 17th 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:

The Family of Mr Kubiak
South Central Ambulance Service
Milton Keynes University Hospital
Health Care Safety Investigation Branch

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

Tom OSBORNE
Senior Coroner for
Milton Keynes
Dated: 22 March 2019