Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. **Chief Executive of East Midlands Ambulance Service NHS Trust**
2. **Chief Executive of Nottingham University Hospitals NHS Trust**
3. **Chief Executive of Sherwood Forest Hospitals NHS Foundation Trust**

1 CORONER

I am Miss Laurinda Bower, HM Assistant Coroner, for the area of Nottingham and Nottinghamshire.

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 Fourteenth November 2019, I commenced an investigation into the death of Morris REDDINGTON, aged 67 years. The investigation concluded at the end of the inquest on 15 April 2021.

The conclusion of the inquest was that Mr Reddington had died as a result of;

I a Brain Stem & Cerebellar Infarction

I b Basilar Artery Thrombosis &
Dissection of the Right Vertebral Artery

I c

II Systemic Hypertension

4 CIRCUMSTANCES OF THE DEATH

Morris Reddington died as a result of a rare type of stroke, namely, a basilar artery thrombosis, likely caused by dissection of the right vertebral artery.

There were delays in reaching a diagnosis, including multiple missed opportunities to have considered and investigated Morris for a stroke earlier on the evening of 29 October 2019, but ultimately, the delay in providing thrombolysis treatment did not cause or contribute to his death.

The only treatment that would likely have prevented Morris' death was Mechanical Thrombectomy, which is not offered regionally outside of Monday to Friday 8am to 4pm. As Morris' stroke occurred outside of the operational hours of the service, he did not receive this treatment, and sadly died as a consequence of the stroke.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

I heard evidence that the Ambulance Service had replaced their paper-based Patient Report Form with an electronic system, many years previously.
The electronic Patient Report Form ('ePRF') is an important template which records all of the pre-hospital interaction with the patient. It forms a crucial part of the professional-to-professional handover of care, and is an adjunct to the concise verbal handover that takes place in the Emergency Department.
The Ambulance Service told me they expect the ePRF to be reviewed by ED staff, rather than staff simply relying on the verbal handover, which can be challenging in the context of a busy hospital environment.
At the point of roll out of the new electronic system, Ambulance Service personnel attended the local Emergency Departments to install software that allowed ED staff to access the electronic Patient Report Form hub from their hospital computers. Further to installing software, the Ambulance Service had also provided ED staff with personalised login details and training to ensure they knew how to access the patient information.
I heard evidence from ED staff that despite having logins and having received training, they did not routinely access the system to review the electronic patient report form. The rationale for this omission, was that the software was "clunky" to use and in some cases it could take up 5 minutes to isolate the correct form; time that busy ED staff do not have. Both Trusts accepted that it had become practise not to review the ePRF but instead to rely upon the verbal handover alone.
In this case, had ED staff reviewed the ePRF early in the admission, they would have appreciated from that documentation that Mr Reddington had been suspected of having a stroke, rather than a simple a head injury. His care would then have been provided in accordance with the stroke pathway much earlier in the evening.
I am concerned that ignoring a written handover from a fellow medical professional is not a safe or proportionate solution to the difficulties faced of accessing the electronic system.
I am further concerned that this practise of ignoring the written handover appears to have persisted for a long time without the organisations reaching a sensible solution.
While the Ambulance Service are taking steps to upgrade the system at another local hospital, I heard evidence that there was no agreed plan or date for seeking to resolve the system issues at Kingsmill or Queens Medical Centre.
Whilst ever this problem persists without resolution, there is a risk of future deaths due to failures in the handover of patient information at the point of transfer of care.

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

Your organisations might wish to work together to provide a joint response to this report, and such would not only be acceptable, but encouraged.

You are under a duty to respond to this report within 56 days of the date of this report, namely by 16 July 2021. 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

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 **Miss Laurinda Bower** **HM Assistant Coroner** **Nottingham and Nottinghamshire** **Dated: 21 May 2021**

Regulation 28: REPORT TO PREVENT FUTURE DEATHS (2)

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. **Clinical Commissioning Group for Nottingham City and Nottinghamshire**
2. **NHS England**

1 CORONER

I am Miss Laurinda Bower, HM Assistant Coroner, for the area of Nottingham and Nottinghamshire.

2 CORONER'S LEGAL POWERS

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3 INVESTIGATION and INQUEST

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4 CIRCUMSTANCES OF THE DEATH

Morris Reddington died as a result of a rare type of stroke, namely, a basilar artery thrombosis, likely caused by dissection of the right vertebral artery.

There were delays in reaching a diagnosis, including multiple missed opportunities to have considered and investigated Morris for a stroke earlier on the evening of 29 October 2019, but ultimately, the delay in providing thrombolysis treatment did not cause or contribute to his death.

The only treatment that would likely have prevented Morris' death was Mechanical Thrombectomy, which is not offered regionally outside of Monday to Friday 8am to 4pm. As Morris' stroke occurred outside of the operational hours of the service, he did not receive this treatment, and sadly died as a consequence of the stroke.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

In January 2018, NHS England published its Clinical Commissioning Policy on the use of Mechanical Thrombectomy as treatment for acute ischaemic stroke (all ages).

The aim of the Policy reports to be two-fold; to improve outcomes for adults with stroke, and to improve access to mechanical thrombectomy as soon as possible after the onset of stroke symptoms.

Despite the publication of the policy some 3 years ago, there remains very limited access to 24/7 mechanical thrombectomy. Save for two Trusts in London, and the West Midlands Network, I am not aware of others providing a 24/7 service. There certainly is no such service in the East Midlands.

There is clear geographical disparity in the access to this vital, life-saving service.

Mechanical thrombectomy would likely have avoided Mr Reddington's death. Instead, because Mr Reddington was unfortunate enough to suffer a stroke outside of the service's operational hours (Monday to Friday 8am to 4pm), his family were left to watch his deterioration, knowing that a treatment had the potential to save his life, but that such treatment simply was not offered after 4pm.

This is a situation that no family ought to be placed in.

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

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Miss Laurinda Bower
HM Assistant Coroner
Nottingham and Nottinghamshire
Dated: 21 May 2021