Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

Chief Executive
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
Gayton Road
King's Lynn
Norfolk
PE30 4ET

1. CORONER

I am Jacqueline LAKE, Senior 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 06/10/2021 I commenced an investigation into the death of Michael Nestor WYSOCKYJ aged 66. The investigation concluded at the end of the inquest on 11/05/2022. The medical cause of death was:

1a) Haemopneumothorax
1b) Ruptured Emphysematous Bulla
1c) Infective Exacerbation of Chronic Obstructive Pulmonary Disease
1d)
2 Chronic Ischaemic Heart Disease, Diabetes Mellitus

The conclusion of the inquest was: Mr Wysockyj died from a pneumothorax which was not identified until shortly before his death..

4. CIRCUMSTANCES OF THE DEATH

Mr Wysockyj had a significant medical history. On 20 September 2021 Mr Wysockyj felt very unwell and was taken by ambulance to Queen Elizabeth Hospital arriving at 18:28 hours. Due to the hospital being very busy, Mr Wysockyj was not taken into the hospital but was seen and assessed on the ambulance. He was admitted to Queen Elizabeth Hospital at 22:21 hours. A chest x-ray and a portable chest x-ray were not carried out as Mr Wysockyj was admitted to the Red Ward. Mr Wysockyj became increasingly restless and agitated which further delayed an x-ray being carried out. He received medication and personal care. At shortly before 02:00 hours it was recognised his agitation was due to low oxygen levels and Critical Care were contacted. At 03:55 hours radiography identified a large right sided pneumothorax. Shortly afterwards Mr Wysockyj went into cardiac arrest. Despite attempts at resuscitation, Mr Wysockyj was pronounced dead at 04:42 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 could occur unless action is taken. In the circumstances, it is my statutory duty to report to you.

This incident has been investigated by the Queen Elizabeth Hospital and much work has been put into place to prevent future deaths occurring. However, there do remain matters of concern.

The matters of concern are as follows:

1. The ED was busy at the time and unable to offload ambulances. An x-ray cannot be carried out on an ambulance and must wait until the patient is in ED. If the patient remains on the ambulance for several hours this can delay the x-ray taking place.
2. The need for an x-ray remains with the nurse, nurse in charge and/or doctor. If an x-ray is not carried out, the request remains with the nurse, nurse in charge and/or doctor and it was not clear from the evidence there is anything in place to ensure this is escalated and the x-ray takes place. This is something that can be missed in a busy department.

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 18 July 2022. 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] – daughter-in-law

I have also sent it to:

- The Department of Health
- Care Quality Commission (CQC)
- HSIB
- Healthwatch Norfolk
- NHS England & NHS Improvement

who may find it useful or of interest.

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any other person who I believe may find it useful or of interest.

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.

9. Dated: 24 May 2022

Jacqueline LAKE
Senior Coroner for Norfolk
Norfolk Coroner Service
County Hall
Martineau Lane
Norwich NR1 2DH