ANDREW JAMES COX
Assistant Coroner for Plymouth Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive Health Education England Blenheim House Leeds LS1 4PL
1	**CORONER** I am ANDREW JAMES COX, Assistant Coroner for Plymouth Torbay and South Devon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 24 June 2015 I commenced an investigation into the death of Trevor Paul Hunking, The investigation concluded at the end of the inquest on 26 October 2016. The conclusion of the inquest was that Mr Hunking died from complications of a necessary surgical procedure.
4	**CIRCUMSTANCES OF THE DEATH** In July 2003, Mr Hunking suffered a myocardial infarction. After tests, he was diagnosed with diffuse coronary artery disease which was managed medically. In 2008, following an admission with chest pain he was additionally diagnosed with moderate aortic stenosis. A consultant directed that Mr Hunking have annual surveillance but this did not happen and he was lost to follow-up at this point. By 2015 Mr Hunking had developed severe aortic stenosis. He was referred for aortic valve replacement and coronary artery bypass grafting, with surgery planned for 21 June 2015. On 17 May 2015 he was admitted to Royal Cornwall Hospitals Trust with an acute deterioration. He was managed as an in-patient. On 22 May he was accepted for in-patient transfer into Plymouth Hospitals NHS Trust with a target of treatment being provided in the next 7-10 days. Mr Hunking's transfer had not happened by 11 June 2015. On that date following the personal intervention of his cardiologist his in-patient transfer was expedited and he was admitted to Plymouth Hospitals NHS Trust at approximately 21:00. Mr Hunking underwent unremarkable surgery the next day but sadly did not recover. He died in Plymouth Hospitals NHS Trust on 16 June 2015. Evidence was heard at the Inquest of the steps that have been taken since the death of Mr Hunking to address some of the pressures on the Cardiology and Cardiothoracic resources within the Royal Cornwall Hospital, Truro and Plymouth Hospitals NHS Trust in Plymouth. The evidence that was heard from [redacted], Service Lead for Cardiothoracic Surgery in Plymouth Hospitals NHS Trust as well as [redacted] Medical Director, was that the current constraints on the service relate to the provision of qualified Cardiac Intensive Care Unit Specialist Nurses. In short, there are insufficient adequately trained Nurses available.

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	The Inquest heard that the problem is particularly acute away from London. The capital is able to attract more qualified staff because of the easier transport connections it enjoys with Europe from where, I was told, some of the Nursing specialists originate. In turn, this has led to Plymouth Medical Staff undertaking procedures in London so that patients can have the necessary cardiac intensive care specialist nursing treatment they require. I heard from NHS England at the Inquest [redacted] and he felt that it would be sensible to draw the consequences of the lack of specialist cardiac intensive care nursing staff to your attention. He indicated that you would be well placed to answer what steps were being taken to address the current shortage in the necessary staff.
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) A shortage of Cardiac Intensive Care Unit Specialist Nurses to deal with patients post-operatively.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [redacted] 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 28 December 2016. 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 who are the Family, the Royal Cornwall Hospital Trust and Plymouth Hospitals NHS Trust. 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 1 November 2016 Signature_____ Assistant Coroner for Plymouth Torbay and South Devon