OFFICE OF HER MAJESTY'S CORONER
DERBY& DERBYSHIRE CORONER'S AREA

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Derby Teaching Hospitals NHS Foundation Trust**
1	**CORONER** I am Dr Robert W Hunter, senior coroner, for the coroner area of Derby and Derbyshire.
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 12th May 2015 I commenced an investigation into the death of Barbara Turner, Aged 81 years. The investigation concluded at the end of the inquest on 21st October 2016. The conclusion of the inquest was that Mrs Turner died from: **1a. Multi organ failure.** **1b. Acute Myocardial infarction.** **1c. Acute Intracerebral event.** **II. Systemic Hypertension, Atrial Fibrillation, Post-Operative knee replacement.** My conclusion was that: **Barbara Turner died from a recognised complication of a necessary surgical procedure.**
4	**CIRCUMSTANCES OF THE DEATH** Mrs Turner was an 81 year old lady who was admitted to the Royal Derby Hospital on the 6th May 2015 for an elective left total knee replacement. The operation was undertaken on the same day and she returned to ward 206 at 18:30 hours. At around 21:47 hours she was found unresponsive by the nursing staff. Who called the SHO in orthopaedics to attend. She underwent a CT scan and was admitted to ITU where she died on the 11th May 2015.

During the course of the inquest the following facts were found:

1. There was a failure to undertake vital signs observations on six occasions and was contrary to the established orthopaedic protocol for observations in force at the time of Mrs Turner's admission.
2. There was a failure by the nursing staff who found Mrs Turner unresponsive and unconscious to appreciate how critically ill she was and thus called the orthopaedic SHO to attend to Mrs Turner by the usual methods.
3. There was a failure by the attending SHO to appreciate how critical ill she was and consequently a failure to summons appropriate and senior medical assistance.
4. There was a failure to summons that assistance by means of a "crash" call to the Resuscitation Team.
5. Nursing staff were unaware of the procedures of the Trust Policy: ' Policy and Procedures for Resuscitation.'
6. There was a failure to escort Mrs Turner to the CT scanner and return to the ward in a safe manner. There was inadequate monitoring, no emergency equipment and in the opinion of the Trust's ITU consultant no appropriately trained staff for the escort who could deal with airway management and medical emergencies en route to the scanner, in the scan room and return to the ward. The ITU consultant in evidence described this action as dangerous. The court found it to be palpably dangerous and wrong.

The Court found these to be gross failures, however on the evidence the court found that none of these failures had caused or contributed to Mrs Turner's Death.

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. It is also my opinion that the nature of these issues are such that **URGENT ACTION** needs to be taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

(1) The Trust Policy and Protocol for Resuscitation states at Appendix 3 that the call out criteria for the Adult Resucitation Team is :

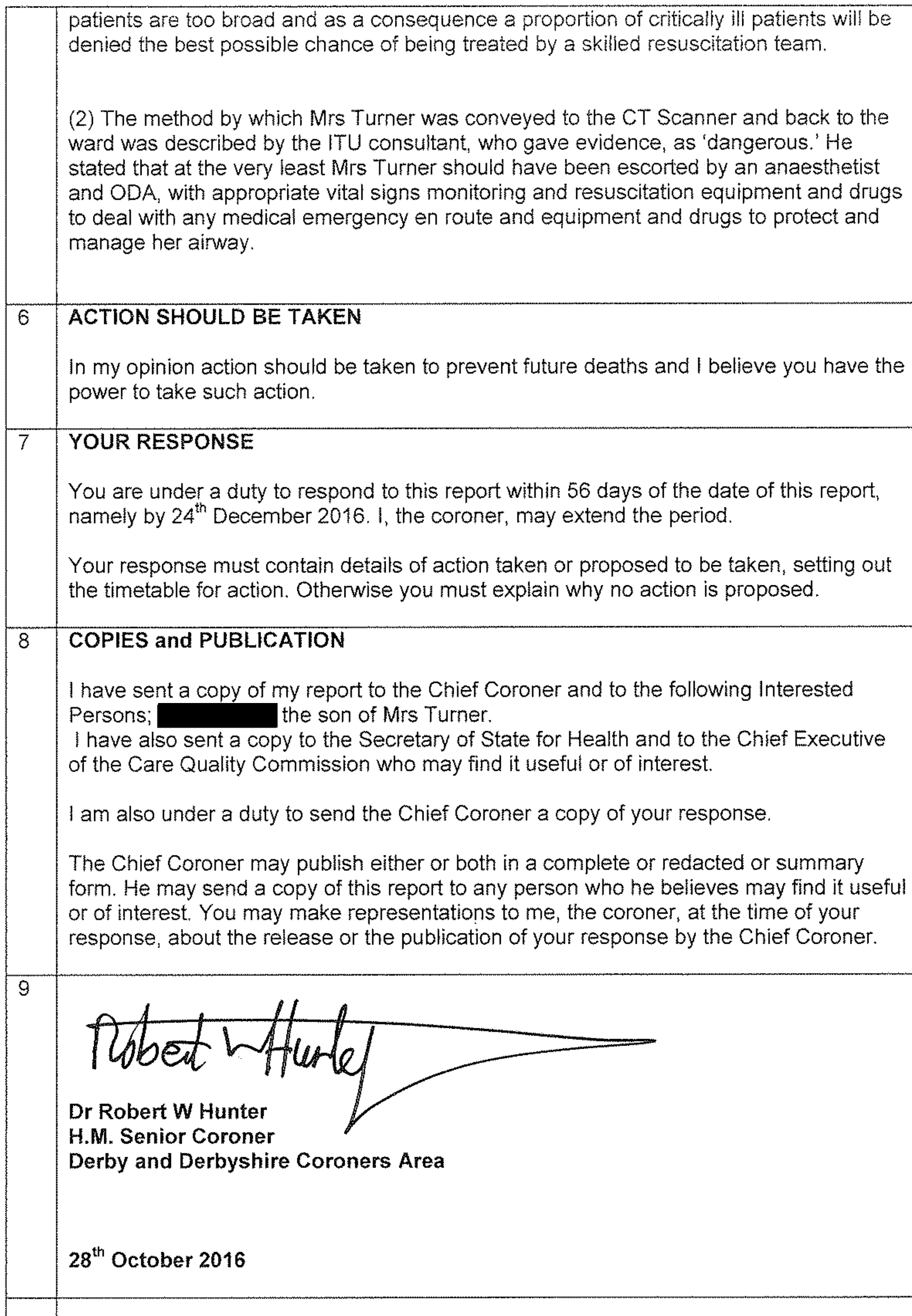
All Cardiac Arrests
All Respiratory arrests
Any **Unresponsive** patient or visitor with

Heart rate > 150
Heart rate < 40
Respiratory rate >40
Respiratory rate < 8
Systolic BP < 80 mmHg
Oxygen Saturations < 90%

Had these criteria been applied to Mrs Turner then the resuscitation team would not have been called, despite clinicians who gave evidence to the court that she was critically ill.

The court heard evidence that person's suffering an intracerebral event or head injury can be critically ill and in need of resuscitation but have initial normal vital signs parameters.

It may be that in the policy and protocol the parameters for critically ill unresponsive



	patients are too broad and as a consequence a proportion of critically ill patients will be denied the best possible chance of being treated by a skilled resuscitation team. (2) The method by which Mrs Turner was conveyed to the CT Scanner and back to the ward was described by the ITU consultant, who gave evidence, as 'dangerous.' He stated that at the very least Mrs Turner should have been escorted by an anaesthetist and ODA, with appropriate vital signs monitoring and resuscitation equipment and drugs to deal with any medical emergency en route and equipment and drugs to protect and manage her airway.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 24th 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; the son of Mrs Turner. I have also sent a copy to the Secretary of State for Health and to the Chief Executive of the Care Quality Commission 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	**Dr Robert W Hunter** **H.M. Senior Coroner** **Derby and Derbyshire Coroners Area** **28th October 2016**