IN THE WEST YORKSHIRE (WESTERN) CORONER'S COURT
IN THE MATTER OF:

RITA GIULIANNA NICOLA BRITTEN

The Inquest Touching the Death of Rita Giulianna Nicola BRITTEN
A Regulation Report – Action to Prevent Future Deaths

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. **NHS ENGLAND**
2. **RESUSCITATION COUNCIL**
3. **……**
4. **……**

1 CORONER

I am John BROADBRIDGE Assistant Coroner for the area of West Yorkshire (Western)

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 First October 2018 I commenced an investigation into the death of Rita Giulianna Nicola BRITTEN ("Mrs Britten") aged 54. The investigation concluded at the end of the Jury inquest begun on 9 May ending on 13 May 2022.

The jury recorded

"Mrs Rita Britten died at Pinderfields Hospital on 29 July 2018 after life support was withdrawn. This was a direct result of a choking incident on 26 July at the Priestly Unit"

The conclusion of the Jury as to the medical cause of death was:

"I a Hypoxic Brain Injury
I b Cardiac Arrest
I c Upper Airway Obstruction Secondary to Food Bolus (choking)
II "

Their Conclusion was expressed in the form of a questionnaire which is attached to this Report but the Jury included the words at Part 4 of their Record of Inquest:

"-lack of communication/insufficient handover between staff
-System shortfalls in recording updating and accessing key information
-Risk assessments incomplete
-Inadequate first aid training"

4 CIRCUMSTANCES OF THE DEATH

Mrs Britten was a detained patient under s3 MHA 1983. She choked while trying to bite off and swallow pieces of fresh apple. Despite efforts at rescue and resuscitation on the Ward where she was detained, she died later in Hospital without regaining consciousness from the effects of occlusion of airway.

She was 15 stone or so in weight with a BMI last assessed at 31 ("obese")

Abdominal thrusts otherwise "Heimlich Manouevre" ("conventional abdominal thrusts")(after backslaps) to assist in ejection of material were indicated to be difficult if not impossible because of her body shape/size.

An unusual manoeuvre of inversion of her body over the upright of an upholstered chair was also attempted; all attempts met with limited ejection of material from the airway.

A larger piece of apple was eventually removed by forceps used by an attendant ambulance operative before adrenaline created ROSC but GCS was at 3/15 en route on pre alert emergency to Hospital, despite increase in her respiratory effort, and remained so.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)

The concern is of want of clear guidance on the steps to be taken to most effectively rescue the individual from the urgent and developing choking emergency when that individual does not conform to the competent adult to whom conventional abdominal thrusts are possible or might be effectively applied. In particular, this concern relates to but is not limited to the overweight/obese/bariatric individual (however that may be best described).

a) There should be clear national emergency /resuscitation guidelines for dealing effectively with choking incidents where the individual is overweight/obese or otherwise where "conventional abdominal thrusts" are not possible or are less able to be effectively applied. In Mrs Britten's case a significant element of early rescue techniques was compromised. It is perceived this will be an increasing present and future risk in the UK population due to obesity.

b) There should be early review and assessment of papers that discuss the efficacy (or otherwise) in such circumstances of "inversion" of the affected choking individual said to be set out in:

Hubert Blaine et al in American Journal of Medicine ref, Am J Med 2010 Dec; 123 (12)
And
"Effect of body position on relieve of foreign body from the airway", Artur Luczak AIMS Public Health 6(2): 154-159

And how this or similar technique(s) might have application in the Hospital/clinical setting in which this choking episode occurred.

c) There should be identified and assessed any specialist equipment to assist in these circumstances.

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 08 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]
and

South West Yorkshire Partnership NHS Foundation Trust
And
[redacted]
……

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.

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JNBroadbridge

John BROADBRIDGE
HM Assistant Coroner for
West Yorkshire Western Coroner Area
Dated: 13 May 2022