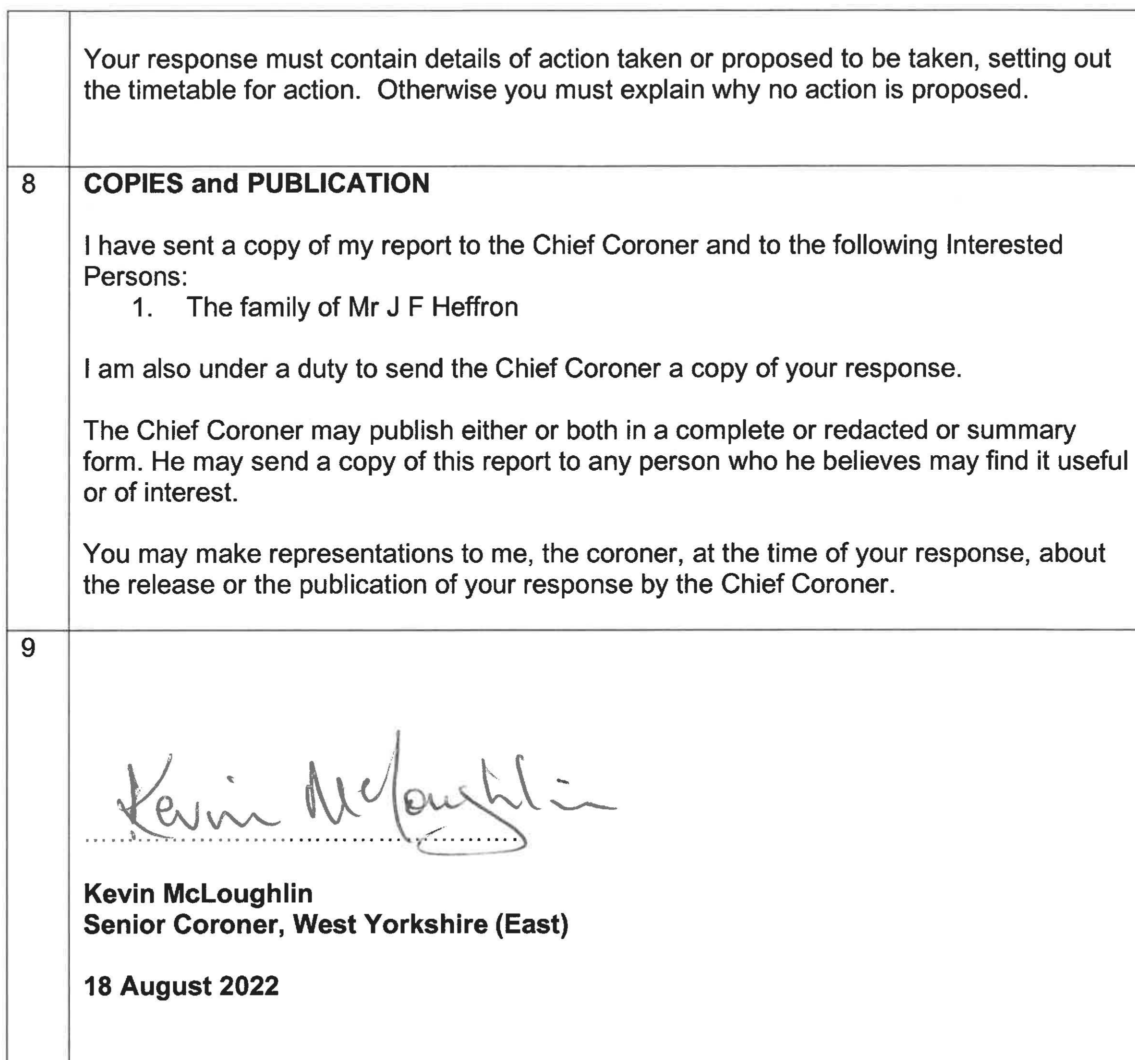
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	THIS REPORT IS BEING SENT TO: 1. **Leeds Teaching Hospitals NHS Trust**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner for the Coroner area of West Yorkshire (East)
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 31 December 2021 I commenced an investigation into the death of John Francis Heffron, aged 50. The investigation concluded at the end of the Inquest on 17 August 2022. A narrative conclusion was returned, based upon a cause of death of I(a) Hypoxic Ischaemic Encephalopathy II Cerebellar degeneration, paranoid schizophrenia, hypertension It was found delay in initiating CPR, after Mr Heffron was found with cardiac arrest, contributed to his death.
4	**CIRCUMSTANCES OF THE DEATH** John Francis Heffron, a wheelchair user aged 50, was found lying on the floor of his flat on 11 December 2021 in a confused state. Whilst alone in a cubicle in A&E he suffered a cardiac arrest. When he was found a bank nurse did not make a crash call immediately. There was a delay in commencing CPR as he was initially thought to be dead and then there was uncertainty concerning his DNAR status. He was eventually resuscitated but a CT scan demonstrated he had a hypoxic brain injury. Despite ICU treatment he died on 18 December 2021 in hospital.
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) The inquest found there was a delay between the patient being found in an unresponsive condition and CPR being initiated. Although the evidence as to the material times was not entirely reliable, the Trust's investigation indicated that the patient had been found unresponsive around 1.15am, yet the statement of the registrar on duty stated she was called at 1.30am. There was then an interval of time whilst the patient's DNAR status was ascertained from the computerised medical records. (2) The lady working as a bank nurse in the Emergency Department (ED), who found the patient unresponsive, admitted to the Trust's investigator she was not familiar with the crash call system. She did not press the buzzer to initiate a crash call. The extent of her training in CPR was unclear. It is understood she normally worked on a part-time basis in an outpatient unit.

	(3) The experienced nurse alerted to the situation also did not press the crash call buzzer. She appears not to have examined the patient, but instead telephoned the Sister in charge of the ED to report the patient had died. She admitted to the Trust's investigator that she was overwhelmed. (4) When CPR was commenced, a return of spontaneous circulation was achieved at 1.50am. A CT scan at approximately 4.30am indicated a hypoxic brain injury had been sustained. (5) Evidence taken at the inquest indicated the collapse and/or death of a patient in the ED is known to occur sometimes. It is a foreseeable risk. Hence there is a need for the nursing staff to be trained and familiar with the emergency systems in place, in order to be able to respond appropriately. (6) It was unclear what steps had been taken by the Trust prior to 12 December 2021 to establish: (i) the nursing qualifications of bank and/or agency staff permitted to work in the ED (ii) whether bank and/or agency staff hold appropriate and current training in resuscitation procedures (iii) whether a suitable induction system was in place to ensure bank and/or agency staff were familiar with the crash call system (7) The Trust saw the need to initiate a "Serious Incident Investigation" but allocated this work to a person (i) present in the ED at the time of the incident, and thus not independent of the events being examined (ii) who had not been trained in such investigations save for a one-day course some five years previously and had never undertaken one of this nature before (iii) who spoke to the staff involved during the shift on the night of the incident, only when time permitted, alongside their other work. No written statements were obtained. In consequence, the precise chronology of events is unclear (iv) no context was provided which may have enabled an assessment of the workload or staffing levels in the ED at the material time For these reasons the inquest felt unable to rely upon the conclusions reached in the Serious Incident Investigation Report (8) It is acknowledged that some additional refresher training has been carried out since this incident. There is, however, no system of audits, spot checks or dip testing to verify that bank and/or agency nurses are actually familiar with the essential procedures relating to crash calls. (9) It was unclear whether the Trust's contractual arrangements with nursing agencies stipulate the requirement for those supplied to (a) be professionally qualified (b) have current training to specified standards and (c) have undergone appropriate induction to the ED.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 19 October 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: 1. The family of Mr J F Heffron 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	Kevin McLoughlin .... **Kevin McLoughlin** **Senior Coroner, West Yorkshire (East)** **18 August 2022**