REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, University Hospitals of Derby and Burton NHS Foundation Trust**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 the 2nd April 2022, I commenced an investigation into the death of Jodie Catherine McCann. The investigation concluded at the end of the inquest on the 19th April 2023 The conclusion of the inquest was a Narrative as follows: Jodie died on the 2nd April 2022 at Queens Hospital, Burton-on- Trent, following a prolonged cardiac arrest, caused by a lack of oxygen, as the trachea could not be re-intubated following the sudden displacement of her tracheostomy tube. Jodie required the tracheostomy tube to provide ventilation to her lungs, as she had developed multi organ failure following an earlier cardiac arrest of at least 17 minutes at Kings Mill Hospital on 18.3.22. This first arrest at Kings Mill Hospital was sudden and unpredictable, likely caused by airway obstruction, from a combination of opiates affecting her breathing, her high BMI, and the pain and stress of gallstone pancreatitis which required strong opiate medication. Undertreated Hypothyroidism also likely made a more than minimal contribution to this first arrest. Jodie was making a reasonable recovery from the first arrest, with improving neurology and reducing ventilatory requirements. She was transferred to Burton Hospital on 22.3.22 for further critical care management. There she continued to improve, but required continuing ventilation. A tracheostomy tube to aid weaning from ventilation was inserted on 31.3.22. There was no individualised planning for the possibility of tracheostomy displacement , which was a known risk, with no plan to ensure the correct equipment was available, and no plan to ensure senior help was available as quickly as possible, should the tracheostomy tube become displaced. These serious issues of care at Burton Hospital, on a balance of probability, made a more than minimal contribution to Jodie's death.
4	**CIRCUMSTANCES OF THE DEATH** Jodie was a previously fit and well young woman aged twenty two. She developed gallstone pancreatitis requiring admission to Kings Mill Hospital on 16.3.22. She had a cardiac arrest on the ward at KMH on 18.3.22, and as a consequence developed multi organ failure, requiring Critical Care treatment. She had a period of care at KMH CCU, but had to be transferred to Burton Hospital on 22.3.22 as KMH CCU was at operational capacity.

	She continued to make good progress on the CCU at Burton Hospital, but there were continuing issues of difficult airway management. Jodie had a tracheostomy tube placed on 31.3.22, which became displaced early morning on 2.4.22. This could not be replaced, nor another airway achieved. She died from a further prolonged cardiac arrest as a consequence of this final hypoxic event. The Determination dated 19.4.23 gives detailed findings as to the circumstances of Jodie's death, and is appended to this report.
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 – • There is limited evidence to date for the introduction and continuing use of comprehensive airway strategies, with structured planning and preparation, when a difficult airway is anticipated. There should be airway plans A, B, and C recorded, shared, and the equipment and skills to carry them out must be available • There is limited evidence to date for the universal use of the NAP4 algorithms and checklists, which should be available on the difficult airway trolley, and be familiar to all ICU nursing and medical staff, and to the wider anaesthetic team • There is limited evidence to date, for the robust daily checking of all necessary equipment on the difficult airway trolley, to ensure immediate replacement of all key equipment if it is broken or misplaced • The Mortality Review policy was not followed, leading to a significant delay in completing the serious incident review, delaying Trust learning, and delaying the family's understanding of the circumstances of Jodie's death. There is limited evidence of progress in implementing the national Patient Safety Incident Response Framework at the Trust I am not reassured that necessary actions to address these serious issues identified are in place.
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 the **16th June 2023**. 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. Jodie's family 2. Sherwood Forest Hospitals NHS Foundation Trust 3. [redacted], Consultant in Critical Care Medicine and Anaesthesia, UHDBT 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 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 by the Chief Coroner.
9	**20.4. 2023 Dr E A Didcock**