## Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1 Nottinghamshire Healthcare Trust - NHCT** |
| **1** | **CORONER**<br><br>I am Michael WALL, Assistant Coroner for the coroner area of Nottingham City and Nottinghamshire |
| **2** | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 11 November 2022 I commenced an investigation into the death of Andrew Vizard, aged 58 years. The investigation concluded at the end of the inquest which took place before myself as coroner sitting alone on 6 July 2023. My conclusion at the end of the inquest was:<br><br>Natural causes. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>Andrew Vizard was 58 years old when he died on 14 July 2022 at Queen's Medical Centre, Nottingham. He died from a pulmonary embolism.<br><br>At the time of his death, he was detained on the Rowan 1 Ward of Highbury Hospital under section 2 of the Mental Health Act 1983 and was subject to constant 1:1 observations. He had a relatively short but significant history of mental ill-health dating back to March 2021. Andrew also had the following physical health conditions: Systemic Hypertension; Hypertensive Heart Disease; Ischaemic Heart Disease; and Obstructive Sleep Apnoea. None of these conditions caused or contributed to his death. Andrew's hypertension was identified upon admission to Rowan 1 on 2 July 2022 and was monitored regularly throughout his admission.<br><br>On 14 July 2022, at approximately 12:23pm, the healthcare assistant responsible for observing Andrew became concerned about him snoring loudly. At approximately 12:25 she asked a colleague peer support worker for a second opinion. At approximately 12:27, that colleague left and returned one minute later with the Ward Manager. Andrew was still breathing at that time but he was unresponsive to voice or pain. A minute after that, at approximately 12:29, other members of staff arrived with physical monitoring equipment and a life support bag. The ward trainee GP was summoned and arrived at Andrew's room at 12:32. He identified that Andrew was in cardiac arrest and commenced CPR. An ambulance was called at 12:34:06, over 10 minutes after concerns were first identified. Further, the staff who performed CPR prior to the attendance of the paramedics were unaware that the life support bag contained a Bag Valve Mask. In its place, they used a rebreather mask to deliver oxygen. That device will provide oxygen but, unlike a Bag Valve Mask, will not assist to push that oxygen around the body. |

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| | A single paramedic and a double crewed ambulance attended within 3 and 15 minutes of the 999 call respectively. Paramedics provided emergency care and achieved return of spontaneous circulation at 12:50pm. Andrew sadly suffered a further cardiac arrest at 13:20. He was transported under blue lights to Queen's Medical Centre, arriving at 13:34. He continued to receive emergency treatment at hospital. Sadly, he did not recover and was declared deceased at 14:05 on 14 July 2022.<br><br>The Serious Incident Investigation revealed several concerning issues with the staff response when concerns arose for Andrew's wellbeing on 14th July 2022. I heard evidence that appropriate action has since been taken to address those issues, with further work ongoing.<br><br>However, in respect of the timeliness of the response to the emergency situation, the Serious Incident Investigation concluded that "*the response to Mr AV when he went into a medical emergency, found that the staff reacted immediately to the situation.*" One of the authors of that report and the current Service Manager of Highbury Hospital gave evidence at the inquest. They both expressed views consistent with that conclusion.<br><br>I found this difficult to reconcile with the chronology of events above. |
| **5** | **CORONER'S CONCERNS**<br><br>During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows:<br>(brief summary of matters of concern)<br><br>During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The MATTERS OF CONCERN are as follows:<br>(brief summary of matters of concern)<br><br>Despite there being concerns for an unresponsive patient's breathing, it took:<br><br>a) At least 6 minutes to obtain and utilise physical monitoring equipment.<br>b) Nearly ten minutes for a ward doctor to attend the patient.<br>c) Over 10 minutes for an ambulance to be called.<br><br>Existing staff training and systems of emergency response do not appear to ensure an immediate and effective response in circumstances where there are concerns for a patient's breathing.<br><br>Although the delays did not cause or contribute to death in this case, I am concerned that if there are similar delays in similar life-threatening situations in future, deaths will occur. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by September 20, 2023. I, the coroner, may extend the period.<br><br>Your response must contain details of action taken or proposed to be taken, setting out the |

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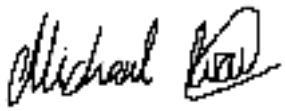
| | timetable for action. Otherwise you must explain why no action is proposed. |
| **8** | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>1. Andrew's family<br>2. Nottinghamshire Healthcare Trust<br><br>who may find it useful or of interest.<br><br>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.<br><br>I may also send a copy of your response to any person who I believe may find it useful or of interest.<br><br>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.<br><br>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: 20/07/2023**<br><br>  <br>**Michael WALL**<br>**Assistant Coroner for**<br>**Nottingham City and Nottinghamshire** |