REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

IN THE MATTER OF THE INQUEST TOUCHING THE DEATH OF IAN JACKA

	THIS REPORT IS BEING SENT TO: [redacted] **Chief Executive Officer** **University Hospital Plymouth NHS Trust**
1	**CORONER** **I am Guy Davies, His Majesty's Assistant Coroner for Cornwall & the Isles of Scilly.**
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 7 July 2022 I commenced an investigation into the death of 51 year old Ian Jacka. The investigation concluded at the end of the inquest on 23 November 2023. At the end of the Inquest the following was recorded. The medical cause of death was established on the evidence as follows *1a Bilateral bronchopneumonia due to hypoxic brain injury* *1b Airway obstruction during intubation* *1c Multiple Injuries Due To Fall From Height* The four questions - who, when, where and how – were answered as follows

	Ian Jacka died on 15 June 2022 at Derriford Hospital Plymouth Devon from complications following surgery for trauma consistent with a partially witnessed fall from height, whilst under the influence of alcohol, at Chapel Porth, Cornwall on 3rd June 2022. The complications followed surgery on 6th June 2022 and were likely contributed to by the use a ManuJet ventilator with Cook catheter to support an unsuccessful airway exchange leading to airway obstruction. Ian went into cardiac arrest and was resuscitated but not before suffering hypoxic brain injury. The surgical team proceeded with surgery in the absence of knowledge of the full extent of a serious medical episode suffered by Ian on 5th June 2022. Had the surgical team known of the full extent of that medical episode of 5th June 2022, the surgery would have been delayed for further investigations and assessment which may have resulted in a different outcome. My conclusion as to the death was as follows *Ian died from complications of necessary medical procedures following polytrauma contributed to by an error of omission on handover from critical care to surgery and by the use a ManuJet ventilator with Cook airway exchange catheter.*
4	**CIRCUMSTANCES OF THE DEATH** On 3 June 2022 Ian had a fall from height, from an unofficial pathway/ embankment, into the National Trust car park, Chapel Porth. Ian fell so that he landed in front of the toilet block in the car park, suffering very serious injuries. Cardiopulmonary resuscitation was conducted at the scene by lifeguards and off duty doctors, before being conveyed to RCHT by ambulance. Ian was examined at hospital and found to have sustained multiple fractures to his skull, spine and ribs. On 4 June 2022, Ian was transferred to Derriford Hospital for treatment of complex spinal fractures, under the neurosurgical team. On 5 June 2022 Ian suffered a medical episode which developed into a critical incident in which Ian deteriorated rapidly and required life saving measures. On 6 June 2022 Ian was taken to theatre for spinal surgery. Before surgery, the critical care flexible endotracheal tube was replaced by an armoured tube. After surgery, the anaesthetic team commenced an airway exchange, namely removing the armoured tube which had been inserted for the operation, in order to replace it with the more flexible critical care tube. However, having removed the armoured tube, the team were unable to insert the flexible tube despite repeated attempts. Ian then started to desaturate due to lack of oxygen. The Consultant Anaesthetist proceeded to jet ventilate Ian, the first jet was uneventful, the second resulted in massive neck swelling, Ian went into cardiac arrest. The medical

	team then resorted to cardiopulmonary resuscitation and an emergency tracheostomy. Return of spontaneous circulation occurred after 20-25 minutes During this time Ian suffered hypoxic brain injury from lack of oxygen. Over the following days, Ian suffered seizures on the intensive care unit and an MRI on 9 June 2022 showed extensive changes consistent with hypoxic brain injury. On 15 June 2022, Ian's care was transitioned to end–of-life care. Ian died in the intensive care unit at Derriford hospital at 17:10 on 15 June 2022.
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) There was an error of omission in record keeping and in handover from critical care to surgery, and that this error likely contributed to Ian's death. (2) There was no entry in Ian's hospital notes to indicate the full extent of the critical incident of 5 June 2022. (3) There was a lack of information on handover from critical care to the surgical team regarding the full extent of the critical incident of the 5 June 2022. There was a verbal handover which was brief and vague. There was no formal written handover process highlighting significant events. (4) The error of omission was unexplained and has not been investigated by the NHS. The evidence regarding the error of omission came to light after the completion of the NHS investigation into Ian's death. The Consultant Anaesthetist involved in Ian's operation discovered the fact of the critical incident of 5 June 2022 on a later examination of ventilator data. The data indicated that Ian deteriorated significantly, that he was close to a cardiac arrest and the critical care team saved his life. (5) The surgical and anaesthetic team had no reason to suspect a secondary brain injury. The team had no information on Ian's neurological status. Ian is likely to have suffered a hypoxic brain injury during the critical incident of 5th June. This will have undermined his resilience and ability to physically withstand the rigors of spinal surgery and airway exchange. (6) Had the surgical and anaesthetic team known of the extent of the critical incident of 5 June, the operation would have been delayed and further tests and assessments undertaken. The anaesthetic team may have opted for elective tracheostomy if the full circumstances of the critical incident of 5 June 2022 had been known. An elective tracheostomy would have led to a different outcome because it would have avoided the complications that

	ensued from the attempted airway exchange. (7) I note the NHS Investigator and the Investigatory Panel both recommended that action is required for the handover of complex patients. The panel recommended as follows: *More robust and formalised handover of complex patients before transfer to theatre, to include review of airway management, cardiopulmonary status, potential avenues of deterioration and any significant events during admission* (8) The Trust had chosen not to accept this recommendation but at the time the Trust made that decision it was not aware of the extent and significance of the error of omission.
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 2 February 2024. 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 family 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	**7 December 2023** **Guy Davies, Assistant Coroner**