# 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 Association of Anaesthetists Great Britain and Ireland**<br>**2 Royal College of Anaesthetists**<br>**3 Chief Executive Health Education, England**<br>**4 CQC (Care Quality Commission)** |
| **1** | **CORONER**<br><br>I am Dr Karen Henderson, HM Assistant Coroner for West Sussex, Brighton and Hove |
| **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 7th January 2022 I resumed an investigation into the death of David Bryan Moore sitting with a Jury. On 21st July 2022, the investigation was concluded:<br><br>The medical cause of death given was:<br><br>1a. Hypoxic ischaemic brain injury<br><br>1b. Cardiac arrest<br><br>1c. Dislodged tracheostomy tube and delayed replacement<br><br>1d. Burns suffered in an industrial accident requiring a tracheostomy tube<br><br>II. Obesity, Hypertension<br><br>The jury determined:<br><br>Mr Moore was a self-employed industrial electrician, employed on the 29th May 2021 to change a molded case circuit breaker (MCCB) at a property in Uxbridge. Mr Moore energized the circuit to allow the front doors of the property to open. On doing this the metal plate divider between the MCCB's made contact with the exposed live bus bars resulting in an electrical flashover. As a result, Mr Moore sustained burns covering 32 % of his body surface area.<br><br>Mr Moore was transferred to St Mary's Hospital where he was intubated, ventilated and had surgical release of burns in his upper arms to improve blood supply. Following this Mr Moore was transferred to the Queen Victoria Hospital, East Grinstead on the same day for further management of his burns. |

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| | On the 3rd June 2021, an adjustable flanged tracheostomy was undertaken, due to the size of Mr Moore's neck and difficulties arising from his injuries. On the 10th June 2021 whilst being turned onto his right side to change dressings the tracheostomy became dislodged from his trachea resulting in an hypoxic cardiac arrest. The airway was re-established and following six cycles of CPR he was successfully resuscitated.<br><br>It was determined that Mr Moore suffered a non-survivable cerebral hypoxic brain injury. Mr Moore died at 17.20 hours on 14th June 2021 after an agreement was made to withdraw care. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>The conclusion of the jury at the Inquest provides a summary of the circumstances which led Mr Moore to be admitted to Queen Victoria Hospital, East Grinstead for ongoing management and describes the circumstances of his death.<br><br>During the hearing itself I heard evidence that there was an absence of national and local guidelines for the management of flanged tracheostomy tubes in particular relating to their ongoing assessment of their position in the trachea and in circumstances whereby no specific assessment was ongoing for Mr Moore within the High Dependency Unit for such assessment. As a consequence, Mr Moore's flanged tracheostomy tube became dislodged and the time taken to re-establish his airway resulted in an hypoxic brain injury incompatible with survival. |
| **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>**1. Guidelines for the anaesthetic and/or Intensive Care management of a flanged tracheostomy tube** |
| **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 4th March 2024. 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 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 |

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| | I have also sent it to:-<br><br>1. See names in paragraph 1 above<br>2. [redacted], Sister<br>3. [redacted], Son<br>4. [redacted], Daughter<br>5. Chief Executive, Queen Victoria Hospital, East Grinstead<br>6. Medical Director, Queen Victoria Hospital, East Grinstead<br>7. Clinical Director, Anaesthetics, Queen Victoria Hospital, East Grinstead<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: 08/01/2024**<br><br>**Karen HENDERSON**<br>**Assistant Coroner for**<br>**West Sussex, Brighton and Hove** |