ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Department of Health and Social Care 2. NHS England
1	**CORONER** I am Georgina Nolan, Senior Coroner for the coroner area of Newcastle and North Tyneside.
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 20th July 2023 I commenced an investigation into the death of Michael Trevor Walton, 66. The investigation concluded at the end of the inquest on 3rd July 2024. The medical cause of death was 1a) Ischaemic hypoxic brain injury; 1b) Aortic arch injury during coronary artery bypass procedure. The conclusion of the inquest was that Mr Walton died due to a very rare complication of a necessary surgical procedure.
4	**CIRCUMSTANCES OF THE DEATH** Mr Walton suffered from coronary artery disease for which he elected to undergo a coronary artery bypass procedure. He was a good candidate for the surgery and at low risk of complications. The procedure was undertaken on 13th June 2023. The Consultant Surgeon's preferred choice of cannula was not available due to supply issues and a cannula with a slighter shorter tip was therefore used by the operating surgeon. During the course of the procedure, the aortic cannula became dislodged causing a loss of perfusion and a prolonged period of interrupted blood flow to the deceased's brain which caused an ischaemic hypoxic brain injury from which he died on 13th July 2023 at the Eden Valley Hospice, Durdar Road, Carlisle.
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 could 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 surgeon's preferred choice of cannula was not available for the procedure due to supply issues. (2) A cannula with a shorter tip was therefore used for the procedure. (3) The cannula type contributed to its dislodgement from the lumen of the aorta and to Mr Walton's death. (4) An arterial catheter is a basic and inexpensive medical device used daily in a hospital setting. (5) Operating surgeons are best placed to decide on the most appropriate equipment to use and should not be restricted in that choice by supply shortages. (6) Using sub-optimal medical equipment poses an avoidable risk to patients of significant harm including death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 29th August 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 following Interested Persons, the family of Michael Trevor Walton and Newcastle upon Tyne Hospitals NHS Foundation Trust. 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. She may send a copy of this report to any person who she 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	**[DATE]** **[SIGNED BY CORONER]**  4th July 2024