Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], President of Royal College of Anaesthetists**
1	**CORONER** I am Philip BARLOW, Assistant Coroner for the coroner area of Cambridgeshire and Peterborough
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 20 July 2022 I commenced an investigation into the death of Rachel Gibson, age 47. The investigation concluded at the end of the inquest on 21 August 2024. The conclusion of the inquest was: Medical Cause of Death: 1a Hypoxic-Ischaemic Brain Injury 1b Cardiorespiratory arrest caused by infiltration of local anaesthetic during surgery 1c Right hip replacement (April 2022) Narrative conclusion: Rachel Gibson sustained irreversible brain damage following cardiac arrest caused by administration of excessive local anaesthetic (Ropivacaine) during surgery.
4	**CIRCUMSTANCES OF THE DEATH** Dr Rachel Gibson had severe osteoarthritis and underwent hip replacement surgery at Spire Lea Hospital, Cambridge on 12 April 2022. Towards the end of the procedure an infiltration of Ropivacaine was used in excess of the recommended dose. Upon return to her room she suffered an unwitnessed cardiac arrest. She was resuscitated and transferred to Addenbrooke's Hospital where she was found to have sustained irreversible brain damage. She died at Addenbrooke's Hospital on 14 July 2022. The evidence was that it is routine practice before the procedure for the anaesthetist to give oral instructions to the scrub nurse specifying the type and dose of local anaesthetic to be used to infiltrate the operation site. Towards the end of the operation the scrub nurse hands the local anaesthetic to the surgeon who then carries out the infiltration. The intention in this case was for a 0.2% solution of Ropivacaine to be diluted 50/50 with normal saline before it was infiltrated. The evidence suggested that this was not done. The result was that excessive Ropivacaine was administered by mistake. The evidence at the inquest was that this type of practice is common nationally.

5	**CORONER'S CONCERNS** 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. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) 1. The responsibility for checking and administering the local anaesthetic is unclear: 1. The instruction was given orally and not written down by the anaesthetist (the prescriber). 2. The anaesthetist did not check what the nurse had written down. 3. The nurse drew up the local anaesthetic from a stock bag and checked this with another nurse, but not with the anaesthetist. 4. The nurse then handed the drawn-up anaesthetic to the surgeon to administer. 2. There is inconsistency in the way the local anaesthetic was prescribed. The evidence was that the drug was sometimes specified in millilitres and sometimes in milligrams. This is of particular concern when the intention is for the drug to be diluted. If the drug is always prescribed in milligrams then the scope for error may be reduced. 3. The hospital in question has now introduced a system for labelling and countersigning the drug that is being given during the operation. However, the evidence at the inquest was that, on a national basis, there is wide variation in the way local anaesthetic is prescribed, checked and administered in this type of procedure; and that it is common to use similar practice to that which occurred during this operation. This is why I believe I am under a duty to draw it to your attention.
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 **29 October 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 **4. Dr Gibson's family**

	5. Spire Lea Hospital **6.** [redacted] **7.** [redacted] **8.** [redacted] I have also sent it to I have also sent it to [redacted] and [redacted] (who gave expert evidence) and to Addenbrooke's Hospital (where Dr Gibson died) who may find it useful or of interest. who may find it useful or of interest. 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	**Dated: 30/08/2024** **Philip BARLOW** **Assistant Coroner for** **Cambridgeshire and Peterborough**