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 NHS England** **2 HSE**
1	**CORONER** I am Paul D SMITH, HM Senior Coroner for the coroner area of Greater Lincolnshire
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 11 September 2020 I commenced an investigation into the death of Jean DYE aged 77. The investigation concluded at the end of the inquest on 02 July 2025. The conclusion of the inquest was that: Jean Dye died on 7 September 2020 at Scunthorpe General Hospital as a consequence of an iatrogenic artery dissection which occurred during Percutaneous Coronary Intervention to treat underlying cardiac disease. That was a rare but recognised complication of the procedure. Once the dissection was identified there was a limited opportunity to provide the necessary remedial treatment by the deployment of cardiac stents. Coincidentally at that moment there was a sudden and unexpected failure of electrical power within the treatment room which persisted for approximately 10 minutes. Save that it resulted from an activation of the Emergency Power Off (EPO) Circuit, which overrode the back up electrical supply, no clear cause of that loss of power was identified. There was no manual activation of the EPO buttons and a fault within the circuitry was suspected but not established to the required standard. The loss of electrical power removed the ability to provide x ray images and consequently prevented commencement of the stenting procedure until power was regained. Although the stenting was then completed Mrs Dye failed to recover and her death was confirmed. On balance of probabilities, Mrs Dye would have survived but for the loss of electrical power.
4	**CIRCUMSTANCES OF THE DEATH** Jean Dye died on 7 September 2020 at Scunthorpe General Hospital as a consequence of an iatrogenic artery dissection which occurred during Percutaneous Coronary Intervention to treat underlying cardiac disease. That was a rare but recognised complication of the procedure. Once the dissection was identified there was a limited opportunity to provide the necessary remedial treatment by the deployment of cardiac stents. Coincidentally at that moment there was a sudden and unexpected failure of electrical power within the treatment room which persisted for approximately 10 minutes. Save that it resulted from an activation of the Emergency Power Off (EPO) Circuit, which overrode the back up electrical supply, no clear cause of that loss of power was identified. There was no manual activation of the EPO buttons and a fault within the circuitry was suspected but not established to the required standard. The loss of electrical power removed the ability to provide x ray images and consequently prevented commencement of the stenting procedure until power was regained. Although the stenting was then completed Mrs Dye failed to recover and her death was confirmed. On balance of probabilities, Mrs Dye would have survived but for the loss of electrical power.

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) The circumstances of Mrs Dye's death are set out above. Her death arose as a consequence of the combination of an iatrogenic injury sustained during a clinical procedure and an untimely loss of power to the Catheter Lab where she was being treated for a period of approximately ten minutes at exactly the time at which her treating consultant required the benefits of real time xray to facilitate a necessary emergency stenting procedure. The delay whilst power was restored was a critical factor in this death. The loss of power arose as a result of the Emergency Power Off (EPO) circuit activating. It overrode the emergency power back up system. The reason for that activation was unclear although a physical activation of any of the three EPO buttons was excluded on the evidence. All staff at the scene were unaware of the cause of the loss of power, never having experienced such a situation previously, and an engineer was summoned to attend to reinstate the power, which he did. There was no light or other indicator within the lab to confirm to those present that the EPO circuit had activated. Likewise there was no restart button within the lab to permit the EPO circuit to be reset. That lay within the plant room elsewhere within the hospital. I received evidence of a small number of accidental activations of EPO circuits nationally over a 12 month period. It is plainly something which can, and does, occur. Had staff been aware of the exact cause of the loss of power on this occasion and had they had the opportunity to reset the circuit without the need to await the arrival of an engineer, who inturn had to attend a separate plant room, the downtime would likely have been significantly reduced. Whilst it was not possible to say that the additional time spent on this occasion made a difference between the patient surviving or not, there may well be future cases within which such fine margins are time critical. I received evidence that there is no current guidance in relation to the siting of such controls remote from the affected room. I invite review of that guidance and of the need for any consequential training.
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 August 28, 2025. 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 [redacted] **- Family** [redacted] **– Capsticks representing NLAG** [redacted] **– Eversheds-Sutherland representing GE Precision Healthcare** **Royal College of Radiographers**

	MHRA I have also sent it to [redacted] 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: 21/07/2025** **Paul D SMITH** **HM Senior Coroner for** **Greater Lincolnshire**