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 Abigail Combes, assistant coroner, for the coroner area of South Yorkshire (West District)
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 24 January 2022 I commenced an investigation into the death of Lee Dryden born on 1 January 1978. The investigation concluded at the end of the inquest on 6 July 2023. The conclusion of the inquest was:- Narrative Conclusion: On 16th December 2021 Lee Dryden was admitted to hospital and suffered from a cardiac arrest. This resulted in a hypoxic brain injury and his death on 12th January 2022. Prior to the cardiac arrest it was apparent on the 15th that his tracheotomy tube was misplaced however this was not actioned before his cardiac arrest on 16th December 2021. His death was contributed to by neglect. The medical cause of death was: 1a: Hypoxic brain injury 1b: Cardiac arrest 1c: Displacement of tracheotomy tube 2: Laryngeal Squamous Cell Carcinoma
4	**CIRCUMSTANCES OF THE DEATH** Lee Dryden received a diagnosis of advanced squamous cell carcinoma of the voice box. This was found by chance following a cardiac arrest. As a result of that diagnosis he required a permanent tracheotomy whilst there were investigations undertaken about the best course of treatment for him. Lee was assessed as able to leave hospital with a tracheotomy whilst those investigations were undertaken. He attended an outpatient appointment on 7 December 2021 and there were no obvious signs of difficulties with his tracheotomy. He required further scans to look for metastases and see whether the treatment the MDT would recommend would be surgical or chemotherapy/radiotherapy. On 10 December 2021 Lee underwent an MRI scan which did pick up an incidental finding of potential emphysema which was not reported. The MRI scan is not the optimal test for picking this up and that was not the purpose of the MRI scan but the potential presence of emphysema on 10th is relevant to later actions.

	On 14 December 2021 Lee had a PET scan. This scan definitively picked up the presence of emphysema and reported that this was likely as a result of the displaced tracheotomy tube. This scan was reported on the 15 December 2021 and the secretaries at Barnsley Hospital ENT team were contacted by the caseworker from Alliance Medical to notify them that there was a report being sent with a critical finding on. There were delays in the caseworker being identified within Alliance Medical to report the scan to the hospital. When the email was sent from Alliance Medical to the hospital it was not flagged as urgent however the subject line did state 'Critical findings'. The first email did not attach the report and the secretary had to ring Alliance Medical back to request the report which was sent a short time later. This was sent to the Consultant who had given Lee his initial diagnosis. Also on 15 December 2021 Lee began to feel unwell and contact his GP who believed that Lee had a chest infection following a telephone consultation and prescribed antibiotics. He stated that he had a low level of suspicion for the chest infection but did not feel it was necessary to see Lee. He stated that he did not know about that Lee had a tracheotomy although this is recorded within the clinical notes. The Consultant at Barnsley hospital was aware of the critical findings on the scan on 15 December 2021. His initial view was that Lee should not have been allowed to leave hospital or that this was a false positive result. He asked that the nurse, [redacted] try to ascertain where Lee was and sent her a text requesting her to do this. His view in evidence was that he believed this was a false positive rather than a displaced tube. However the text which was sent states:- 'Sorry to trouble you. It appears on PET that Mr Dryden's tube is not in the trachea. Apparently he was allowed to walk off the premises at NGH. Could you contact him to make sure he is o.K. And encourage him to come in for a review/Re-siting Regards.' This text was sent at 17:49 on 15 December and was not picked up until 09:16 on 16 December 2021. There was therefore no contact made with Lee after the scan findings. Late on 15 December 2021 Lee's mum became so concerned about him that she rang for an ambulance. The ambulance grading was a grade 2 which has an expected response time of 18 minutes with a second target of 9 in 10 grade two calls being responded to in 40 minutes. Lee's call was responded to in 2 hours and 26 minutes. This was due to pressures on the service at the time. This meant that Lee presented at hospital on 16 December 2021 at 00:57 and was very unwell and required treatment for a cardiac arrest. Unfortunately they were unable to ventilate Lee through the tracheotomy as it was not ventilating properly and therefore an additional tube needed to be placed. As a result of the cardiac arrest Lee suffered with a hypoxic brain injury which was ultimately the cause of his death. The failure to take additional steps to contact Lee following the critical findings in the scan on the 15 December 2021 amounts to a gross failure of basic care. Once the findings were known to the consultant body, who clearly felt that Lee required eyes on checking at that time is a basic and ongoing failure which is very very significant. In relation to whether the failure to contact Lee following the scan results being known by the Trust on the 15 December 2021 was causative or contributory to Lee's death in a way that was more than minimally negligibly or trivially. Lee had evidence of emphysema on the MRI scan on 10 December 2021. This was confirmed and attributed to the misplacement of the tube on the 15 December 2021. Lee had therefore potentially managed with the misplaced tube and no ill effects for a number of days. It is apparent to me, on the basis of the evidence that the turning point for Lee was the 15th and 16th December 2021. Had sufficient attempts been made to contact Lee after the scan results were known on the 15th of December 2021 he would have been seen in hospital prior to the cardiac

	arrest which resulted in the hypoxic brain injury. Although death did not occur for some time after the cardiac arrest, the fatal event was effectively the cardiac arrest on the 16 December 2021.
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. There is Royal College Guidance as to how and by what means the images are reported from external organisations such as Medical Alliance to NHS Trusts however this appears to not be understood or embedded by NHS Trusts. 2. The Ambulance Service graded Lee's mother's call to them on the 15th December 2021 as a category 2 call which has two targets as described in evidence, the first being a response time of 20 minutes call time and that 9 out of 10 calls would be responded too within 40 minutes. Yorkshire Ambulance Service were unable to respond to Lee's call until 2 hours and 26 minutes had passed. Yorkshire Ambulance Service were on their highest level of escalation at that time with significant delays at hospital handover caused or contributed to the delay in an ambulance being available to Lee.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 27 September 2023. 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: Lee's family, Barnsley District General Hospital, Medical Alliance, Yorkshire Ambulance Service NHS Foundation Trust. 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 other 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.
9	 **2nd August 2023** **Abigail Combes**