## **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 RE: KEITH THOMAS GRAHAM Deceased

THIS REPORT IS BEING SENT TO:

 Mrs. Ann Farrar – Chief Executive – North Cumbria University Hospitals – NHS Trust, The Cumberland Infirmary, Newtown Road, Carlisle, Cumbria. CA2 7HY

#### 1 CORONER

I am David Llewelyn Roberts senior coroner, for the coroner area of North and West Cumbria.

#### 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 the 30<sup>th</sup> May 2012 I commenced an investigation into the death of Keith Thomas Graham aged 45 years. The investigation concluded at the end of the inquest on the 29<sup>th</sup> November 2013. Cause of death – Multiple Injuries. On the 22<sup>nd</sup> May 2012 the deceased left a public house in Burgh by Sands on his motor cycle having consumed three pints of beer. He travelled along the c.2042 road at high speed when he was in collision with a bullock. He was transported to the Cumberland Infirmary, Carlisle where he underwent surgery, dying from his injuries on the 28<sup>th</sup> May. The conclusion of the inquest was Road Traffic Collision.

#### 4 CIRCUMSTANCES OF THE DEATH

The deceased was involved in a Road Traffic Collision. He reached the Cumberland Infirmary, Carlisle at 20.08 hours. He was in a poor condition. It was planned that he be taken to a CT Scanner which occurred at 21.20 hours. He was suffering from Hypotension and was taken to Theatre at 21.30 hours. The on call Consultant was not contacted until 21.15 hours. A chest drain was misplaced and caused damage to the liver. He underwent a Throacotomy and three Laparotomies in the space of some  $5 \frac{1}{2}$  hours. The consensus of medical evidence was that on the balance of probabilities he would have died of his injuries in any event.

### 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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The MATTERS OF CONCERN are as set out in 4 above.

To review the procedures to deal with seriously injured trauma patients on arrival at A &

	E to include the timing of the summons to the on call Clinicians, the contra-indications for the use of CT Scanning, and where surgery is indicated, minimising the time between presentation and theatre.
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 30 <sup>th</sup> January 2014 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 – his Wife  I have also sent it to the Care Quality Commission who may find it useful or of interest.
	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. 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.
)	4 <sup>th</sup> December 2013
	D.LI. Roberts H.M. Senior Coroner