	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, St Peters and Ashford hospitals Chertsey**
1	**CORONER** **I am Karen HENDERSON, assistant coroner for the coroner area of Surrey**
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 18th March 2013 an investigation was commenced into the death of Keith Ronald Martin, 64 years of age. The investigation was concluded at the end of the inquest on 5th February 2014. The medical cause of death given was: 1a. Myocardial infarction 1b. 1c. 2. My conclusion was: Natural Causes
4	**CIRCUMSTANCES OF THE DEATH** Mr Martin attended the A&E department of St Peter's Hospital Chertsey at 2200 hours on March 2013 after complaining of central chest pain and tingling down his left arm from approximately 1600 that day. He was not triaged by an A&E nurse until 2250 hours and did not have an ECG or blood tests until one hour later. His initial ECG showed no significant changes but his troponin level was significantly raised. No treatment was instituted until 0140 hours when he became significantly unwell and further ECG's showed a significant myocardial infarction requiring emergency transfer to Frimley Park Hospital for angiography and possible recanalization of his coronary blood vessels. This was undertaken but Mr Martin subsequently bled from a cannulation site for attempted introduction of an intra-aortic balloon pump but his myocardial infarction was incompatible with life.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise for concern. In my opinion there is a risk that future death will 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 length of time taken to initially assess Mr Martin in A&E, given his presenting symptoms 2. The significance of Mr Martin's symptoms were not appreciated at triage 3. The length of time taken to undertake an ECG and blood tests after initial triage 4. The length of time taken to receive the results of these tests 5. The significance of the rise in troponin was not appreciated or acted upon promptly 6. The length of time taken for Mr Martin to be reviewed by a senior member of staff 7. The length of time taken to provide standard pharmacological treatment for chest pain or myocardial infarction 8. A lack of clarity as to the protocol for the management of chest pain in A&E 9. An overall lack of effective documentation

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation: St Peters and Ashford Hospital NHS Trust has 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 22nd April 2014. I, the coroner, may extend this 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 following Interested Persons: [redacted] 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.
9	**DATE:** **SIGNED:**