REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England**
1	**CORONER** I am Grahame Antony Short, Senior Coroner for the coroner area of Central Hampshire
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 17 August 2011 I commenced an investigation into the death of Matthew David James Simmonds, age 39. The investigation concluded at the end of the inquest on 14 March 2014. The conclusion of the inquest was that the deceased died due to Interrupted ventilation in a patient dependent on assisted ventilation due to Von Hippel-Lindau Syndrome and I recorded a narrative conclusion set out in Box 4 below.
4	**CIRCUMSTANCES OF THE DEATH** 1. Matthew Simmonds was suffering from Von Hippel-Lindau Syndrome, as a result of which he was quadriplegic and was fully dependent on invasive ventilation. 2. He was ventilated by a ventilator, which required changing every 24 hours, a procedure which operated satisfactorily whilst he remained in hospital. 3. A discharge care plan was put in place on 24 June 2011, by which time his condition had deteriorated to the extent that he had a short life expectancy, but he continued his wish to spend the remainder of his life at home. 4. The limited time before his discharge from hospital contributed to a condensed period for the planning of, and appropriate training for, his care package to be put in place by a provider in the community. 5. Matthew Simmonds was discharged from Southampton Hospital on 6 July 2011 and returned to his home at 68 Oakmount Road, Chandlers Ford, where he was cared for initially by a nurse who had no experience of working in an intensive care or high dependency unit in hospital. He was using the same ventilator provided by the hospital successfully during the day. 6. At approximately 20.00 hours a second nurse arrived at the house. She has intensive care training and experience. The handover was in progress and both nurses were present and assisted when the original ventilator was substituted. 7. At a time before 21.35 and likely to be about an hour earlier, during the change of ventilators, assisted ventilation to Matthew Simmonds ceased, as a result of the replacement ventilator not being switched to a functioning mode. 8. This fact was not observed until just before 21.35 when the ventilator was found

	to be in stand-by mode and he was seen to be deceased.
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 follows. – (1) Hampshire Primary Care Trust (then responsible for commissioning services) carried out a Serious Incident Review as a result of this death and have since put into effect an action plan for commissioning services in the case of complex care pathways for discharges to the community particularly in the case of ventilated patients. (2) I heard evidence that Hampshire Clinical Commissioning Groups as successors to the Primary Care Trust have adopted this plan and that it is working satisfactorily. (3) The plan was prepared locally and has not been shared with CCG's outside the County. My concern is that to prevent deaths in other parts of the country all Clinical Commissioning Groups should adopt the plan.
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 13 May 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 [redacted], University Hospital Southampton NHS Foundation Trust, West Hampshire Clinical Commissioning Group, [redacted] [redacted] and Team Medical Nursing Agency. I have also sent it to The Secretary of State for Health and NHS South Commissioning Support Unit 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	**18 March 2014** **Signed:**