REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Rt Hon Jeremy Hunt MP** **Secretary of State for Health,** **Richmond House,** **79, Whitehall,** **London. SW1A 2NS**
1	**CORONER** I am Dr Fiona Wilcox, Senior Coroner, for the coroner area of Inner West London
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 21st December 2010, I commenced an investigation into the death of Ms Pauline Verona Edwards, aged 49 years. The investigation concluded at the end of the inquest on 27th October 2014. The conclusion of the inquest was: Medical Cause of Death 1 (a) **Hypoxic Ischaemic Encephalopathy** (b) **Cardiorespiratory Arrest** (c) **Operation under general anaesthetic for Benign Ovarian Cyst.** How, when and where and in what circumstances the deceased came by her death: ***Ms Pauline Edwards, a healthy 49 year old female patient, died at St Georges Hospital, Tooting, London at 17:20 on the 15th December 2010. After successfully undergoing an operation for the removal of an ovarian cyst, the patient had difficulty in waking up, suffered a laryngospasm leading to hypoxia and a cardiac***

	arrest which resulted in the patient's death. Conclusion of the Jury as to the death ***On the 10th of December 2010, Ms Edwards was admitted for the removal of an ovarian cyst. The surgery finished C. 18:36. Prior to 19:00 the patient coughed and was extubated at this point.*** ***Shortly after 19:00, the responsible anaesthetist asked the ODP to get Naloxone. He failed to find it in the adjacent anaesthetic room and decided to fetch it form recovery, some minutes away, without first communicating this to the responsible anaesthetist. We find this a failure on the part of the ODP in serving the anaesthetist.*** ***Around 19:05, the patient stopped breathing due to a laryngospasm. The responsible anaesthetist failed to diagnose the cause of the respiration difficulties. We find this to be a serious failure.*** ***The laryngospasm was diagnosed when a junior colleague entered the operating theatre at approximately 19:16, monitor time, by which time irreversible brain damage was likely to have occurred.*** ***The responsible anaesthetist did not call for help using standard hospital protocol. This was a contributing factor to the death of the patient. We find this to be a serious failure within the first two minutes. We find the anaesthetist's continued failure to call for help to be a really serious failure.*** ***At or around 19:16 a junior anaesthetist entered the operating theatre and the patient was re-intubated by the responsible anaesthetist. The tube was wrongly inserted into the oesophagus. The fact that the responsible anaesthetist did not recognise that the tube was in the wrong place, despite no endtidal CO2 readings constitutes a serious failure.*** ***The patient subsequently suffered cardiac arrest due to prolonged hypoxia.*** ***The patient was sufficiently oxygenated at 19:30 after 24 minutes of insufficient oxygenation. The damage to her brain and other organs was by then irreversible and caused her death on 15th December 2010 at 17:20.*** ***We find that throughout these events , communication among the team members within the hospital was in relation to the unplanned over run to be inadequate but that this was not a direct cause of the death.***
4	**CIRCUMSTANCES OF THE DEATH** It was clear from the evidence taken during the inquest that the responsible anaesthetist, who had trained in Italy, had clearly insufficient experience to deal with the most common anaesthetic emergency, and that had reacted appropriately in recognising and treating the laryngospasm when it first developed this death would probably not have occurred. On paper, this doctor was supposed to be qualified to the level of a consultant, whilst in reality she had probably had little practical training, especially in the management of anaesthetic emergencies. She had been employed as a clinical fellow, and should have been qualified to act alone. EU Regulations require the UK to recognise EU qualifications of doctors even though their training may be well below that of an equivalently graded doctor in the UK.
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) That UK Hospitals are forced by EU law to accept the qualifications of EU trained doctors even though such doctors may not have the same training and experience as an equivalently graded doctor in the UK (2) That UK Hospitals are unaware of this and thus allow such doctors to practice unsupervised and thus put patients' lives at increased risk.
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. **I would commend the training and supervision programme put in place art St George's Hospital to try and mitigate such risks following this death, and suggest that the DOH may wish to consider reviewing the St George's programme as an example of good practice to be shared by the NHS.**
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 13th February 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] [redacted] Clinical Director Theatres and Anaesthetists St George's Hospital Blackshaw Road London SW17 0QT [redacted] Anaesthetics Senior Clinical Fellow St George's Hospital Blackshaw Road London SW17 0QT [redacted] Advanced Theatre Practitioner St George's Hospital Blackshaw Raod London SW17 0QT

	I have also sent it to the following persons or organisations who may find it useful or of interest: [redacted] OCCE General Medical Council Regent's Place 350 Euston Road London NW1 3JN 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	**19th December 2014.** **Dr Fiona Wilcox,** **HM Senior Coroner,** **Inner West London,** **Westminster Coroner's Court,** **65, Horseferry Road,** **London.** **SW1P 2ED.**