REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive** **Queen Elizabeth Hospital** **Gayton Road** **King's Lynn** **Norfolk**
1	**CORONER** I am JACQUELINE LAKE, senior coroner, for the coroner area of NORFOLK
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 26 June 2014 I commenced an investigation into the death of DAVID JOHN MOUNTAIN, Aged 71 years. The investigation concluded at the end of the inquest on 22 December 2014. The conclusion of the inquest was medical cause of death: 1a) Haemopericardium and Pericarditis b) Myocardial Perforation c) Pacemaker Insertion for complete Heart Block II Aortic Stenosis. Conclusion: Recognised risk of a necessary medical procedure.
4	**CIRCUMSTANCES OF THE DEATH** Mr Mountain was found incidentally to have a slow heart rate. He was referred to Queen Elizabeth Hospital (QEH) on 13 June 2014. Following investigation this was confirmed and as he was found to be at high risk of developing heart failure, he was admitted to Cardiology Ward and recommended for permanent pacemaker implant. Risks were explained to him. He was transferred to Papworth Hospital on 20 June 2014. Procedure performed without any recognised complications. Mr Mountain was reviewed following procedure on 21 June 2014 and chest x ray raised no concerns. Mr Mountain was discharged. On way home he developed chest pain and was taken directly to QEH. Started on antibiotics for sepsis of unknown source. He deteriorated and died on 23 June 2014.
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. – Despite having had a permanent pacemaker inserted on 20 June 2014 and Mr Mountain developing chest pain on 21 June 2014, the risks recognised on the consent form, including risk of bleeding and vascular damage were not fully investigated and an Echocardiagram was not performed until afternoon of 23 June 2014. The results, which showed a mild to moderate bleed around the heart, were not available until after Mr Mountain's death.

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 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] (wife) Chief Executive, Papworth Hospital 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	**24 December 2014** ..... **SIGNED BY CORONER**