ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive, Huddersfield Royal Infirmary** 2. **Chief Coroner** 3. [redacted]
1	**CORONER** I am Mary Burke, Assistant Coroner, for the coroner area of West Yorkshire (Western)
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 March 2014 I commenced an investigation into the death of Phillip Roy Smith, a 64 year old married gentleman. The investigation concluded at the end of the inquest on 10th December 2014. The conclusion of the inquest was that Mr. Smith died as a result of natural causes. The medical cause of death was established to be due to 1(a) Duodenal haemorrhage and hypovolaemic shock 1(b) Duodenal infiltration by pancreatic tumour 1(c) obstructing tumour head of pancreas.
4	**CIRCUMSTANCES OF THE DEATH** Phillip Roy Smith had a previous medical history of suffering a myocardial infarction, following which he underwent coronary artery stenting. On the 24th February 2014 he was fast tracked by his general practitioner to Huddersfield Royal Infirmary with sudden onset of jaundice. His mother and sister had previously both died from pancreatic carcinoma. Following ultrasound and CT scan imaging a likely diagnosis of pancreatic carcinoma was made. An ERCP procedure was subsequently attempted with a view to alleviating Mr. Smith's symptoms and at the same time to take a biopsy in order to confirm the likely diagnosis. Unfortunately the treating clinician was unable to enter the duodenum and therefore the procedure was stopped. After further MDT review a decision was taken for Mr. Smith to undergo a percutanaeous transhepatic cholangiogram, together with insertion of external drain. This was undertaken on the morning of the 14th March 2014 and proceeded uneventfully. Following return to the ward Mr. Smith appeared to be stable, however standard

observations undertaken by nursing staff at around 2045 hours gave rise for concern. The senior nurse on duty requested observations to be repeated after 30 minutes.

This was implemented and observations returned within normal range. No record was made of these further observations within Mr. Smith's medical notes and records.

Shortly thereafter Mr. Smith refused his night-time medication. No note was made of this within the nursing notes and records.

At approximately 1.00 a.m. in the early hours of the 15th March 2014 Mr. Smith's condition appeared to significantly change. He vomited and was experiencing severe significant pain. Mr. Smith was given Tramadol by one of the nurses on duty but no record was made of this within the nursing records.

Mr. Smith's condition was not improving and at approximately 1.30 a.m. nursing staff requested the attendance of the duty junior house officer, who duly attended and prescribed fluids and morphine. A blood sample was taken with a view to undertaking blood gasses.

No note was made by the junior doctor of his attendance and review, nor any record made of blood gas results.

Shortly thereafter the senior nurse returned to the bedside, at which point the junior house officer was still in attendance at Mr. Smith's bedside. She found Mr. Smith on the floor. No detailed note was made, either by the nurse or doctor, of these events within the medical notes and records and no record was made of whether this was a witnessed or unwitnessed fall.

By this stage the senior nurse on duty on the ward was very concerned with regard to Mr. Smith's presentation and suggested to the junior doctor that a more senior doctor review should take place. The junior doctor indicated that he did not need any additional support.

Mr. Smith's condition continued to give rise for concern and therefore the senior nurse requested another nurse to summon a more senior doctor's attendance.

A senior house officer attended and reviewed Mr. Smith. No note was made by this doctor, although following review he requested the on-call registrar to attend, who did so a short time thereafter and noted Mr. Smith had no pulse. CPR was commenced and a crash team summoned. Mr. Smith's cardiac output returned. Other tests were undertaken. It was noted that Mr. Smith's haemoglobin levels had significantly reduced. In addition he appeared to be acidotic.

A likely diagnosis of hypovolaemic arrest due to internal bleeding was made, although sepsis or myocardial infarction were also considered as possible causes for Mr. Smith 's presentation.

In order to confirm the diagnosis Mr. Smith required a CT scan, however Mr. Smith was not well enough to undergo significant intervention at that stage as his condition appeared to be very unstable.

Mr. Smith was subsequently transferred to the Intensive Care Unit and was fully supported, however he remained profoundly unwell with no signs of improvement. Following discussion with Mr. Smith's family the decision was taken to stop active treatment but to ensure he was kept comfortable. Sadly, Mr. Smith's condition continued to deteriorate and he died at 11.40 ours on the 15th March 2014 in the Intensive Care Unit at Huddersfield Royal Infirmary.

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise for 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) **The Standard of Nursing Records** i) On the evening of the 14th March 2014 observation were repeated 30 minutes after the standard observations were undertaken, but no record was made of these repeat observations. ii) Mr. Smith declined his evening medications, but this was not recorded. iii) Mr. Smith was given Tramadol at around 1.00 a.m. on the morning of the 15th March but this was not recorded. iv) Mr. Smith was found laid on the floor beside his bed in the early hours of the 15th March but full details of this event was not made by the nursing staff on duty. (2) **Standard of Doctors' Records** i) Junior Doctor's involvement – neither the junior or middle grade doctors who reviewed Mr. Smith in the early hours of the 15th March 2014 made accurate records of their review and assessment of Mr. Smith. ii) Blood gasses assessment was undertaken by the junior doctor on his attendance around 1.30 a.m. but no record was made of this. (3) **Junior Doctor's Involvement** i) The senior nurse on duty was concerned of Mr. Smith's deterioration in the early hours of the 15th March. At the time of the junior doctor's attendance she suggested that a more senior medical review should take place, however the junior doctor indicated that he did not require any further support in the circumstances notwithstanding Mr. Smith's presentation.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 18th March 2015, 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] 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	**21st January 2015** **Mrs. M. T. Burke, Assistant Coroner**