Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Department of Health Richmond House 79 Whitehall London SW1A 2NS
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater 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 the 10 day of February 2013 I opened an investigation touching the death of Anthony Dwyer , 50 years old. The inquest concluded on the 29th June 2015 The conclusion of the inquest was "Narrative", the medical case of death was 1a Hypoxic cardiac arrest following extubation of endotracheal tube
4	**CIRCUMSTANCES OF THE DEATH** On the 9th February 2014 between 10am and 10.30 Anthony Dwyer collapsed in hospital having taken his tracheostomy out from his neck. Anthony Dwyer was a complex,(multiple medical needs), vulnerable, (lacking capacity) long-term tracheostomy patient in a side room,(due to a risk of spread of infection), in a Regional Rehabilitation Unit in hospital. Mr Dwyer was not nursed on a one to one basis and had he been in a bay with other patients, or been looked after continuously in the side room, it is likely that when he took out his tracheostomy tube he would have been seen, and the tracheostomy tube replaced, before Mr Dwyer suffered a hypoxic cardiac arrest.
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. –

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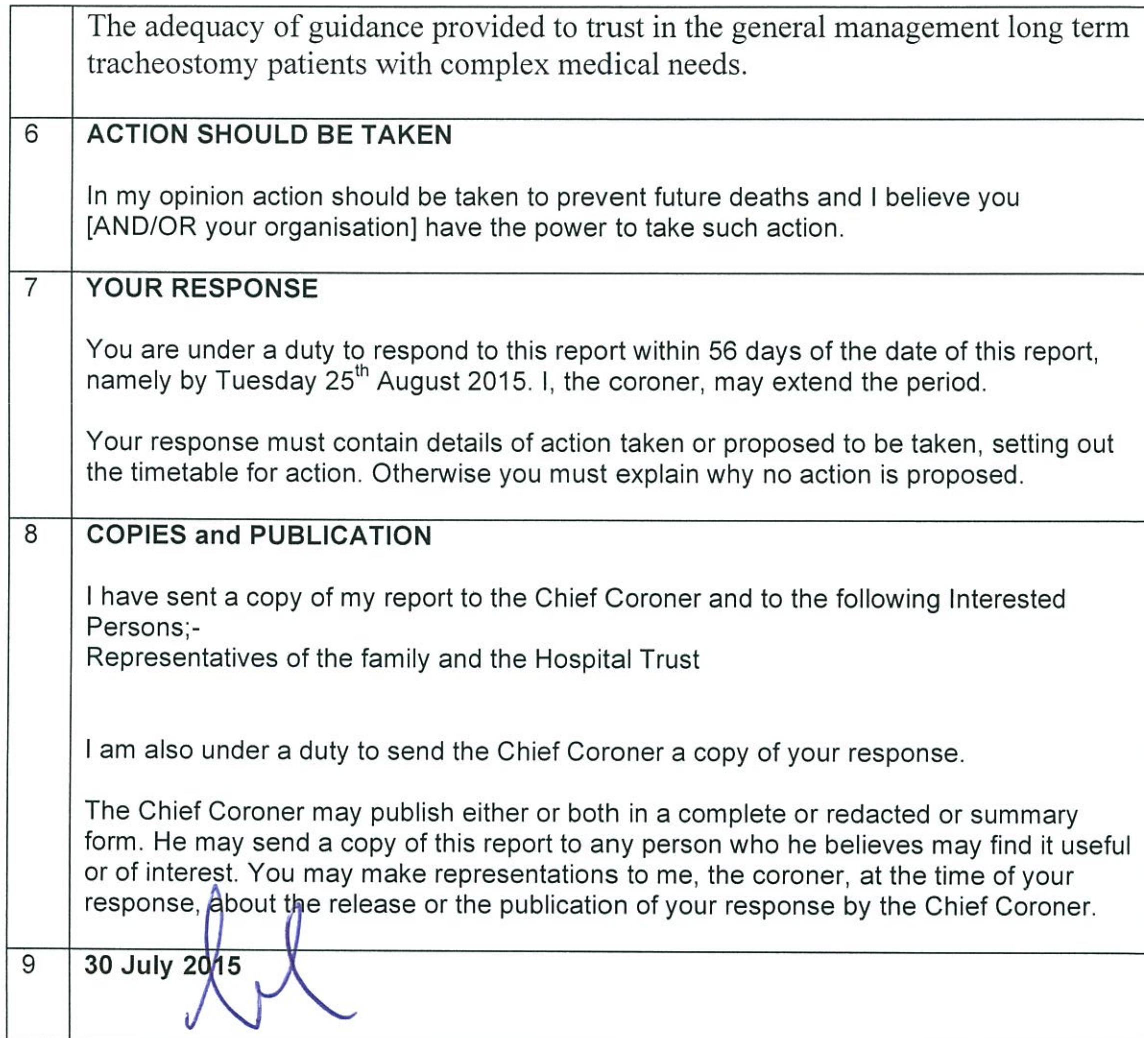

	The adequacy of guidance provided to trust in the general management long term tracheostomy patients with complex medical needs.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Tuesday 25th August 2015. 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;- Representatives of the family and the Hospital Trust 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	**30 July 2015**