REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Dr Jackie Bene, Chief Executive, Trust Headquarters, Royal Bolton Hospital, Minerva Road, Farnworth, Bolton, BL4 0JR
1	**CORONER** I am Alan Peter Walsh, Area Coroner, for the Coroner Area of Manchester West
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 31st March 2015 I commenced an Investigation into the death of Brian Anthony Gillard, 79 years, born 12th June 1935. The Investigation concluded at the end of the Inquest on 11th June 2015. The medical cause of death was 1a) Congestive cardiac failure, 1b) Asbestosis. The conclusion of the inquest was Industrial Disease.
4	**CIRCUMSTANCES OF THE DEATH** 1. Brian Anthony Gillard died at the Royal Bolton Hospital, Minerva Road, Farnworth, Bolton on the 20th March 2015. 2. Mr Gillard had been exposed to asbestos during his working life at various locations and at various times between 1951 and 1999 when he worked as a Pipe Lagger. In July 2014 Mr Gillard presented to the Respiratory Service at the Royal Bolton Hospital, Bolton with a six month history of rapidly progressive breathlessness and , subsequently, he was diagnosed as suffering with Asbestosis. He was treated on Oxygen at home from September 2014 after seeing a Consultant Respiratory Physician at the Hospital and he was reviewed on a monthly basis by various Respiratory Nurses with regard to his Oxygen requirements. 3. On the 28th February 2015 Mr Gillard was admitted to the Royal Bolton Hospital, Bolton with a history of recurrent collapses and by this time he was known to be on long term Oxygen therapy for breathlessness due to Pulmonary Fibrosis. During his time in Hospital Mr Gillard was noted to have increased Oxygen requirements and the Respiratory Nurses

arranged for him to have increased Ambulatory Oxygen at home, which was delivered to his home address at the time of his discharge on the 14th March 2015.

4. On the 18th March 2015 at 17.20 hours Mr Gillard attended the Emergency Department of the Royal Bolton Hospital, Bolton by ambulance and it was known that he had a past medical history of Asbestosis and he was on long term Oxygen therapy. He presented to the Hospital with increased shortness of breath, low Oxygen saturations and poor mobility. The Respiratory Nurses had seen him in the community and the Nurses advised his admission to the Hospital. After preliminary investigations he was treated for pneumonia pending a chest x-ray and the chest x-ray showed increased right sided congestion. He was using Oxygen during transfer from his home address to the Hospital in the ambulance and he continued to use Oxygen in the Emergency Department at the Hospital.

   He was known to require Ambulatory Oxygen from the Hospital notes in relation to his previous admission and at the time of his admission to the Emergency Department at the Hospital.

5. Mr Gillard had arrived at the Emergency Department at the Hospital at 17.20 hours on the 18th March 2015 and later that evening he was transferred from the Emergency Department to D1 Ward at the Hospital.

6. Mr Gillard was taken to D1 Ward by a Hospital Porter and he was received on D1 Ward by [redacted], who is an Assistant Practitioner.

   [redacted] gave evidence at the Inquest that he did not receive a formal handover from the Emergency Department and he was not aware that Mr Gillard required Ambulatory Oxygen.

   [redacted] also gave evidence that there was no system in place at the Hospital in relation to handover from the Emergency Department to the Ward, particularly in relation to Oxygen requirements.

7. At approximately 05.30 hours on the 19th March 2015 Mr Gillard was in bed when he requested the toilet and he was offered a commode next to his bed. However, Mr Gillard insisted that he be taken to the toilet and [redacted] took him to the toilet in a wheelchair without continuing Oxygen. [redacted] accepted that portable Oxygen supply was available for use between the Hospital bed and the toilet but Mr Gillard was happy to go to the toilet without Oxygen and [redacted] was not aware that Mr Gillard required Ambulatory Oxygen.

8. When Mr Gillard was taken to the toilet he was left in the toilet, which did not have an Emergency pull-cord, for privacy and [redacted] returned to his duties for three to four minutes leaving Mr Gillard in the toilet on his own.

   When [redacted] returned to the toilet approximately four minutes later he found Mr Gillard collapsed behind the toilet door and Mr Gillard had

	suffered a cardiac arrest believed to be due to Hypoxia. Mr Gillard was resuscitated and he was transferred to his bed. A repeat chest x-ray showed worsening congestion and subsequent clinical assessment revealed a raised JVP and bilateral chest crepitations. Mr Gillard was treated with intravenous diuretics, intravenous antibiotics and increased oxygen support but on the 20th March 2015 he deteriorated and died.
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. During the Inquest evidence was heard that i. Mr Gillard had been diagnosed with Asbestosis and he was started on Oxygen at home after seeing a Consultant Respiratory Physician and a Specialist Respiratory Nurse on the 8th September 2014. He was reviewed on a monthly basis by various Respiratory Nurses with regard to his Oxygen requirements. During his admission to the Royal Bolton Hospital on the 28th February 2015 his oxygen requirements increased and he was seen by the Respiratory Nurses who arranged for him to have increased Ambulatory Oxygen at home following his discharge from the Hospital on the 14th March 2015. ii. When Mr Gillard was admitted to the Royal Bolton Hospital Emergency Department on the 18th March 2015 he was receiving Oxygen and he was known to require Ambulatory Oxygen, which continued until he was transferred to D1 Ward at the Hospital. iii. There was no handover in relation to Mr Gillard's transfer from the Emergency Department at the Hospital to D1 Ward at the Hospital, particularly in relation to his need for Ambulatory Oxygen and subsequently he was taken to the toilet without the use of Oxygen. He was left in the toilet on his own, and without supervision by a Nurse outside the door, for approximately four minutes during which he suffered a cardiac arrest believed to be secondary to Hypoxia. iv. It was accepted that there was a facility to use a portable Oxygen supply for use between his bed and the toilet but the portable supply was not used because Mr Gillard was happy to go to the toilet without Oxygen and his need for Ambulatory Oxygen was not known to the Ward Staff on D1 Ward.

	2. I request you to consider the above concerns and to carry out a review with regard to the following: i. The handover of patients from one department to another department within the Hospital particularly in relation to the need for Oxygen and other treatment. ii. The use of portable Oxygen units for the supply of Oxygen to a patient whilst being transferred from the bed to the toilet or any other facility within a Ward at the Hospital. iii. The information available to Ward Staff and the knowledge of Ward Staff when receiving a patient to the Ward, particularly in relation to necessary and continuing treatment and the need to identify and highlight the continuation of necessary treatment, particularly in relation to the use of Oxygen. iv. The training of all staff in relation to the transfer of patients from one department to another department in the Hospital and the need to identify and highlight the need for necessary treatment to continue, particularly in relation to the use of Oxygen. v. The evidence raised concerns that there is a risk that future deaths will occur unless action is taken to review the above issues.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and 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 21st 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 1. [redacted] Mr Gillard's wife 2. [redacted] Mr Gillard's daughter 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	**Dated** **26th June 2015**	**Signed** **Alan P Walsh**