ANNEX A

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. **Chief Coroner** 2. **Minister for Health, National Assembly for Wales** 3. **Chief Executive, Cwm Taf University Health Board** 4. [redacted] **Cwm Taf University Health Board Investigator** 5. [redacted]
1	**CORONER** I am Dr. Sarah-Jane Richards, Assistant Coroner, for the coroner area of Powys, Bridgend and Glamorgan Valleys
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 4th March, 2015 I commenced an investigation into the death of Mrs. Gail Prentice. The investigation concluded at the end of the inquest on the 17th April, 2015. The conclusion of the inquest was '*Complications of a surgical procedure on a background of multiple and severe health conditions*'.
4	**CIRCUMSTANCES OF THE DEATH** Mrs. Prentice, 46 years, had suffered multiple and serious ill health events in life including dialysis dependent diabetes, breast cancer with bilateral mastectomy, thyroidectomy, toe amputations, cardiac arrest and renal failure. She had been admitted to the Royal Glamorgan Hospital falling a fall and had suffered a PEA arrest. She had been ventilated fully and a previous attempt to extubate had failed. It was considered that a tracheostomy would assist Mrs. Prentice being weaned off the ventilator but it was not an essential, life sustaining procedure. The percutaneous dilation tracheostomy was performed in the ITU and commenced by [redacted] ENT registrar under the supervision of [redacted] associate specialist ENT surgeon. [redacted] had previously performed only two percutaneous tracheostomies. Complications arose when the patient bled profusely after the insertion of the second dilator by [redacted] The bleed could not be stemmed and Mrs. Prentice died in consequence. The post-mortem cause of death was given as - 1a massive blood loss; and 1b transection of the brachiocephalic artery during attempted tracheostomy formation. Witness evidence confirmed that in patients requiring tracheostomy and where there had been previous neck surgery, ultrasound should have been undertaken to identify internal structures within the altered neck anatomy and to determine the site of entry. At the very least, the tracheal rings should have been counted in order to avoid puncturing the

	artery on insertion. The usual placement is between the 2nd and 3rd tracheal rings whereas in Mrs. Prentice, the site was low down the neck at the level of the 9th and 13th rings. The outcome of the Cwm Taf University Health Board's investigation was submitted to the Coroner prior to the inquest. In this report, the 'lessons learned' cited that • a patient's previous medical history should be noted prior to tracheostomy; • in the event of previous neck surgery having been undertaken, a full ultrasound should be completed; and • where previous neck surgery had been performed any new tracheostomy should be inserted in theatre and not in the ITU. The Health Board acknowledged its Guidelines for Tracheostomies did not address the scenario of altered neck anatomy post previous neck surgeryand this was an omission which it was seeking to address from these 'lessons learned'.
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) The requirement for surgeons to acknowledge having read the Health Board's Hospital Guidelines and those of other bodies e.g. NICE Guidelines
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action in the area of: ➢ Ensuring the Hospital's Tracheostomy Guidelines take into account the checks required when there has been previous neck surgery; ➢ Percutaneous tracheostomies should be performed in the theatre environment rather than in the ITU; and ➢ Feedback to Health Boards that ENT surgeons have read its Guidelines.
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 September, 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; Mr. Mark Drakeford, Minister of Health, National Assembly for Wales; Mrs. Allison Williams, Chief Executive, Cwm Taf University Health Board; [redacted] Cwm Taf University Health Board Investigator; and [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	**2nd July 2015** **SIGNED:** [redacted] **Dr. Sarah-Jane Richards** **HM Assistant Coroner** **Powys, Bridgend & Glamorgan Valleys**