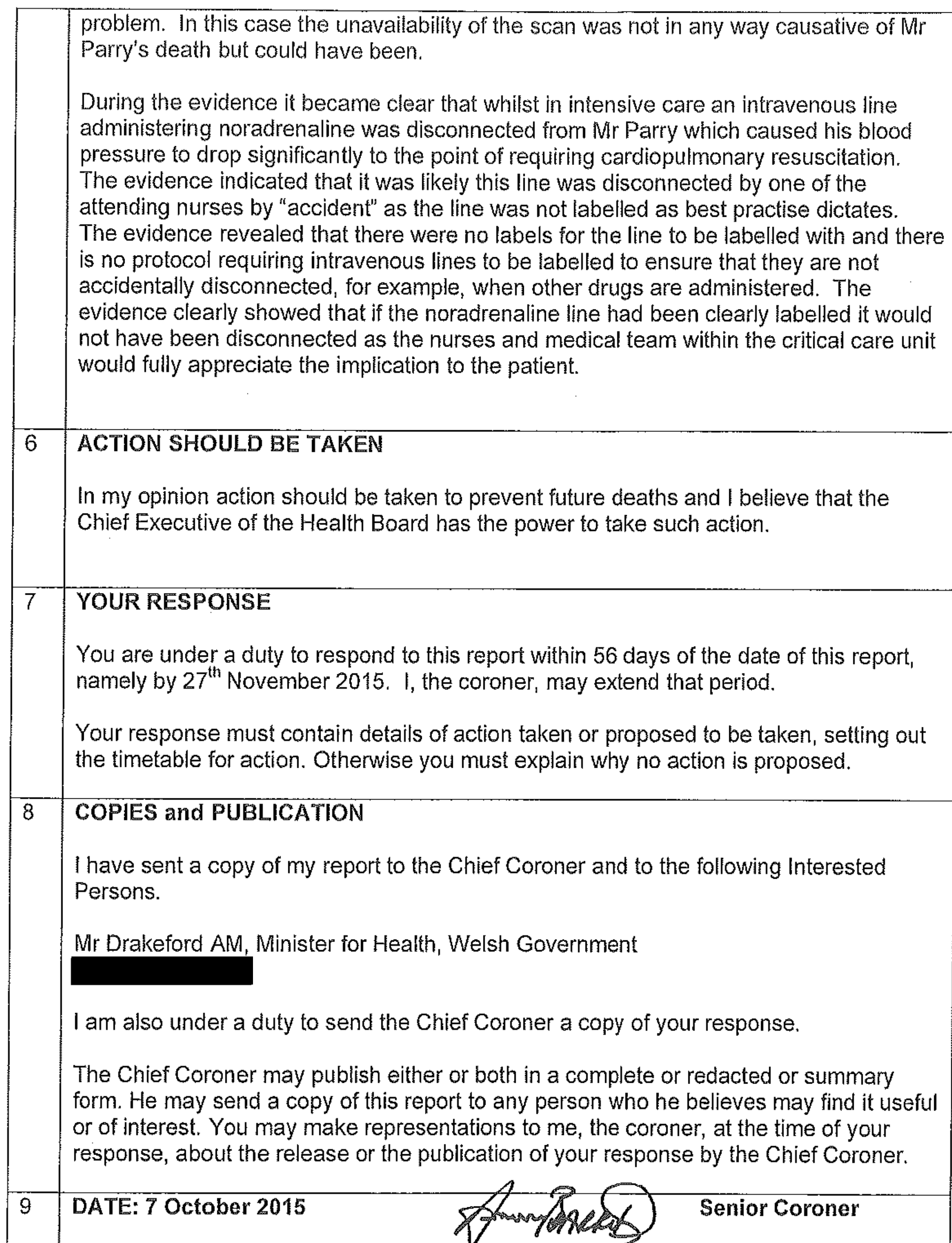
REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Adam Cairns Chief Executive, Cardiff and Vale University Health Board, UHW Heath Park, Cardiff CF14 4XW**
1	**CORONER** I am Andrew Barkley, Senior Coroner for Cardiff and the Vale of Glamorgan area
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 8th July 2015 I commenced an investigation into the death of Geoffrey Parry, aged 74. The investigation concluded at the end of an inquest on 30th September 2015. The medical cause of death was 1a pneumonia, 1b locally advanced bladder cancer (operated). I returned a narrative conclusion "*Geoffrey Colin Parry died from the effects of pneumonia which he contracted having undergone major surgery for bladder cancer.*"
4	**CIRCUMSTANCES OF THE DEATH** Mr Parry had been complaining of urinary symptoms for in excess of twelve months, was referred to a urologist at the University Hospital of Wales and was diagnosed with suffering from an aggressive bladder cancer. He elected to undergo surgery for the removal of the tumour which took place on 1st May 2015. During the lengthy and complex surgery he developed several episodes of abnormal heart rhythm which caused the surgery to be suspended. The surgery was eventually completed, successfully, and he was taken to the intensive care unit for further support. He made steady progress before developing infection which turned into pneumonia from which he passed away on 29th June 2015.
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. – During the evidence it transpired that an ECG test which was undertaken on 21st April 2015 was not available to the reviewing consultant anaesthetists prior to surgery. The evidence suggested that there was a problem within the hospital, not specific to ECG tests whereby results from investigative tests and scans are not kept with the patient's medical notes. In this instance, it appeared that there was a facility for the result of the ECG to be electronically uploaded onto the hospital computer system but this had not happened. The evidence at the hearing suggested that this was a not uncommon



	problem. In this case the unavailability of the scan was not in any way causative of Mr Parry's death but could have been. During the evidence it became clear that whilst in intensive care an intravenous line administering noradrenaline was disconnected from Mr Parry which caused his blood pressure to drop significantly to the point of requiring cardiopulmonary resuscitation. The evidence indicated that it was likely this line was disconnected by one of the attending nurses by "accident" as the line was not labelled as best practise dictates. The evidence revealed that there were no labels for the line to be labelled with and there is no protocol requiring intravenous lines to be labelled to ensure that they are not accidentally disconnected, for example, when other drugs are administered. The evidence clearly showed that if the noradrenaline line had been clearly labelled it would not have been disconnected as the nurses and medical team within the critical care unit would fully appreciate the implication to the patient.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Chief Executive of the Health Board has 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 27th November 2015. I, the coroner, may extend that 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. Mr Drakeford AM, Minister for Health, Welsh Government 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	**DATE: 7 October 2015** **Senior Coroner**