REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) The Chief Executive of London Bridge Hospital** **(2) HCA Healthcare UK** **(3) Fisher and Paykel** **(4) The Nursing and Midwifery Council** **(5) The Care Quality Commission**
1	**CORONER** I am **HENRIETTA HILL QC**, Assistant Coroner, for the coroner area of Inner South 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** **ROBERT ENTENMAN**, who was born on 1 March 1958, died on 30 May 2015 at London Bridge Hospital. An investigation into his death was opened, and an inquest held from 17-21 October 2016. The medical cause of Mr Entenman's death was recorded as follows: I(a) Hypoxic-ischemic encephalopathy I(b) Blocked endotracheal tube 1(c) Mitral valve disease that had been operated upon on 15 May 2015 2. Obesity and fatty liver disease I returned a narrative conclusion as follows: *"Mr Entenman was an intubated patient on the intensive care unit at London Bridge Hospital. At around 12.00pm on 22 May, the humidifier in his room was turned off. It remained off until 6.00am on 23 May 2015. This equipment reduced the risk of mucus secretions in his airway becoming sticky and thick. A mucus plug did develop and blocked his endotracheal tube. He went into cardiac arrest shortly after 6.00am on 23 May 2015. He was reintubated and return of spontaneous circulation was established, but he died on 30 May 2015, as a result of the denial of oxygen to his brain. The failure to provide him with the treatment of the humidifier amounted to neglect. Delays in identifying that the tube had become blocked between 5.32 and 6.00am on 23 May 2015 also played a causative role in his death".* There followed a period of time during which the Interested Persons were permitted to make submissions and provide evidence on Regulation 28 issues.

4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as set out in the narrative conclusion above.
	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 that: (1) Three nurses cared for Mr Entenman between 12.00pm on 22 May 2015 and 6.00am on 23 May 2015. During that time they did not observe that the humidifier had been turned off, either at the handovers that took place between them or each hour when they should have recorded the temperature reading from the humidifier. (2) The humidifier machine does not have an alarm on it, to indicate when the machine has been turned off. (3) There were delays in identifying that the endotracheal tube had become blocked between 5.32 and 6.00am on 23 May 2015, and thus replacing it earlier. There may have been further such delays after 6.00 am. There may have been a delay by the nursing staff in providing information about difficulties with the suction catheter to the doctors who arrived after the cardiac arrest call was put out.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that: **(1) The Chief Executive of London Bridge Hospital and** **(2) HCA Healthcare UK** have the power to take action in respect of concern (3) above; **(3) Fisher and Paykel** has the power to take action in respect of concern (2) above; **(4) The Nursing and Midwifery Council** ("the NMC") has the power to take action in respect of concerns (1) and (3) above, in respect of one nurse whose name shall be provided to the NMC separately; and **(5) The Care Quality Commission** ("the CQC") has the power to take action in respect of concern (3) above. The CQC is also provided with the entirety of this report pursuant to the Memorandum of Understanding between the Coroners Society and the CQC.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **31 March 2017**. 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: the family of Mr Entenman, London Bridge Hospital and the individual medical professionals who were separately recognised as Interested Persons. 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	**Signed ....*Henrietta Hill QC*..** **Assistant Coroner** **3 February 2017**