REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Secretary of State for Health**
1	**CORONER** Sarah Louise Slater assistant coroner, for South Yorkshire (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 (Investigatory) Regulations 2013. (1) Where – a. A senior coroner has been conducting an investigation under this Part into a person's death and b. Anything revealed by the investigation gives rise to concern that circumstances creating a risk or other deaths will occur, or will continue to exist, in the future, and c. In the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have the power to take such action. (2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it. (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner
	INVESTIGATION and INQUEST On 15th March 2016 I commenced an investigation into the death of Mr Simon Timothy Harper. The investigation concluded at the end of the inquest on 28th October 2016. The conclusion of the inquest was the Mr Simon Timothy Harper died from; 1a) Multiple Organ Failure 1b) Pneumonia 1c) Alcohol related liver disease A narrative conclusion was recorded as follows: Mr Harper was admitted to the Northern General Hospital on the 6th March 2016 with jaundice and abdominal distention. His condition deteriorated and he was transferred to the intensive care unit on the 7th March 2016. However, during the transfer Mr Harper's oxygen cylinder was not turned on and it is likely this lead to him suffering a cardiac arrest whilst on route. Mr Harper was successfully resuscitated but he continued to deteriorate and died on the 9th March 2016. It is not possible to state what effect, if any, this cardiac arrest has had on Mr Harper's death.

4	**CIRCUMSTANCES OF THE DEATH** Mr Harper was admitted to the Northern General Hospital on 6th March 2016 with jaundice and abdominal distention. On the 7th March 2016, Mr Harper suffered liver failure, kidney failure and respiratory failure. Mr Harper was receiving oxygen via a non-rebreathe mask from the main hospital wall supply to support his lung function. Later that evening the patient underwent a Critical Care Review who agreed a transfer to the General Intensive Care Unit. In order to transfer Mr Harper safely a portable oxygen supply was required and this was supplied by the portering department. It is the responsibility of nursing staff to connect the cylinder to Mr Harper. On route to the General Intensive Care Unit the patient, Mr Harper suffered a sudden deterioration and it was noticed that the portable oxygen cylinder had not been turned on. Mr Harper suffered a cardiorespiratory arrest to which resuscitation attempts were successful. He was admitted to the General Intensive Care Unit shortly after midnight at which point he was deeply comatose and anuric. On 9th March 2016 treatment was withdrawn and death occurred at 1800.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving raise 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. – The inquest heard that in November 2010 the act of connecting a patient to an oxygen cylinder for transfer was reassigned from porter staff to nursing staff. Upon the reassignment of the task, one session of training was provided by an external company to a small number of nursing staff who were on duty at the time. There is no record regarding the contents of the induction/training or who was present at the time. In addition, the Trust confirmed that since that date there has been no formal training and they have relied on 'peer to peer' training. In addition, no register of individuals trained or content of training is documented. There is no record of who has and has not received relevant training and no audit is in place to assess the appropriateness of this 'on the job' his training. The inquest heard that the nurse responsible for connecting the patient to the oxygen cylinder did not turn the valve to allow oxygen flow. It is probably that this lead to the cardiorespiratory arrest although it was accepted no-one could be certain of this. The Secretary of State for Health is asked to consider whether it is appropriate for training to be provided and documented regarding the use of portable oxygen cylinders for patients. The implementation of a Transfer of Patients Policy should also be considered as those available did not cover this issue.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 26th January 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 Harper The Chief Executive, Sheffield Teaching Hospitals NHS Foundation 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	**9th November 2016** **Louise Slater**