Regulation 28: Prevention of Future Deaths report

Mary Patricia MULDOWNEY (died 23.07.16)

	THIS REPORT IS BEING SENT TO: **1. Professor Simon Mackenzie** **Chief Executive** **St George's University Hospitals NHS Foundation Trust** **Blackshaw Road** **Tooting** **London SW17 0QT** **2. Dr Gillian Fairfield** **Chief Executive** **Brighton and Sussex University Hospitals NHS Trust** **Eastern Road** **Brighton BN2 5BE** **3. Mr Nick Moberly** **Chief Executive** **King's College Hospital** **Denmark Hill** **Brixton** **London SE5 9RS** **4. Mr Simon Stevens** **Chief Executive** **NHS England** **PO Box 16738** **Redditch B97 9PT**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.

3	**INVESTIGATION and INQUEST** On 26 July 2016 I commenced an investigation into the death of Mary Muldowney, aged 57 years. The investigation concluded at the end of the inquest earlier today. I made a narrative determination, which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Ms Muldowney's medical cause of death was: 1a spontaneous subarachnoid haemorrhage (operated 20.07.16) 1b right posterior communicating artery rupture. She was admitted to East Surrey Hospital at about 10am on Wednesday, 20 July 2016 and an intracranial bleed was immediately suspected. A CT scan performed at 11.11am demonstrated subarachnoid and subdural bleeds. Transfer to a specialist neurosurgical unit was sought as a matter of urgency. However, the transfer was refused by St George's Hospital, Royal Sussex Hospital, King's College Hospital and others, on the basis that they did not have an available intensive care bed. In desperation, knowing of the neurosurgical expertise of a former colleague, one of the East Surrey Hospital doctors went out of area and rang a consultant neurosurgeon at the Royal London Hospital (RLH). Invoking the universal acceptance policy [see Wells 1996], he accepted transfer immediately, though in fact the RLH had no intensive care bed available at that time. Meanwhile, at about 1pm, Ms Muldowney woke up very briefly while intubated and interacted with her daughter. Ms Muldowney was at high risk of a re-bleed. The 2013 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) subarachnoid haemorrhage audit only recommended that sub arachnoid haemorrhages be treated within 48 hours. However, I heard evidence that this lady was obtunded, she was under anaesthetic, and her ruptured aneurysm was complicated by a sub dural haemorrhage, so she needed surgery immediately, regardless of whether there was an intensive care bed currently available at the same hospital. Ms Muldowney was transferred to the RLH and taken straight to theatre at 4.40pm. Unfortunately, her pupils had become fixed and dilated in the ambulance during transfer to the RLH and surgery did not save her. If she had been transferred promptly, it probably would have.

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. In the light of the gravity of Ms Muldowney's situation, with the only definitive treatment being surgery, she required immediate transfer to a specialist neurosurgical unit, yet she was refused transfer by at least three hospitals who said they had no intensive care beds. She could have been transferred, undergone surgery, spent time in recovery, and then an intensive care bed procured, perhaps even by transferring out a non neurosurgical patient. If such a bed was still unavailable, she could then have been transferred to a different hospital, at least having undergone the time critical clot evacuation and aneurysm clipping. With prompt transfer and surgery, Ms Muldowney would probably have survived.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 6 February 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 following.

	• HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • Professor Dame Sally Davies, Chief Medical Officer for England • Mr Michael Wilson, Chief Executive of Surrey & Sussex Healthcare • [redacted] Chief Medical Officer of Barts & The London • [redacted], consultant neurosurgeon, RLH • [redacted] son & daughter of Mary Muldowney 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 08.12.16