REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Professor Marcel Levi, Chief Executive, University College London Hospitals NHS Foundation Trust (UCLH), 235 Euston Road, London, NW1 2BU
1	**CORONER** I am R Brittain, Assistant Coroner for Inner London North.
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** Nuala Seddon died on 7 April 2016, from the consequences of hypoxic brain injury which resulted from an episode of cardiac arrest on 27 November 2014. A pre-inquest review hearing was held in August 2016 and the inquest into Mrs Seddon's death was concluded on 3 February 2017. I recorded a narrative conclusion, which is attached.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Seddon was admitted to Whittington Hospital in November 2014 with a recurrence of a left-sided pneumothorax. She was transferred to UCLH's Heart Hospital (a hospital which has now been transferred to Bart's NHS Trust). The intention was for her to undergo a procedure to treat the air leak which had caused the pneumothorax and also address the risk of future recurrence. Unfortunately the procedure was unsuccessful and resulted in tracking of air under the skin ('surgical emphysema') and a further pneumothorax on the right-hand side. Mrs Seddon was admitted to ITU at the Heart Hospital and improved to a certain extent. On 27 November 2014 the initial decision, after the morning ward round, was for her to remain under the care of ITU. However, between 4-5pm that day it is clear that she was discharged to ward-based care. The rationale for this discharge is unclear as no documentation was available to explain the change in plan. The potential was raised by the ITU consultant that discharge resulted from a non-clinical manager's decision because of pressure on bed spaces. There was no evidence this was the case and ultimately the clinicians who gave evidence at the inquest were satisfied that the decision to discharge Mrs Seddon to the ward was reasonable. After arriving on the ward Mrs Seddon had observations performed which warranted a review by ITU outreach nurses (as was planned in any event). They were satisfied that the trend of these observations was in keeping with Mrs Seddon's known history. However, the nursing plan was for increased observation, to include attempting to institute telemetry and moving Mrs Seddon to a bed which was more visible from the nursing station. No

	telemetry was available and, before the plans for moving beds could be undertaken, Mrs Seddon was found to be unresponsive and in cardiac arrest. She was successfully resuscitated but the period of cardiac arrest resulted in hypoxic brain injury. I heard evidence that the level of monitoring undertaken on the ward more than minimally contributed to the development of the brain injury. Despite transfer to ITU, initially at the Heart Hospital and subsequently at the Whittington Hospital Mrs Seddon's condition did not substantially improve. Plans were put in place for transfer for neurorehabilitation but she developed a terminal episode of pneumonia which, despite treatment with intravenous antibiotics, resulted in her death on 7 April 2016. At the pre-inquest review hearing in August 2016 I requested a statement from the ITU consultant involved in the discharge decision on 27 November 2014 and from the nursing staff involved in monitoring Mrs Seddon after discharge from ITU on this day. The deadline for receipt of these reports was in October 2016. A comprehensive and helpful statement was received from the Consultant a few days before this inquest resumed on 1 February 2017. At this point no evidence was available from the ward nursing staff. Thankfully I was able to conclude the inquest on 3 February 2016 after the attendance of the ward nurse was secured through contact with her by UCLH on 2 February. I heard evidence that this was the first time she had been made aware of the inquest into Mrs Seddon's death and that she had not provided any input or statements for any internal investigation into the circumstances of Mrs Seddon's arrest and subsequent death.
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 may 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) It seems clear that a decision was made to transfer Mrs Seddon from ITU on 27 November 2014. There remains the potential that this decision was made by non-clinical staff. The lack of documentation regarding this significant decision is concerning and leaves open the possibility that future discharges could be based on non-clinical need or inappropriate decision-making which is not subsequently able to be scrutinised because of a lack of documentation. (2) The lack of both telemetry and direct nursing visualisation raises a concern that patients who are discharged from the highest level of clinical care on ITU are then exposed to significant risk of unrecognised deterioration, owing to a lack of appropriate monitoring. This potentially remains the case even though the Heart Hospital has now transferred to be part of Barts NHS Trust, as the hospital at Westmoreland Street still operates as part of UCLH. (3) The ward nurse who was caring for Mrs Seddon at the point of her arrest was not involved in any debrief or significant event investigation. This raises a concern that there was a lack of appropriate investigation into Mrs Seddon's arrest. Future deaths could occur if the hospital Trust is not able to identify and address patient safety issues because of this failure to investigate appropriately.
6	**ACTION COULD BE TAKEN** In my opinion action could be taken to prevent future deaths and I believe that the addressee, 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 3 April 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, Mrs Seddon's family, Barts NHS Trust and the Care Quality Commission. 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	**6 February 2017**  **Assistant Coroner R Brittain**