REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sheffield Teaching Hospitals Trust**
1	**CORONER** Christopher Peter Dorries, senior 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 (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 23rd November 2015 I commenced an investigation into the death of Terence Millington (aged 82). The investigation concluded at the end of the inquest on 7th November 2016. The (narrative) conclusion of the inquest was that: *Mr Terence Millington died at Weston Park Hospital Sheffield on the 18th November 2015, primarily in consequence of his severe lung disease although this was not expected to take his life at that moment. His persistent epistaxis through the early morning of 18th November was the trigger for the physiological failure that led to his death and as such was a significant cause of death whilst not leading to exsanguination.*
4	**CIRCUMSTANCES OF THE DEATH** Mr Millington was admitted to Weston Park Hospital on 12th November 2015 with severe back pain related to metastatic cancer. He also suffered from significant pre-existing respiratory disease. Early on 18th November Mr Millington suffered a nose bleed which was dealt with. Unfortunately he then suffered a second bleed which was again dealt with although with more difficulty. However a subsequent (third) bleed proved more intractable and Mr Millington suffered a cardiac arrest. As noted in the narrative conclusion (see above) the persistent epistaxis was found to be the trigger for the physiological failure leading to death. The doctor who had attended Mr Millington during that night was an SHO with some (albeit limited) ENT experience. He had previously placed an anterior nasal pack but never a posterior pack. As the situation progressed this doctor made efforts to escalate Mr Millington's care to the ENT SpR on call without success. A Trust investigation was told that the doctor slept through the ring tone of her mobile phone despite repeated calls. The SHO then made contact (without difficulty) with the on-call consultant who gave telephone advice. This doctor told the court that he lived in Retford. At the time of the final bleed there was further discussion between SHO and consultant at which time the junior doctor wanted physical assistance -- but in fairness Mr Millington deteriorated and arrested so quickly that even a doctor resident in the hospital complex may not have

	reached him in time. The inquest also noted that whilst one of the two packs requested by the SHO arrived from the Royal Hallamshire site, the other one was wrong and thus could not be used.
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. It is acknowledged that an incident investigation was undertaken by the Trust at my invitation during the inquest which sets out steps to be taken to prevent a repetition of the contact issue. Nonetheless I believe this report remains necessary so that lessons might be learnt beyond the Sheffield Teaching Hospitals Trust. The **MATTERS OF CONCERN** are as follows: – • That an on-call senior doctor (the SpR) did not make satisfactory arrangements to ensure that she would waken if telephoned. • That the next on-call (the consultant) would have had no opportunity to attend promptly because of the distance from his home. The AA website shows that from the centre of Retford to Weston Park would take over 50 minutes although it is accepted that the consultant may live on the Sheffield side of Retford. For clarity, it is acknowledged that the consultant would not have had time to attend in this case (from when the request was actually made) even if living much closer. • That the request for two packs was not met correctly.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 April 2017. I may extend this period upon request. 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. Again the Investigation Report is noted and your reply will no doubt make reference to this
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to Mr Millington's family. I have also sent a copy to the Care Quality Commission who may wish to disseminate the issues further. 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	**2nd March 2017** **CP Dorries**