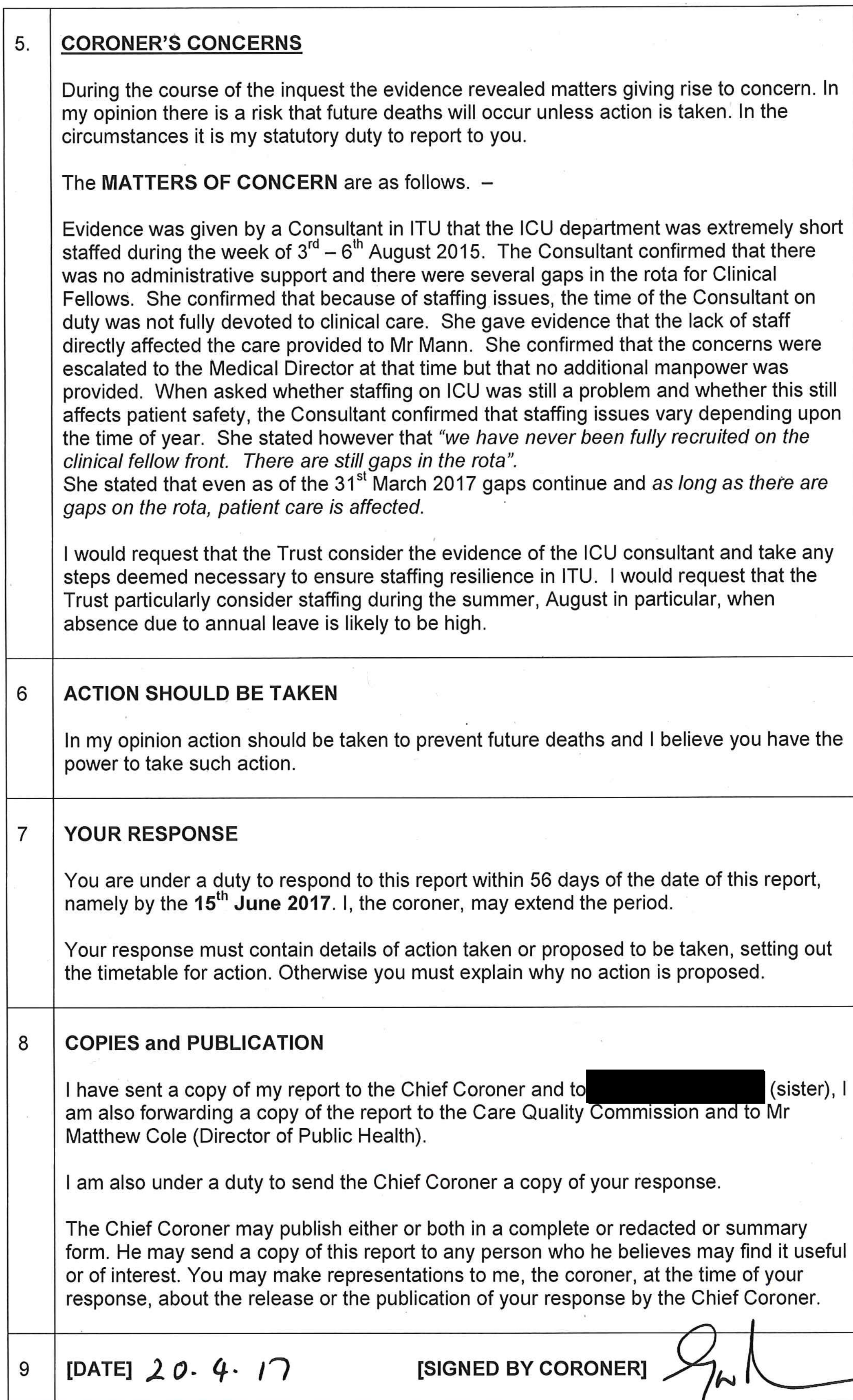
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Alwen Williams, Chief Executive, Barts Health, Royal London Hospital, Whitechapel Road, Whitechapel, London, E1 1BB**
1	**CORONER** I am Nadia Persaud, Senior Coroner for the area of Eastern Area 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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 3rd August 2016, I commenced an investigation into the death of Mr Errol Mann. The investigation concluded at the end of the Inquest on the 19th April 2017, the conclusion of the Inquest was a narrative conclusion: *Mr Errol Mann was admitted to hospital on the 2nd August 2015. During the course of his admission he was at high risk of developing a pulmonary embolism. He exhibited clinical signs of multiple small emboli. Despite this, arrangements were not put in place to investigate/exclude a pulmonary embolism or steps taken to ensure that consistent VTE prophylaxis was provided. Mr Mann died on the 7th August 2015 from a pulmonary embolism. The failure to investigate this condition and to ensure consistent prophylactic treatment, contributed to his death.*
4	**CIRCUMSTANCES OF THE DEATH** Mr Mann was admitted to Newham University Hospital in the evening of 2nd August 2015. The differential diagnosis upon presentation included hyperosmolar non-ketotic hyperglycaemia (HHS); sepsis of unknown cause and pulmonary embolism. The A & E team provided a treatment dose of Clexane and recommended, amongst other things, a D Dimer and CTPA. Mr Mann was admitted to ITU in the early hours of the 3rd August 2015. Steps were not taken to progress the investigation for a PE. An assumption was made in ITU that a PE had been excluded by CTPA, but no checks were made to confirm this. Mr Mann did improve clinically from the HHS perspective, but he had ongoing respiratory requirements. An expert witness gave evidence at the Inquest that the clinical presentation in ICU on the 5th and 6th August 2015 was indicative of Mr Mann suffering multiple small pulmonary emboli. Mr Mann was at a high risk of developing a PE. Mr Mann was discharged from ITU on the 6th August 2015. His respiratory condition deteriorated significantly shortly after discharge from ITU. The medical team on the ward diagnosed a pulmonary embolism and a treatment dose of Tinzaparin was administered. In the early hours of the 7th August 2015 Mr Mann suffered a fatal pulmonary embolism and died at Newham University Hospital at 05:30 am. A post-mortem examination confirmed a cause of death of 1a pulmonary embolism 1b right DVT.



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. –

Evidence was given by a Consultant in ITU that the ICU department was extremely short staffed during the week of 3rd – 6th August 2015. The Consultant confirmed that there was no administrative support and there were several gaps in the rota for Clinical Fellows. She confirmed that because of staffing issues, the time of the Consultant on duty was not fully devoted to clinical care. She gave evidence that the lack of staff directly affected the care provided to Mr Mann. She confirmed that the concerns were escalated to the Medical Director at that time but that no additional manpower was provided. When asked whether staffing on ICU was still a problem and whether this still affects patient safety, the Consultant confirmed that staffing issues vary depending upon the time of year. She stated however that *"we have never been fully recruited on the clinical fellow front. There are still gaps in the rota".*
She stated that even as of the 31st March 2017 gaps continue and *as long as there are gaps on the rota, patient care is affected.*

I would request that the Trust consider the evidence of the ICU consultant and take any steps deemed necessary to ensure staffing resilience in ITU. I would request that the Trust particularly consider staffing during the summer, August in particular, when absence due to annual leave is likely to be high.

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 the **15th June 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 [redacted] (sister), I am also forwarding a copy of the report to the Care Quality Commission and to Mr Matthew Cole (Director of Public Health).

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 **[DATE]** 20. 4. 17 **[SIGNED BY CORONER]** [signature]