for PRESTON AND WEST LANCASHIRE

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Medical Dir Lancashire Teaching Hospitals NHS Trust**
1	**CORONER** I am Dr James Adeley, Her Majesty's Coroner for PRESTON AND WEST LANCASHIRE
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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 4 April 2017 I commenced an investigation into the death of Michael John NEWELL aged 70. The investigation concluded at the end of the inquest on 11 April 2017. The conclusion of the inquest was as set out in the attached summing up on the last page.
4	**CIRCUMSTANCES OF THE DEATH** The full circumstances of the death set out in chronological order together with a summary of the expert evidence is attached in my summing up. The Trust already has a complete copy set of the medical records and particular reference should be paid to the clinical entries made whilst Michael Newell was on the Neurosurgical ward on 4-5 May 2014, the fluid prescription charts, the fluid balance charts and the TPR chart.
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. – (1) the Accident & Emergency staff, neurosurgeons and ENT surgeons of various grades were unaware of the substantial effect that Mr Newell's decompensated liver failure would have on his clinical course and subsequent management. No input was sought from any medical team to assist in the management prior to Mr Newell's first collapse at 11:14 AM on 5 May 2014. This lack of awareness raises significant concerns about the knowledge base of Accident & Emergency and surgical junior staff of the significant effect of substantial underlying hepatic compromise may have on any form of admission with some form of haemorrhage. As a result, the family were completely unaware of the significance of Mr Newell's admission due to the lack of awareness by attending clinicians. (2) the junior ENT surgeons and neurosurgeons showed a startling lack of knowledge of the early signs of hypovolaemia and, if any did realise, made no attempt to treat Mr Newell adequately. Whilst this PFD report is primarily sent with regard to the death of Mr Newell, this has been a feature over a number of years of other cases where hypovolaemia was not appropriately diagnosed and late resuscitation ensued. (3) there was a worrying lack by the ENT surgeons to realise the complexity of the case due to the ongoing haemorrhage, decompensated liver failure and associated coagulopathy, that there

	were no base of skull fractures and to select a method of treatment with Rapid Rhino Pack's that in the view of the ENT expert was only appropriate as a first-line measure and not for facial fractures. Firstly, there was no consultant ENT input into Mr Newell's case at any point prior to his death. Secondly, none of the above issues were brought to the attention of the Court in the ENT consultant's statement raising issues within the Trust for improving patient care. (4) the Trust's ENT team made no input into the mortality review prior to it reaching its conclusions. Alternatively, the mortality review team made no request for ENT input prior to reaching its conclusions. Either formulation reduces the effectiveness of the mortality review. (5) the conduct of the Nurse in charge of the ward of making no notes after her presence at a peri-arrest, neither seeking or obtaining any direction from the medical team as to future management, not directing any further resuscitation in accordance with documented medical plans in the notes and lack of completion of the fluid balance chart would suggest that the Trust's procedures for determining which nurse clinicians may lead a nursing shift should be reviewed.
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 **(DATE)**. 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 Family. 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	Dated 13/04/2017 Signature _____ for PRESTON AND WEST LANCASHIRE