ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Calderdale Royal Hospital**
1	**CORONER** I am Mary Burke, Assistant Coroner, for the Coroner area of West Yorkshire Western
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 December 2014, I commenced an investigation into the death of June Elsie Parkes aged 68 years. Date of birth 13.06.1946. The investigation concluded at the end of the inquest on 27th January 2016, The conclusion of the inquest was that June Elsie Parkes died at 02.00 hours on 17 December 2014 at Huddersfield Royal Infirmary, shortly after transfer from Calderdale Royal Hospital, as a result of a massive upper gastrointestinal haemorrhage caused by a bleeding duodenal ulcer. Mrs Parkes initially became unwell on the morning of 14 December 2014 and was reviewed by an out of hours general practitioner. At the time she was not admitted to hospital. It is likely that if she had been and treated she would not have died at 02.00 hours on 17 December 2014. She was admitted to Calderdale Royal Hospital shortly before midnight on 14 December 2014 due to a further deterioration in her condition. She was subsequently diagnosed with a non-bleeding deep duodenal ulcer. If Mrs Parkes had been transferred to Huddersfield Royal Infirmary for ongoing investigations and treatment on or before the afternoon of 16 December 2014, it is likely that her death at 02.00 hours on 17 December 2014 would have been avoided.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Parkes became unwell at home on Sunday 14th December 2014 and was admitted to Calderdale Royal Hospital shortly before midnight with a history that day of being clammy, suffering abdominal pain, passing dark stools and low blood pressure. Immediately before admission she had suffered a sudden collapse, followed by 2 episodes of vomiting dark fluid with the appearance of fresh blood present. Upon admission she was found to be unstable and in a state of clinical shock. A working diagnosis of an upper gastro intestinal bleed was made. Resuscitation treatment was implemented with the plan that if Mrs Parkes condition stabilised, she would undergo an urgent endoscopy. Her condition did improve and a written request was hand delivered to the endoscopy department for an urgent endoscopy to be performed.

Subsequently at 9.00am her condition deteriorated. Mrs Parkes was reviewed by a critical care outreach sister who considered that Mrs Parkes required an emergency endoscopy and she should be transferred to Huddersfield Royal Infirmary. Mrs Parkes was subsequently reviewed by a consultant who thought transfer may result in a delay in the endoscopy being performed, and received reassurances that Mrs Parkes would be placed first on the afternoon list to undergo an endoscopy.
I heard evidence at the inquest that at Calderdale Royal Hospital, endoscopies are performed in either a morning or afternoon list, Monday to Friday, with urgent or emergency endoscopies fitted in where possible. This was dependant on, and subject to, appropriately qualified staff being available and that such staff that were qualified did not have a "ring fenced" list, which would mean no urgent or emergency endoscopies could be added to their list.
I was advised that staff suitably qualified on the morning of the 15th December did have a ring fenced list. Although, this didn't appear to be communicated to Mrs Parkes consultant.

I also heard evidence that there was no facility to undertake out of hours endoscopies, or at weekends or, surgical intervention for upper gastro intestinal bleeds at Calderdale Royal Hospital. Patients would require to be transferred to Huddersfield Royal Infirmary for these procedures.

In addition, in the afternoon of the 15th December, bloods had not been ordered by her treating clinicians which were required before Mrs Parkes transfer for endoscopy.

Mrs Parkes underwent her endoscopy at 16.45 hrs, she found it very difficult to tolerate. No active bleeding site was identified, but it was noted that she had a deep ulcer with evidence of previous bleeding. The Endoscopist was unable to proceed further with the examination. She recommended medication and that in the event of a further bleed Mrs Parkes should undergo further examination under deep sedation, or, a CT angiography. Both of which would require to be undertaken at Huddersfield Royal Infirmary.

At 22.00 hrs that evening Mrs Parkes suffered an episode of melaena. No doctor was requested to review Mrs Parkes. Mrs Parkes observations were not checked or monitored. The next observations were undertaken at 8.00am the following morning, now 16th December. The following morning Mrs Parkes was reviewed in a consultant led ward round, no blood tests were requested.

Mrs Parkes experienced a further episode of melaena at 2.30 that afternoon. Shortly afterwards Mrs Parkes was reviewed by a critical care outreach sister who requested blood tests and senior doctor review.

Blood test results reviewed by a senior house officer, two hours later revealed reduced haemoglobin levels

These were verbally discussed with a consultant, who recommended that Mrs Parkes should receive a further blood transfusion, and that if there was any further deterioration in Mrs Parkes condition overnight, she should undergo an emergency endoscopy. Otherwise, she should undergo an endoscopy the following morning. No arrangements were put in place for Mrs Parkes transfer to Huddersfield Royal Infirmary.

Mrs Parkes vital signs remained stable throughout this period.
At 20.30 Mrs Parkes became dizzy. Her condition rapidly deteriorated. She had a recordable blood pressure; she passed significant amounts of melaena and vomited fresh blood. Mrs Parkes was reviewed and supported by a number of doctors and nurses, including an intensive care consultant, who gave evidence that he expected that Mrs Parkes to be transferred at 23.00 hours although she was still gravely ill . However, at the inquest it was difficult to establish the precise sequence of events, and it was not possible to establish why Mrs Parkes was not transferred to Huddersfield Royal Infirmary until 1.25 hrs now the 17th December.

	Mrs Parkes was transferred by ambulance with a nurse in attendance. Mrs Parkes arrived at Huddersfield Royal Infirmary at 1.45 hours and transferred to the surgical assessment unit. She was immediately assessed and sadly found to be unresponsive and her death was confirmed a short time later.
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) I would first wish to confirm that many of the points which I raise below were identified within the serious incident and complaint report. However, no action plan was presented to me and I therefore consider it appropriate to undertake this report and to raise a number of additional matters A. The provision and systems in place to identify and undertake urgent or emergency endoscopies at Calderdale royal hospital "in hours" i) From the details set out in section 4, there appears to have been various issues which resulted in a significant length of time elapsing between Mrs Parkes being identified as requiring an urgent endoscopy, and it actually being carried out, which didn't reflect the timescale recommended within current NICE guidance. ii) The present protocol gives guidance for patients that present with a suspected upper GI bleed out of hours but does not provide guidance for "in hours" iii). the present protocol does not provide guidance to identify a patient who may have suffered a rebleed post endoscopy and what measures should be considered (2) There is no provision at Calderdale Royal Hospital to undertake urgent or emergency endoscopies "out of hours", if a patient is deemed to require such procedure and transfer to Huddersfield Royal Infirmary is required. In light of no facility to undertake out of hours endoscopies, a number of doctors who gave evidence at the inquest, stated that present protocol guidance results in patients often being transferred in a critical condition, and there appeared to be a generalised view that if such facilities were not available 24 hours a day, the time to transfer such patients was when a further rebleed was suspected and whilst the patient remained stable (3) There is presently no provision at Calderdale Royal Hospital to undertake urgent/ emergency surgery if deemed necessary, for patients with upper GI bleeds at Calderdale Royal Hospital "out of hours" . The comments made in the final paragraph of B also applies to this point. (4) Nursing staff compliance with the news system both in respect of accurately scoring each of the various vital signs, and recognising and implementing any escalation measures that are recommended . (5) Record keeping of nursing staff (6) Record keeping of doctors

	(7) The criteria for when a doctor should be present during ambulance transfer between Calderdale Royal Hospital and Huddersfield Royal Infirmary of a critically ill patient
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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, . 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 following Interested Persons [redacted] 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	**23rd March 2016** **Mary T Burke** **HM Assistant Coroner**