REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Ms J Fowler, Chief Nurse, Thames Valley Area Team, NHS England.**
1	**CORONER** I am Nicholas Gardiner, assistant coroner, for the coroner area of Oxfordshire.
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 19 October 2012 I commenced an investigation into the death of John Cook aged 73. The investigation concluded at the end of the inquest on 29 May 2014. A copy of the Record of Inquest is attached. It will be seen that I returned a conclusion that He Died of Natural Causes. The Cause of Death was given by [redacted] Hunt at Inquest as: **1 a** Coronary Artery Thrombosis (and underlying Myocardial Fibrosis) **b** Coronary Artery Atherosclerosis **c** **2** Bilateral Pneumonia and Severe Cerebrovascular Disease
4	**CIRCUMSTANCES OF THE DEATH** This 73 year old man was discharged from the John Radcliffe Hospital on 28 September 2012, and was receiving palliative care at The Manor Nursing Home, Bicester. He had been admitted to the John Radcliffe Hospital on 24 September 2012, with reduced responsiveness, a productive cough and reduced oral intake. The diagnosis was dehydration and hypernatremia. Active co-morbidities were noted to be vascular dementia, previous Cerebrovascular Accident together with sadly being bed bound and doubly incontinent. On 6 October 2012, Mr Cook was being cared for by staff at The Manor Nursing Home, when it was observed that Mr Cook was experiencing great difficulty in breathing and was deteriorating rapidly. Upon arrival of ambulance personnel, they discovered that Mr Cook was exhibiting Cheyne-Stokes respiration. At that time he was thought not to be for resuscitation, it was believed that a 'Do Not Attempt Resuscitation' (DNA CPR) form had been signed whilst in the John Radcliffe Hospital on 24 September 2012, the date of his admission. The ambulance personnel were asked to perform CPR on the instructions of the deceased's son. They did not comply with his wishes and Mr Cook was verified dead at 1820 on 6 October 2012 by [redacted] the Thames Valley Police Medical Examiner. Subsequently it was found that the DNA CPR notice had expired on Mr Cook's discharge from hospital on 28 September.
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) My concerns relate to the DNA CPR form coloured lilac. It is inevitable that queries will occasionally arise as to the validity of the form and related matters and by their very nature these are likely to be urgent. Although this particular Case Consultant who issued the form was reasonably clear there was no indication to which hospital or institution he worked for. It would be convenient if the name of the hospital were incorporated in the form, with a telephone number. (2) Under Section 3 headed Review there is "Decision valid to date of discharge from hospital". I understand that this is an unusual form of wording. Normally an expiry date would be specified which seems to me to be good practice, however, once an expiry date has been reached and if there is no renewal, it seems to me that to avoid confusion, it would be better if the form were retrieved and clearly marked 'Cancelled', 'Expired' or some similar wording. In this particular case, given the wording used on the form, I think it should never have left the hospital. In this particular case, there was failure to read and/ or understand the wording used and those attending recluded that the fall-back position was not to attempt resuscitation when the opposite was the correct interpretation. The difficulties were compounded by the quality of English spoken by some concerned but this is not uncommon and should be allowed for. Having said this, I am satisfied that these failures of communication did not affect the outcome and that any attempt at resuscitation would have been quite futile. It did however mean that an Inquest which should have been unnecessary had to be conducted, there was an unnecessary Police investigation and, of course, consequent distress to the family.	
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. I may extend the period on 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.	
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the Interested Persons. 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, at the time of your response, about the release or the publication of your response by the Chief Coroner.	
9	**Signed**  **Assistant Coroner for Oxfordshire**	**Dated** **9 June 2014**