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:** The Chief Executive, Insure and Go, 2nd Floor, Maitland House, Warrior Street, Southend-on-Sea SS1 2JY
1	**CORONER** I am Timothy W Brennand, HM Assistant Coroner for the Coroner Area of Manchester 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 the 2nd of June 2017 an investigation into the death of Ruth Thompson, aged 60 years was commenced. The investigation concluded at the end of the inquest on the 6th October 2017. The medical cause of death was:- Ia Dissecting Aortic Aneurysm and its treatment There was a narrative conclusion that Ruth Thompson died as a consequence of naturally occurring disease exacerbated by recognised complications of necessary surgical intervention and the effects of resulting prolonged immobility.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a history of a cerebrovascular accident in 2006. On the 14th April 2017 whilst on holiday in Italy the deceased collapsed and was admitted to Ospedale Monaldi, Naples via initial assessment at a hospital in Sorrento and there diagnosed as having suffered a dissecting aortic aneurysm. Her condition was actively treated with surgical intervention in the form of grafting of the aortic valve, aortic root and ascending aorta. The surgical "Bentall" procedure was completed without complication. The recovery of the deceased was then impaired by her then sustaining a pontine brain infarction and she underwent percutaneous tracheostomy and required hemofiltration for acute kidney failure. Following prolonged hospitalisation and conservative management of her condition, the deceased was diagnosed as having developed tissue breakdown and pressure sores whilst in hospital in Italy by reason of prolonged immobility. Despite ongoing active treatment, care and management the condition of the deceased was noted to deteriorate around the 25th May 2017 and by the 30th May 2017 she was recognised to be entering end of life phase, receiving

	palliative medication until her death on the 31st May 2017.
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. Whilst the family and next of kin accepted that medical discharge from the Ospedale Monaldi and a decision for transfer was made on an assumption that the deceased was medically fit for transfer, the evidence revealed that:- a. In fact, the deceased died within 16 days of her repatriation having survived post operatively for over a month in hospital in Italy; b. The assurances that the transfer team could speak English and communicate with the deceased were not met as in fact, the deceased was accompanied by a German clinician with limited English compounding an inadequate and insufficient handover to clinicians in the United Kingdom; c. No proper or informed consent was obtained for the transfer as the evidence suggested that very little information as to the condition and care plan for the deceased had been communicated to the family; 2. On her transfer to the United Kingdom, clinicians within the Accident & Emergency Department at the Royal Bolton Hospital were only supplied with two A4 sheets of information from the Italian hospital, written in Italian which required the doctors to use "Google Translate" in an attempt to interpret that document. The documentation was inadequate and not fit for purpose in that it failed to note or provide basic handover information including:- a. Operative details; b. Intensive care treatment and observations; c. Ongoing prescribed medication; d. Recent blood test results; e. Identification of investigative procedures and their results; f. Treatment and care plan following discharge; 3. Accordingly, the issue of the adequacy of communication of vital information to the deceased, her next of kin and treating clinicians in the United Kingdom following air ambulance transfer from abroad created delay and uncertainty in treatment and care.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that 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 Thursday 7 December 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 the following Interested Persons:- 1 [redacted] (next of kin), [redacted] 2 [redacted], Dean of the Faculty of Intensive Care Medicine and The Intensive Care Society 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** **12th October 2017**	**Signed** **Timothy W Brennand** **HM Assistant Coroner**