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:** **Acting Chief Executive** **Blackpool Teaching Hospitals NHS Foundation Trust** Blackpool Victoria Hospital Whinney Heys Rd Blackpool
1	**CORONER** I am Alan Wilson, Senior Coroner, for the area of Blackpool & Fylde
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** **The death of Mr Keith James Harwood was reported to me on 4th January 2017. An investigation was commenced and in due course an inquest held at the Town Hall, Blackpool on 10th & 11th January 2018.** **The medical cause of death was recorded as follows:** 1a **sepsis due to sub-phrenic abscess and bronchopneumonia** b **necrosis around PEG tube feeding site** c **cerebral atrophy due to hypoxic brain injury following aortic valve replacement** **The inquest concluded by way of a Narrative conclusion as follows:** **Diagnosed with Parkinson's disease in 2000 Keith Harwood underwent elective cardiac surgery on 23rd July 2014. Nine days post - operatively he went into cardiac arrest whilst being treated on ward 38 (Blackpool Victoria Hospital) on 2nd August 2014. A re-sternotomy procedure was performed on the ward but it was later confirmed that he had suffered a significant hypoxic brain injury the impact of which was he remained in a persistent vegetative state. Nourishment was thereafter provided by a PEG tube. In August 2016 he was referred for a review of the PEG (Percutaneous endoscopic gastrostomy) tube site. The site was regularly reviewed over subsequent months. In October 2016 Buried Bumper Syndrome was confirmed. At a time when consideration was being given as to how to address this syndrome he was admitted to hospital on 17th December 2016 with a suspected pneumonia. Whilst in hospital his condition deteriorated and he died on 29th December 2016. A subsequent post mortem examination identified that he died as a result of the combined effects of bronchopneumonia and of a sub-phrenic abscess which had developed during the week prior to his death.**

4	**CIRCUMSTANCES OF THE DEATH** In addition to the Narrative conclusion above please note the following: The Deceased had suffered with Parkinson's disease for approximately 16 years by the time he was admitted for elective cardiac surgery in July 2014. At the inquest the court heard evidence how his Wife – by now extremely knowledgeable about her Husband's condition and its treatment - had been asked to attend pre-theatre to advise the treating team about the management of his Parkinson's medication. Post – surgery there was some confusion about the administration of his medication, and when some days later he began to demonstrate extreme bouts of dyskinesia this was not recognised by medical staff and [redacted] needed to explain his symptoms to them. When Mr Harwood then suffered a cardiac arrest and resultant hypoxic brain damage his family expressed the view that his cardiac arrest was connected to those earlier bouts of dyskinesia which in turn were connected to the earlier confusion about how his Parkinson's medication had been administered. As it transpired, such a causative connection was not accepted by cardiac experts instructed by the court and the hospital Trust. Nevertheless, it was clear that prior to, during and after his cardiac surgery the medical team had not fully appreciated the potential significance of his Parkinson's disease and that it may have been necessary to seek specialist input and advice both prior to and potentially throughout his admission. (Some limited training of staff had taken place as regards the use of a Apomorphine pump). Indeed the hospital Trust's own Sudden Untoward Incident Review [April 2015] recognised this to some extent commenting as follows: • There was late involvement of the community Parkinson's team. • The severity of his Parkinson's disease was not fully appreciated at the pre-admission clinic • There was no neurology input post –operatively. That review recognised the need for improved preparation and communication prior to hospital admission in respect of a patient's complex medical needs. The review acknowledged that the potential significance of Mr Harwood's condition had not been fully recognised. All Consultants and cardio thoracic staff were therefore informed of the need to notify the Clinical Matron in the event that it became apparent at a pre-admission clinic that someone with complex needs may be about to be admitted to hospital. Further, the Trust introduced a policy document specific to the acute management of inpatients with Parkinson's disease and the need for early involvement of the "Parkinson's specialist team" but unfortunately it remains unclear as to what the Parkinson's specialist team is comprised of , the level of assistance that team may be able to provide, and from where and how quickly neurology input may be obtained and I therefore felt that despite the introduction of this policy, the Trust's response to the events surrounding Mr Harwood's hospital admission in the summer of 2014 has not eradicated the risks of future deaths. For example, the inquest received some evidence about that policy document during the course of the inquest from one of the co-authors of the Sudden Untoward Incident Review, I was left far from convinced that hospital personnel have been equipped with the knowledge and the information to know who to contact and how to source the necessary assistance in the event that a patient with complex needs should attend the hospital for surgery in the future, be it Parkinson's disease or some other complex illness and particularly in the event that specialist advice needs to be sourced from a different location. At the Blackpool Teaching Hospitals NHS Foundation Trust there is no specialist neurological input available on site. It was unclear at the inquest from where such neurology input would be sourced if required.

	Further, the need for such advice may arise relatively quickly if the need for such advice has not been appreciated fully at the pre-admission stage because (as a consultant from the hospital Trust in Blackpool informed the court) the Trust does perform a large number of procedures on the day of admission. Mr Harwood's cardiac surgery was carried out on the same day as his admission. This was an issue commented upon by an independent cardiac surgeon who felt that "Mr Harwood was quite a complex patient who underwent relatively major cardiac surgery. His complex medical problems with his Parkinson's disease did not make him the ideal candidate for same day admission." That this may allow little time for medical staff to source any expertise from elsewhere prior to surgical procedures taking place adds to the need for greater clarity about where to go for advice if dealing with a patient who's condition is complex and unfamiliar to the medical professionals dealing with the patient.
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: When giving consideration to writing a report to prevent future deaths Coroners are not limited to deaths which are felt to have been contributed to by the issue causing the Coroner some concern. As stated above the expert opinion received at the inquest and accepted by the court was that a connection between Mr Harwood's Parkinson's disease and his cardiac arrest could not be established. However, I have concerns that despite the introduction of a Trust policy, the evidence heard at this inquest suggests that medical professionals may find themselves in a position whereby, as with events surrounding Mr Harwood's care, they are faced with an unfamiliar condition and without being able to source the requisite (possibly urgent) specialist advice. The co-author of the SUI review was unsure about what assistance would be available particularly in relation to neurology input. I remain therefore concerned that a family such as Mr Harwood's may find themselves being asked to educate medical staff about the potential implications of a certain condition.. At the conclusion of the inquest, I indicated to the Properly Interested Persons that I proposed to write to the Trust by way of a report in accordance with the provisions of paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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,

	namely by 13th March 2018. 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: Harwood family Lancashire Teaching Hospitals NHS Foundation Trust 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	A.A.Wilson **Alan Wilson** **Senior Coroner for Blackpool & The Fylde** **Dated: 16th January 2018**