ANDREW JAMES COX
Assistant Coroner for Plymouth Torbay and South Devon

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Dr P Hughes
Medical Director Plymouth Hospitals NHS Trust Derriford Plymouth PL6 8DH

1 **CORONER**

I am ANDREW JAMES COX, Assistant Coroner for Plymouth Torbay and South Devon

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 29 July 2014 I commenced an investigation into the death of Barry Gordon Pike. . The investigation is due to conclude with an Inquest that has been listed to be heard on 12 October 2015. The medical cause of death from the Post Mortem Report is:
1 (a) Hypoxic Encephalopathy;
1 (b) Acute Cardiac Failure;
1 (c) Coronary Artery Atheroma

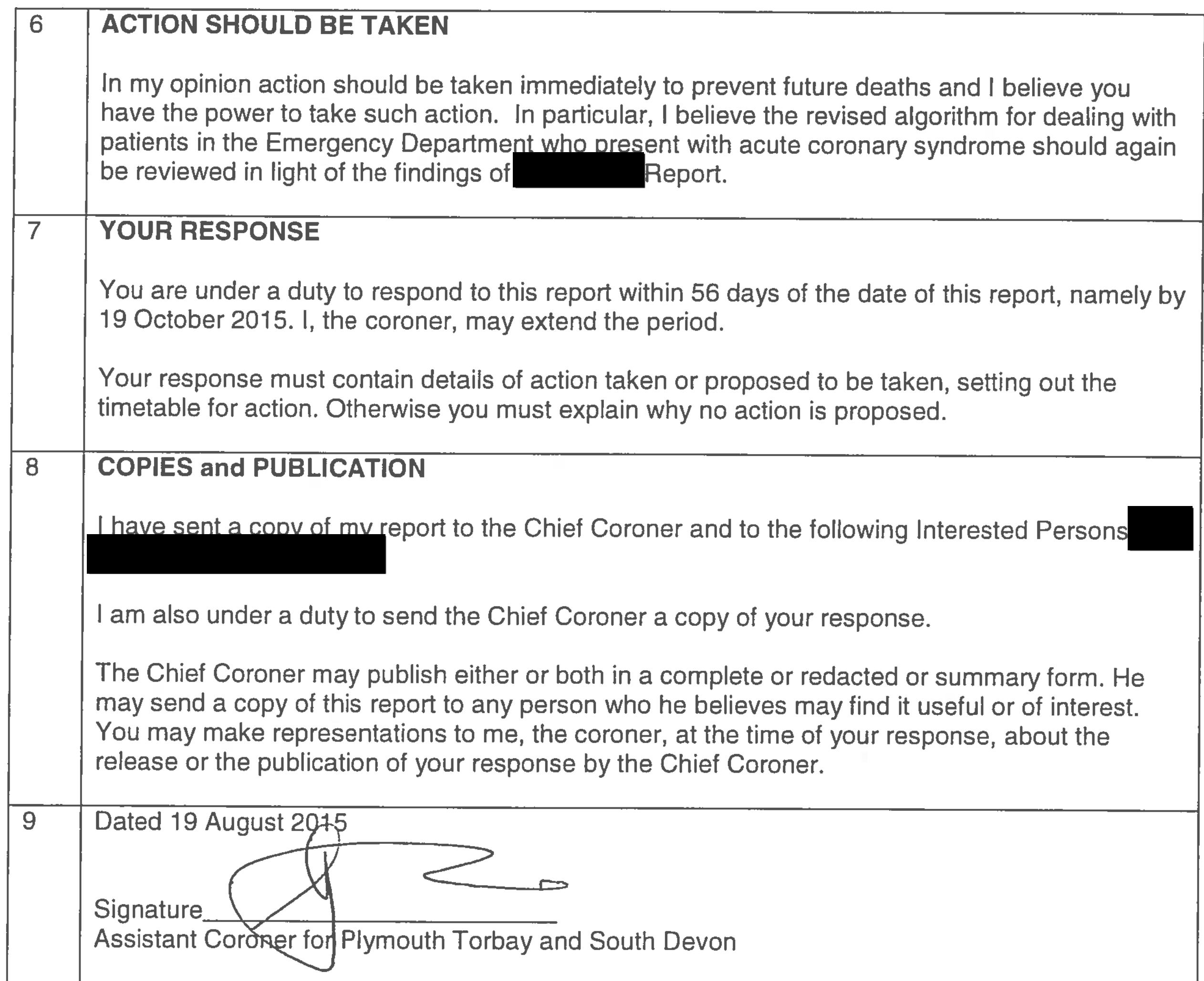
4 **CIRCUMSTANCES OF THE DEATH**
Mr Pike was 57 years of age. He was seen in the Emergency Department of Derriford Hospital on 2 July 2014 complaining of chest pains. He was triaged and then reviewed by a Junior who felt that Mr Pike was suffering from reflux. It is not clear from the evidence whether Mr Pike was the subject ofa Senior review, but in any event, he was discharged from Hospital later that afternoon.
It appears as though the results of blood sent for testing at the time of Mr Pike's initial triage had not been reviewed. This revealed a raised Troponin level.
Mr Pike died suddenly 10 days later.
Mr Pike's death has been reviewed in a Root Cause Analysis Investigation Report. That reveals a number of care and service delivery problems. Included in the Root Cause Analysis is that the Emergency Department Acute Coronary Sydrome Algorithm recommended patients with intermediate risk of major acute coronary event to be discharged for GP follow up.
Subsequent to this incident that algorithm has been reviewed.

As part of the Inquest process, the revised algorithm has been considered by an independent expert, A copy of his Report is enclosed. Of concern is that believes the revised algorithm is not an improvement on the original document and still requires further clarity and detail to avoid confusion and mismanagement of acute coronary syndrome patients admitted to Derriford A & E Department

5 **CORONER'S CONCERNS**

The **MATTERS OF CONCERN** are as follows. –

[BRIEF SUMMARY OF MATTERS OF CONCERN]
(1) These are set out within the enclosed Report of Dr Stephen Hoole..
(2)
(3)



6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken immediately to prevent future deaths and I believe you have the power to take such action. In particular, I believe the revised algorithm for dealing with patients in the Emergency Department who present with acute coronary syndrome should again be reviewed in light of the findings of [redacted] Report.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 19 October 2015. 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	Dated 19 August 2015 Signature__________________________ Assistant Coroner for Plymouth Torbay and South Devon