## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>[redacted]<br>**Managing Director**<br>**Select Healthcare**<br>**Wellington House**<br>**120 Wellington Road**<br>**Dudley, West Midlands**<br>**DY1 1UB** |
| 1 | **CORONER**<br><br>I am YVONNE BLAKE, area coroner, for the coroner area of NORFOLK |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 5 July 2019, I commenced an investigation into the death of Jake Edmund Lee aged 35 years, the investigation concluded at the end of the inquest on 21 February 2020. The conclusion of the inquest was narrative stating that Mr Lee had not had prophylactic heparin since his arrival at rehab and that staff did not commence CPR when he collapsed. He died from 1a) Pulmonary Embolism 1b) Infarction of Spinal Cord. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Lee suffered an infarct of his spinal cord resulting in loss of feeling and immobility below the waist. Whilst in hospital he was given daily heparin, when he was discharged to a rehab unit this was discontinued. The day before his death a prescription for heparin was written. When Mr Lee collapsed, the trained nurse in charge asked an HCA to call 999 which he did. The nurse did not flatten the bed to put Mr Lee into the recovery position, **she did not know that his bed had a special device on it to enable CPR, despite having worked at the unit for 4 years.** She then left an unresponsive patient in the care of an unqualified person to make another call to 999. She did not accept that she should have stayed, she displayed no indication in her evidence that she knew what to do in the event of an emergency and she panicked. A friend of Mr Lee (a paramedic) stated that this nurse had said "I'm too old to do CPR". This was disputed by the nurse who said Mr Lee was still breathing (agonal) but snoring and he was too heavy for her to move to the floor. When paramedics arrived, they described Mr Lee as cyanotic and not breathing. There was a delay of some time in emergency treatment being begun. The nurse appeared in evidence as being unused or untrained in CPR and displayed a marked reluctance to stay and attend to Mr Lee as the only trained nurse on duty. In this instance, any intervention by her is unlikely to have been successful but I believe that if any other emergencies occur whilst she is on duty the same situation will occur and another patient may have a collapse which is reversible. |

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| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) Inability, lack of training/experience of nurse in charge to deal with an arrest/collapse of a patient. Clear panic in the face of an emergency.<br>(2) Nurse leaving collapsed patient in care of untrained HCA whilst she made an unnecessary second phone call, she denied that there was a phone she could have used in his room.<br>(3) Her lack of knowledge about the special bed which Mr Lee had, which allowed CPR on the bed and her stating that she put Mr Lee into the recovery position when he was semi recumbent, she did not flatten the bed and she did not do a mouth sweep to see if his airway was occluded by his tongue. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation has the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 20 April 2020. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br><br>[redacted] – Wife<br>[redacted] – Friend<br><br>I have also sent it to:<br><br>The Nursing and Midwifery Council (Fitness to practice)<br>Care Quality Commission<br>Healthwatch Norfolk<br>who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **24 February 2020**<br><br>.....<br>**Area Coroner, Yvonne Blake**<br>**Norfolk Coroner Service**<br>**Carrow House, 301 King Street**<br>**Norwich, NR1 2TN** |