	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Amanda Pritchard Acting Chief Executive, St Thomas' Hospital Westminster bridge Road, London SE1 7EH
1	**CORONER** I am Rachel Redman Senior Coroner, for the Coroner Area of Central and South East Kent.
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 5th February I commenced an Investigation into the death of Kevin John Gilbert. The Investigation concluded at the end of the Inquest on 2nd December 2015. The conclusion of the Inquest was that Kevin John Gilbert died as a result of natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Mr Gilbert suffered an aortic root dissection in the morning of 29.01.15 which was diagnosed provisionally on his symptoms and then by confirmatory aortogram soon after arrival at the Accident and Emergency Department at William Harvey Hospital by [redacted], Consultant in Accident and Emergency Medicine. Mr Gilbert was stabilised and considered to be a suitable patient for transfer to St Thomas' Hospital for repair of the dissection because of his age (49 years) and lack of relevant previous medical history (mild asthma only). [redacted] spoke to [redacted], on call SpR in Cardiothoracic surgery at St Thomas' Hospital at just after 12.45pm who advised that he would need to see the radiology images before he could accept Mr Gilbert as a patient. [redacted] had already asked the Radiology Department to send them to St Thomas' Hospital but it wasn't until 3.40pm that Dr Cummings confirmed to [redacted] that he had received them and that Mr Gilbert could be transferred. During the previous 3 hours, [redacted] called Mr Cummings several times to stress the urgency of the situation and the critical condition of his patient. At one point, he sought to escalate his request and asked to speak to Mr Cummings' Consultant, Mr Avlonitis, to be told that he was in surgery and unavailable. Mr Gilbert left William Harvey Hospital shortly after 3.40pm in an ambulance for the road journey to St Thomas' Hospital. At 3.54pm he returned to William Harvey Hospital as he had arrested shortly after departure. All attempts were made to resuscitate him including pericardiocentesis and resuscitative thoracotomy but without success. His death was confirmed at 4.25pm. The cause of Mr Gilbert's death was:- 1a Acute haemopericardium 1b Aortic dissection.

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:- • There appeared to be confusion on the part of as to the standing protocols at St Thomas' Hospital concerning transfer of patients with a diagnosis of aortic dissection. • Given that Mr Gilbert was presenting at William Harvey Hospital as an acute emergency requiring specialist surgery at a tertiary centre and that his diagnosis of suspicion made on presenting clinical symptoms by a Consultant in Accident and Emergency medicine which was confirmed by CT scan, it was not reasonable for to rely on his understanding of the procedure of accepting such patients and wait for the CT imagery before agreeing that he could be transferred. • It was not reasonable to decline request for the decision to accept Mr Gilbert to be escalated to a Consultant on the basis that was in theatre and unable to talk to • I heard evidence from my independent expert in Cardiothoracic Surgery, that had Mr Gilbert been transferred to St Thomas' Hospital without delay he may have been in a position to undergo lifesaving surgery. Whilst his blood pressure was low during the 3 hour wait, he was self-ventilating and did not arrest until shortly after 3.40pm. Had he arrested at St Thomas' Hospital, the facilities there to perform emergency surgery were more specialist and suitable than at William Harvey Hospital. Mr Gilbert's chances of survival would have been greater had the delay in accepting him for transfer been avoided.
6	**ACTION SHOULD BE TAKEN** • That all clinicians at St Thomas' Hospital who are involved in decisions to accept the transfer of patients to their hospital are familiar with its procedures. on 30.01.15 expressing his concern that the delay in Mr Gilbert's transfer may have contributed to his death and suggesting that alternative methods to the image transfer system eg telemedicine or a similar direct patient review system are implemented. This prompted an e mail from o all Registrars in the Cardiothoracic Surgery department dated 24th February 2015 referring to the possibility of confusion on their part regarding the process of accepting dissection referrals. He confirmed that such referrals must be discussed immediately with the on-call Consultant and that there is no departmental policy to transfer the CT scan for viewing before a decision for patient transfer is made. If it is necessary to view the CT imagery in the first place, that decision should only be made by a Consultant. • Consultant Cardiothoracic Surgeon gave evidence in absence at the Inquest and confirmed that a Consultant must be informed by his junior staff of the request for emergency admission. • Whilst it appeared that an e mail had been circulated to the Registrars by after Mr Gilbert's death, and receipt of letter I request that all appropriate action is taken to ensure that junior clinical

	staff are aware of the requirement that such emergencies requiring admission are discussed in the first instance with the Consultant. If it is deemed within your hospital that an e mail to this effect is sufficient, then it would seem that appropriate action has already been taken by the hospital.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 15th February 2016 (this dated has been adjusted to take into account the Christmas holiday period). 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:- Care Quality Commission 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	**SIGNED:** Rachel Redman **Rachel Redman** **Senior Coroner** **14 December 2015**