	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Professo[redacted] President ENT UK, 35-43 Lincoln's Inn Fields, London, WC2A 3PE [redacted] President Royal College Anaesthetists, Churchill House, 35 Red Lion Square, London WC1R 4SG
1	**CORONER** I am Philip Barlow, Assistant Coroner for Greater London (Inner South)
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 5 March 2014 I commenced an investigation into the death of Ololade Olaobaju. The investigation concluded at the end of the inquest on 27 November 2015. The conclusion of the inquest was: Natural Causes to which unsuccessful medical attempts at intubation contributed.
4	**CIRCUMSTANCES OF THE DEATH** On 26 February 2014 Ms Olaobaju was treated at University Hospital Lewisham for progressive respiratory failure after developing community acquired pneumonia. She was transferred to the ICU where a decision was taken to intubate for mechanical ventilation. Attempts at intubation, needle cricothyroidotomy and "Quicktrack" were unsuccessful. During an attempt at establishing surgical tracheostomy by an ENT surgeon, Ms Olaobaju suffered a cardiac arrest from which she could not be resuscitated. The medical cause of death was: 1a respiratory failure 1b Acute Lung Injury 1c Community Acquired Pneumonia 2 Recent third trimester delivery with uterine infection causing on-going vaginal bleeding.

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) For the purposes of the inquest I received an expert report from Dr Andrew Hartle. Reference was also made to the Difficult Airway Society Guidelines 2004 and 2015. The DAS guidelines suggest that, for an anaesthetist, an appropriate progression would be to undertake surgical (scalpel) cricothyroidotomy after unsuccessful cannula cricothyroidotomy. In this case, an ENT surgeon (clinical fellow grade) arrived and took over before scalpel cricothyroidotomy was attempted. The ENT surgeon decided to attempt tracheostomy rather than scalpel cricothyroidotomy. The benefit of tracheostomy is that it would have provided a more permanent airway. The evidence was that this is an unusual situation and that the experience of all the witnesses was therefore limited in performing emergency cricothyroidotomy and emergency tracheostomy. I concluded that the decision as to whether to opt for tracheostomy or scalpel cricothyroidotomy was a clinical judgment made in the light of the circumstances at the time. However, this was rapidly deteriorating situation and the ENT surgeon accepted that scalpel cricothyroidotomy may have been a simpler procedure. This became a "Can't Intubate Can't Oxygenate" situation in which both anaesthetists and ENT surgeons were present. My understanding is that the DAS guidelines are provided for anaesthetists. Different considerations may apply to ENT surgeons. The question as to the preferred mode of front of neck access in this situation therefore appears not to be covered by the existing guidelines. Individual practitioners faced with such a situation are likely to have limited experience. My understanding is that there is currently no joint guidance to cover this type of situation when both anaesthetists and ENT surgeons are present. I appreciate that this is an uncommon situation in a specialist area and I understand that you may consider it necessary to forward this report to, for example, the Difficult Airway Society.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 27 November 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: Mr David Oluwole (Ms Olaobaju's partner, represented by Sarah Harman of Scott Moncrieff solicitors) and Catherine Wood (Lewisham and Greenwich NHST). I have also sent it to Dr Andrew Hartle who may find it useful or of interest. 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 10 December 2015 Signature_____ Assistant Coroner for Greater London (Inner South)