	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sheffield Teaching Hospitals NHS Foundation Trust**
1	**CORONER** I am Abigail Combes, assistant coroner, for the coroner area of South Yorkshire (West District)
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 30 April 2019 I commenced an investigation into the death of Brian Rochell born on 27 April 1944. The investigation concluded at the end of the inquest on 7 June 2021. The conclusion of the inquest was:- Brian was admitted to hospital on 10 April 2019 for a surgical procedure related to a cancer of the tongue. This followed a previous cancer cured through radiotherapy. This is relevant because it had altered Brian's oral and throat physiology. The surgery noted a difficult airway and a concerning vessel preventing tracheostomy. The surgery was successful, and Brian was sent to Critical Care for recovery. He acquired an infection which was successfully treated, and a decision was made to extubate him on 21 April 2019. This decision was made without adequate risk assessment and was inappropriate in the circumstances. Brian deteriorated in the hour following his extubation and clinicians were unable to intubate or oxygenate Brian resulting in a hypoxic brain injury. He died as a result of this on 26 April 2019 at the Royal Hallamshire Hospital.
4	**CIRCUMSTANCES OF THE DEATH** On 10 April 2019, Brian was admitted to hospital for a surgical procedure following the diagnosis of cancer of the tongue. He was ineligible for a radiological treatment approach because of previous cancer and therefore required a surgical approach. This surgery was also reconstructive in nature in an effort to enhance his quality of life. As the surgery commenced it was clear that the procedure was going to be complicated by an unusual throat anatomy including a vessel across the trachea that meant a tracheostomy would not be possible. He was operated on using a nasal intubation tube and was sent to intensive care to recover with this in place. In mid-April, Brian developed a ventilator associated pneumonia which required the changing of the nasal tube to an oral one. This was a complex procedure undertaken by a senior member of staff. He documented in the record how the procedure was undertaken which was ultimately successful, but it was not something which was straightforward, and the relevant consultant described himself as anxious undertaking the procedure. He had undertaken some discussions with relevant surgeons prior to the change and had a colleague on standby should they be required during the procedure. Ultimately the procedure was a success, and he was recovering from this procedure and the infection. He was seen on several occasions and described as weak and remained unwell. He did appear to make a significant improvement on 20 or 21 April 2019.

	However, this was Easter weekend and therefore was a bank holiday on the Friday, Sunday and Monday. This is relevant because it meant that staffing levels were lower than during the week. On 21 April 2019 a decision was made to try to extubate Brian because he appeared well. This was against a plan which was that no attempt was to be made to extubate Brian before the 23 April 2019. The extubation was unsuccessful and resulted in Brian suffering a hypoxic brain injury and ultimately dying on 26 April 2019. I made the following findings at the conclusion of the evidence:- 1. The decision not to provide Brian with a tracheostomy at the start of the surgery was appropriate on the balance of probabilities. 2. The way in which Brian's VAP infection was managed, including the changing of the tube on 15 April 2019 was appropriate on the balance of probabilities. 3. Following this there was a plan to consider extubating Brian after the Easter weekend (23 April 2019) and that included, where needed, consideration of a surgical tracheostomy. 4. The decision to extubate Brian on 21 April 2019 was done without adequate risk assessment and with inappropriate weight placed on factors supporting a decision to extubate Brian on that day. 5. Insufficient weight was placed on concerns raised by clinicians caring for Brian about the plan to extubate him on 21 April 2019. 6. Attempts made to reintubate Brian on 21 April 2019 were done without a clear and adequate plan in place and staff were unclear what their role was in that. Whilst ultimately, I do not believe, on the balance of probabilities, that this would have altered the outcome, there is a possibility that this led to additional delay and Brian being deprived of oxygen for longer than if there had been a clear articulated plan in place.
5	**CORONER'S CONCERNS** During the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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) I heard that there were concerns about individual practice in this case and that the result of that was an informal conversation with the relevant professional body and agreed steps being taken to moderate practice until the conclusion of the inquest. Where there are concerns about the professional capabilities and practices of a particular individual these should be addressed with the relevant professional body at the earliest opportunity by the employer. There may be cases where there will not be a coroner's investigation and the purpose of a coroner's investigation is not to assess the competence of professionals but rather to investigate the circumstances of the death. This means that where practice should be reviewed by professional bodies, failure to make appropriate referrals in a timely fashion could place other patients at risk in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action. I would ask that your responses specifically consider the following:-

	1. What is the standard procedure for making referrals to professional bodies in cases causing concern? 2. Is that process affected by coroner's proceedings or other proceedings and if so how and why?
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1 September 2021. 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 Rochell's family, the Sheffield Teaching Hospitals NHS Foundations Trust. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. In this case I have sent a copy of this report to the General Medical Council. 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.
9	**7th July 2021**  Abigail Combes **Assistant Coroner**