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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**The Chief Executive of the East Kent Hospitals University NHS Trust** |
| 1 | **CORONER**<br><br>I am Kate Thomas Assistant Coroner, for the Coroner's Area of North East Kent |
| 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 the 19th May 2021 the Senior Coroner commenced an investigation into the death of Christopher George Osland. The investigation concluded at the end of the inquest before a Jury on the 22md February 2022. The conclusion was narrative verdict. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>On the 30th March 2021, Mr Osland was admitted in to Kent and Canterbury Hospital following an Ischaemic Stroke. He suffered a further Cardiac Arrest on the 1st April 2021 and was transferred to ITU were he made neurological improvement. He still required ventilator support but was subject to weaning programme whereby he breathed without assistance for period of 3 hours at a time.<br><br>On the 26th April 2021, during hand over and within a timeframe of no more than 10 minutes, Mr Osland became increasingly hypoxic, the exact cause of which could not be ascertained, but which lead to Cardiorespiratory Arrest and catastrophic Ischaemic Brain injury.<br><br>Although he benefitted from a fixed monitoring system within his room (hereinafter referred to as the 'room monitor'), the alarm volume had been decreased to a point where the nurses sat outside his room were not alerted to events.<br><br>Furthermore, the fixed monitor in Mr Osland's room had become 'OFF COMS on the 19th April 2021 from the Central Monitor at the Nurses station, (hereinafter referred to as the 'central monitor'), and therefore no alert was sounded and nurses stood at that station similarly were unaware on Mr Osland's distress.<br><br>The evidence at the inquest was that not all nurses knew that the sound level of alarms on room monitors could be reduced and so did not check alarm volume when coming on shift.<br><br>It was also determined that whilst the central monitor would sound an alert when a room monitor went 'OFF COMS, once this alarm was silenced, it was not the case that the |

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| | room monitor would in itself reconnect to the central monitor, although the screen on the central monitor would continue to display that there was no connection.<br><br>There was no evidence at Inquest that once the 'OFF COMS' alarm had been silenced, presumably on the 19th April 2021, any steps had been taken to ensure the room monitor and central monitor were reconnected.<br><br>The evidence at the Inquest was the subject to the room monitor being disconnected to the central monitor, both units were working correctly.<br><br>Mr Osland did not regain consciousness and died on the 12th May 2021 after the withdrawal of clinical support. The medical cause of death was<br><br>1a) Hypoxic Ischaemic Encepalopathy<br><br>1b) Prolonged Hypoxia leading to Cardiorespiratory arrest<br><br>1c) Extensive left Cerebellar Infact involving left Hemi Medulla secondary to left Vertebral Artery dissesecton<br><br>II Hypertension, Hypercholesterolemia |
| 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) Nursing staff are unaware that the room monitor volume could be reduced to the point where it was not audible outside the room – as a result, the volume of the room alarm was not part of hand over equipment checks.<br>2) The circumstances in which the room monitor alerts were reduced were not documented, and accordingly subsequent staff would not be aware that they had been so reduced<br>3) After silencing the 'OFF COMS' alert on the central monitor, no steps were taken to ensure it was reconnected to the room monitor.<br>4) No steps had been taken to respond to the 'OFF COMS' notification on the central monitor screen which had persisted for the 5 days prior to the 26th April 2021<br>5) Specifically in respect of points 3 & 4, it is unclear as to when the 'OFF COMS' disconnection between the room and central monitor would have been rectified had it not come to light after Mr Osland's arrest.<br>6) It was unclear what steps nurses were supposed to take when confronted with an 'OFF COMS' alert or screen notification. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>1. 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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by **6th April 2022**. 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] ( Son )<br>• [redacted] ( Wife )<br>• Quality Care Commission<br>• NHS England and Improvement ( Wellington House 133- 135 Waterloo Road, London SE1 8UG)<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 | **KATE THOMAS, Assistant North East Kent.**<br>**22nd February 2022** |