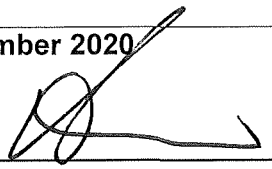
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Medical Director, Derriford Hospital, Derriford, Plymouth, PL6 8DH**
1	**CORONER** I am Ian Michael Arrow, Senior Coroner for Plymouth Torbay and South Devon
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** **An Inquest into the death of Paul Vincent Reynolds (dob: 22 September 1965) was opened on 7 January 2020 and heard on 18 September 2020.** **The Coroner recorded the following NARRATIVE verdict** **The deceased suffered from learning difficulties and comorbidities which made him vulnerable.** **He presented to hospital with a swollen hand. One finger became necrotic and required amputation.** **A decision was made on initial information to carry out surgery on the finger under general anaesthetic.** **The Deceased's full hospital notes were not available and the deceased had limited discussion with medical staff.** **The incomplete appreciation and understanding of the patients underlying medical condition led to an inappropriate choice of monitoring and anaesthetic.** **The deceased suffered a loss of blood pressure and then had a hypoxic period following administration of general anaesthetic.** **He deteriorated and died from the hypoxic event on 31 December 2019 at Derriford Hospital.**
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered a hypoxic period following administration of a general anaesthetic.
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. A Root Cause Analysis by an Independent Anaesthetist found:- **Root Cause** There was an incomplete appreciation and understanding of the patients underlying medical condition which led to an incorrect choice of monitoring and anaesthetic. The unavailability of the full patient record meant that the anaesthetic team were reliant on the patient history and the admission clerking record to assess the patient. **Lessons Learned** The full set of patient medical records must be obtained as soon as possible following admission particularly when a procedure involving anaesthesia is planned. The safe conduct of anaesthesia is reliant on being fully conversant with the patient's pre-existing medical conditions and patients should not be anaesthetised before the medical records have been obtained and reviewed. **Recommendations** 1. Medical records must be obtained as soon as possible following admission to the ward by a ward clerk. 2. The ward administration team must check daily that all medical records are available or have been requested and an expected time-frame for the medical records to be available. 3. If adequate patient records are not available, the patient should not go to theatre unless it is a life or limb threatening emergency.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you as Medical Director of the relevant Trust have the power to take such action. Please confirm the recommendations of the Root Cause Analysis have been implemented.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 November 2020. 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:- The family. 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 21 September 2020** **Signature**  **I M ARROW**