REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Chief Executive - Barts Health NHS Trust**
1	**CORONER** I am R Brittain, Assistant Coroner for Inner North London
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** The investigation into the death of Bertha CRAY, aged 84, was commenced on 4 January 2013 and concluded at the end of the inquest on 22 January 2014. The conclusion of the inquest was narrative (Copy attached).
4	**CIRCUMSTANCES OF THE DEATH** Bertha CRAY underwent an upper-gastrointestinal endoscopy on 11 December 2012 at Newham General Hospital. During this procedure her oesophagus was perforated. She was subsequently transferred to The Royal London Hospital where conservative (non-surgical) management was initially undertaken. She was placed 'nil by mouth' in order to allow the perforation to heal. On 15th December the 'nil by mouth' sign was noted to have been changed to a sign which indicated that she could take 'sips' of water. A jug of water had therefore been provided by the kitchen staff. At the inquest there was conflicting evidence regarding how the sign came to be changed. Evidence from the nursing staff was that the sign was double-sided (comprising 'nil by mouth' on one side and 'sips' on the other) and had inadvertently been turned. The family were clear that the signs were single-sided, of different colours and could not have been inadvertently changed. There was also conflicting evidence as to whether Mrs Cray did ingest any water; the nursing staff provided evidence that she had not taken any sips, whilst the family were clear that she had. Evidence from the treating surgeon indicated that ingestion of a small volume of water is unlikely to have significantly contributed to Mrs Cray's death. An incident form was completed but did not demonstrate that any action had been taken as a consequence of the investigation. Mrs Cray subsequently deteriorated and, despite surgical intervention, died on 29 December 2012 from bronchopneumonia, which resulted from the perforation and surgical treatment.

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) On the account provided by the nursing staff, it is possible that inadvertent alteration of 'nil by mouth' signage could occur in the future, due to the apparent ease with which a double-sided sign can be turned and lack of action taken as a consequence of this clinical incident. (2) On the account provided by the family, the 'nil by mouth' sign was replaced by some other means. The cause of this alteration is unclear, owing to the focus of the incident form being the 'double-sided' account, provided by the nursing staff. As such, it is possible that there could be a recurrence of this incident, as the cause has not been elucidated.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of the Trust, 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 21 March 2014. 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, Mrs Cray's family and The 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	**24 January 2014** **Assistant Coroner R Brittain**