VERONICA HAMILTON-DEELEY, LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove

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CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Mr. Matthew Kershaw, Chief Executive, Brighton & Sussex University Hospitals, Royal Sussex County Hospital, Eastern Road, Brighton** 2. **Dr. [REDACTED] Principal Lead Clinician in Emergency Medicine, Brighton & Sussex University Hospitals, Royal Sussex County Hospital, Eastern Road, Brighton** 3. **Dr. [REDACTED] Chief of Safety & Quality Brighton & Sussex University Hospitals, Royal Sussex County Hospital, Eastern Road, Brighton** 4. **[REDACTED] AMU, Brighton & Sussex University Hospitals, Royal Sussex County Hospital, Eastern Road, Brighton**
1.	**CORONER** I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove
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 **21st August 2013** I commenced an investigation into the death of **Herta Edith Maria WOODS.** The investigation concluded at the end of the inquest on 26th November 2013.The conclusion of the inquest was a **Narrative Conclusion**:- **MRS. WOODS died when, following an accidental fall at home, she became dehydrated and was found to have developed rhabdomyolysis both of which impacted acutely on her chronic renal failure. She was taken to hospital where her care (and the recording of her care) was suboptimal.** **She was overloaded with fluid and was found deceased in her hospital bed very early on the 8th August 2013.**

4.	**CIRCUMSTANCES OF THE DEATH** She lived alone with Carers attending upon her. She was a 94-year old lady. There was evidence that she had been becoming considerably more confused in the weeks immediately preceding her death. On the 6th August, 2013 she was found by her carers having fallen, an ambulance was called; she was cold, had a laceration to her left elbow. The ambulance did a urine dip and this was positive for urinary tract infection. The GP visited bringing with him antibiotics. There was no apparent injury from this fall. The next day, at 09:00 in the morning, Mrs. Woods was once again found by Carers; this time at the bottom of her stairs, lying face-down. She seemed to have fallen some eight stairs and was complaining of neck pain and general discomfort. There was a deep wound to her right calf and to her forehead, above her right eye, and pain and bruising to her right shoulder and a skin flap to her right elbow and multiple bruising. She had likely been there for some hours. She was cold, and she was taken to hospital. In A & E, observations were taken and x-rays were arranged. She was in atrial fibrillation. She arrived in hospital at 11:20 hours and was eventually admitted to the Acute Medical Unit at 17:00 hours. Although she had the lacerations and bruising described, a CT head scan had not shown any brain injury. She did have some Pulmonary Emboli which were not of any great significance. She had not passed any urine. She was suffering from Rhabdomyolysis as a result of the fall, and she was Hypothermic. She also had an element of renal impairment and she had passed no urine. This lady was given fluid resuscitation intravenously and she was also given some intravenous Paracetamol for pain. She was written up for Oramorph, which was never given. This lady's hospital notes are extremely poor, untimed, frequently incomplete and whilst it was not thought that the poor note-keeping was contributory to her death, it certainly reflects the quality of care with which she was provided. The Fluid Balance Charts, in particular, are not written up correctly and the National Early Warning Scoring System, which is an extremely important way of deciding whether a patient's care needs escalating to at least Outreach Critical Care involvement, was not adhered to. In addition, there are no Nursing Notes from 20:30 hours; there is no recording of the fact that a Doctor was asked to see her to monitor her urine output. She eventually arrived at the AMU at 21:30 hours in the evening and the AMU documentation sheets are completely blank. The only note for AMU is at 01:18 hours on the 8th August 2013 when the Doctor arrives and records that he has been told by the Nurses that Mrs. Wood had died less than an hour earlier.
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) The apparent abandoment of this lady in AMU. (2) The failure to record the timing and reason for the Doctor's visit (the reason was only illicited from evidence). (3) The failure to seek an early Senior Review for the failure to record the Fluid Chart correctly - this is important because it was fluid overload that was the immediate cause of Mrs. Wood's death. Her cause of death being: 1. (a) Acute cardiac failure. (b) Fluid overload following administration of intravenous fluid. (c) Acute renal failure due to dehydration and rhabdomyolysis.

	(d) Fall downstairs resulting in minor physical injuries. 2. Hypertensive heart disease and hypertensive chronic kidney disease. (4) Failure to act on the NEWS score and create a plan for Mrs. Woods and assist her. This lady was very likely near the end of her life. However, from the evidence that I heard, it was clear that she would not have died when she did had she been given appropriate care and treatment. (5) Failure to canulate her appropriately. Her cannula had initially been inserted by the ambulance crew; this tissued and needed to be replaced. The requirements concerning cannulation of patients are strict. They were not adhered to in Mrs. Wood's case. This should have been dealt with in A & E.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND your organisation 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 **23rd April 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 and to the following Interested Persons 1. [REDACTED] 2. [REDACTED] I have also sent it to:- 3. Secretary of State for Health, Department of Health 4. Sir David Nicholson / Simon Stevens – Chief Executive NHS England 5. National Patient Safety Agency 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.	**Date: 26th February, 2014.** **SIGNED BY:** V Hamilton-Deeley **Senior Coroner Brighton and Hove**