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. Chief Executive** **Southmead Hospital**
1	**CORONER** I am Maria Voisin, Senior Coroner, for the Area of Avon
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 15th April 2014 I commenced an investigation into the death of **Peter DORNEY** , Aged **64**. The investigation concluded at the end of the inquest on 14th November 2014. The conclusion of the inquest was a narrative which read as follows Peter Dorney had a complex medical history. He was in hospital and unwell. Overnight on the 3rd/4th April 2014 he deteriorated; increased observations were not carried out and a senior member of staff was not notified as they should have been; this resulted in the lost opportunity to render medical care and treatment. He died on 4th April due to bronchopneumonia The medical cause of death was recorded as: Ia Bronchopneumonia II Alcoholic liver disease
4	**CIRCUMSTANCES OF THE DEATH** Peter Dorney was admitted into Frenchay Hospital on 29th March, during his admission it was clear that he was not a well man. During the ward round on 3rd April there was no evidence at that time of a chest infection. Overnight on 3rd/4th April the nurse caring for Peter Dorney said that at 22:00 hours his EWS score was 2 due to his low oxygen saturations. This score of 2 should have resulted in her informing the nurse in charge and increasing his observations to hourly. In evidence she said that it was her intention to do both of these things and that she should have but she didn't. When Peter Dorney's observations were carried out at 07:40 hours on 4th April he was now very unwell and his EWS was 5. Appropriate action was then taken however later that day he suffered a cardiac arrest and died.
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. – During the evidence the ward sister gave evidence and she was of the opinion that there should be mandatory training on EWS for nurses. It was clear in the evidence that the protocol in relation to the EWS score was not followed and I was told that the EWS training was not mandatory currently. This case highlights why EWS scores are so

	important to the well-being of patients
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by 14th January 2015. 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 of Mr. Dorney. 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	**17th November 2014** **M. E. Voisin**