REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Peter Morris, Chief Executive, Barts Health, Royal London Hospital, Whitechapel Road, Whitechapel, London, E1 1BB**
1	**CORONER** I am Nadia Persaud, senior coroner for the coroner area of Eastern District of Greater 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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 30th December 2013, I commenced an investigation into the death of Mrs Awa Jeng. The investigation concluded at the end of the inquest on 12th January 2015. The conclusion of the inquest was a narrative conclusion: *Mrs Jeng was admitted to Newham General Hospital on the 18th December 2013 following a fall at home. She underwent a left hip hemiarthroplasty which proceeded uneventfully. She was due for dialysis on the 19th December 2013, but due to the very recent surgery she was unable to be transferred out for dialysis treatment at the allotted time. A failure thereafter to appropriately monitor her on the ward and a consequent delay in commencing hemofiltration, contributed to her death.*
4	**CIRCUMSTANCES OF THE DEATH** 1. Mrs Awa Jeng was admitted to Newham General Hospital in the early hours of the 18th December 2013 following a fall at her home. She sustained a fracture of the left hip and underwent a necessary surgical procedure during the day on the 18th December 2013. She appeared to recover well from the surgical procedure. 2. Mrs Jeng suffered from a number of medical comorbidities including hypertension, Addison's disease, chronic asthma, type II diabetes and end stage renal failure. She required dialysis three times a week and would attend on a Tuesday, Thursday and Saturday at Whipps Cross Hospital for her treatment. 3. She underwent dialysis at Whipps Cross Hospital on Tuesday the 17th December 2013. Her next dialysis treatment was required whilst she was an inpatient at Newham General Hospital. As she had very recently undergone orthopaedic surgery (hemiarthroplasty) she was not able to be transferred out of the hospital for dialysis. The only option for renal replacement therapy was treatment on the intensive care unit at Newham General Hospital, if her clinical condition required this. 4. She was assessed by the ITU consultant who requested that the ward team

observe her for signs of fluid overload, pulmonary oedema, hyperkalaemia or acidemia. This would have required clinical examinations by the medial staff, frequent nursing observations and a repeat of the arterial blood gases. Following this advice by the ITU consultant, there was no further medical review on the 19 December, there were very infrequent nursing observations and the arterial blood gas was not obtained or requested.

5. The following morning at 09.05, the arterial blood gas was repeated and her potassium level was noted to be at a life threatening level. Her general presentation has also significantly deteriorated.

6. Mrs Jeng was transferred to the intensive care unit after midday and hemofiltration commenced. Her consciousness however continued to reduce and intubation was required. During intubation she suffered a cardiac arrest from which she could not be resuscitated.

7. A post mortem examination as carried out which confirmed a cause of death of 1a. Hypertensive heart disease and end stage renal failure and II. Fracture of the left femur (operation) and asthma.

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. Mrs Jeng was at high risk of suffering life threatening acute renal failure. Her regular dialysis was due on the 19th December 2013. Bearing in mind the recent trauma and necessary surgery, an acute deterioration in her condition should have been foreseeable. In the circumstances, she required close monitoring.

2. The ITU consultant gave a clear direction to the FY2 on Tayberry Ward during the afternoon of the 19th December 2013 that the arterial blood gases should be repeated that evening and she should be checked for signs of pulmonary oedema and fluid overload.

3. The blood tests were not repeated until the following morning when they had deteriorated to a life threatening level.

4. It was not clear from the evidence why the blood tests were not repeated. The FY2 did write a retrospective note confirming that she had asked the on-call doctor to perform the test. Evidence from the on-call doctor denied that this information was passed on to her.

5. Mrs Jeng was also not monitored appropriately on the ward on the evening of 19 December. There was no medical review and insufficient nursing observations.

6. I note that the Trust's internal investigation raised concerns in relation to the handover of responsibilities and tasks between day and night shifts. There is however currently no clear action to address this concern.

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 the 17 March 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 – [redacted] and his solicitors, Your Rights Solicitors. I am also forwarding a copy of the report to the Care Quality Commission and [redacted] (Director of Public Health). 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]** 20.1.15 **[SIGNED BY CORONER]**