

for Leicester (City and South)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: Mr J Adler, Chief Executive, University Hospitals Leicester
1	CORONER
	I am Mrs Catherine Mason, Senior Coroner for Leicester (City and South)
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
	On 08/05/2014 I commenced an investigation into the death of Jane Helen Robinson, 55. The investigation concluded at the end of the inquest on 10 February 2015. The conclusion of the inquest was Natural causes. Jane Robinson was known to have alcoholic liver disease with ascites and was admitted to the Leicester Royal Infirmary on the 16th April 2014 with shortness of breath. Despite treatment she died on the 4th May 2014 at the hospital. At the time it was believed that she had died from sepsis due to spontaneous bacterial peritonitis. However, no positive evidence of sepsis was found at the post mortem examination and there was no positive microbiology in life. The cause of her death was found to be 1a) Systemic inflammatory response syndrome 1b) Decompensated hepatic failure 1c) Hepatic cirrhosis 1d) Alcoholic liver disease and hepatitis C infection. Therefore, although she was not observed in accordance with her needs, this shortfall in her care did not contribute to her death.
4	CIRCUMSTANCES OF THE DEATH Miss Robinson was known to have alcoholic liver disease with ascites and recent admissions to hospital with hepatic encephalopathy and ascites. She was then re-admitted with shortness of breath on the 16 th April 2014 and had a transjugular intra hepatic portasystemic shunt (TIPS) on the 30 th April 2014. After the TIPS procedure she developed an increased white cell count and deteriorating coagulation. It was thought that she was suffering from spontaneous bacterial peritonitis. Her condition continued to deteriorate and she died on the 4 th May 2014.
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) Basic observations repeatedly not being recorded (2) No evidence of on-going senior review on each shift whereby shortfalls in observations would be detected at an early stage (3) Lack of written decision making rational in relation to the frequency of observation (4) No evidence of any reporting system of healthcare professionals that do not practice in accordance with accepted standards and no evidence of support given to those who do report.

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 07 April 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: (sister and brother-in-law)		
	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 10 Pebruary 2015		
	Signature		



Following an investigation commenced on the 8th day of May 2014

And Inquest opened on the 17th day of November 2014;

At an inquest hearing at Leicester Coroners Court on the 10th day of February 2015 heard before Mrs. C.E. Mason Senior Coroner in the coroner's area for Leicester (City and South), the following findings and determinations were made:

1. Name of Deceased (if known

Jane Helen ROBINSON

- 2. Medical cause of death
 - a Systemic inflammatory response syndrome.
 - b Decompensated hepatic failure
 - Hepatic cirrhosis
 1d) Alcoholic liver disease and hepatitis C infection
 - 11
- 3. How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death

Jane Robinson was known to have alcoholic liver disease with ascites and was admitted to the Leicester Royal Infirmary on the 16th April 2014 with shortness of breath. Despite treatment she died on the 4th May 2014 at the hospital due to systemic inflammatory response syndrome as a natural consequence of decompensated hepatic failure resulting from cirrhosis of the liver. Clinically it was thought that she had died from sepsis but no positive evidence has been found to support this. Therefore, although she was not observed in accordance with her needs, this shortfall in her care did not contribute to her death.

4. Conclusion of the Coroner as to the death

Natural causes.

5. Further particulars required by the Births and Death Registration Act 1953 to be registered concerning the death

(a) Date and place of birth 22 November 1958	Barnsley Yorkshire
(b) Name and Surname of de Jane Helen ROBINSO	
(c) Sex Female	(d) Maiden surname of woman who has married
(e) Date and place of death Fourth May 2014	nary, Infirmary Square, Leicester