REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive of the Doncaster and Bassetlaw Hospitals NHS Foundation Trust**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 the 4th April 2014, I commenced an investigation into the death of Philip Robinson, age 42 years. The investigation concluded at the end of the inquest on 28th January 2015. The conclusion of the inquest was a Narrative: Philip Robinson died on the 26th March 2014 at Bassetlaw Hospital from an acute Myocardial Infarction. He had severe coronary artery disease. He had been discharged the previous day, with the significance of his clinical condition not appreciated by the treating team.
4	**CIRCUMSTANCES OF THE DEATH** Mr Robinson was a reasonably fit man, although he did have risk factors for the development of early Coronary Artery disease. He developed symptoms of vomiting and breathlessness over the three days prior to his death, with coughing up blood and pain in his lower back and side. Two days prior to his death he was seen at the Emergency Department at Bassetlaw Hospital. He was sent home, but asked to return that afternoon as some investigations were abnormal. He was monitored overnight on the Assessment and Treatment unit, and had an episode of breathlessness during the night. On the morning of the 25th March, the day before his death, he was seen by a Consultant, and a scan organised, to look for a pulmonary embolus. Throughout the day Mr Robinsons National Early Warning Scores rose from 1 to 3. There was no escalation for medical review. He was discharged home again, and readmitted the following day in cardiac arrest from which he could not be resuscitated. The Trust completed a Serious Untoward Incident report, produced an action plan, and submitted further statements and reports following the Inquest. All these documents went some way to addressing concerns raised in evidence, however, in my view there remain outstanding concerns that allow for the continuation of circumstances creating a risk that other deaths will occur if such matters are not addressed.
5	**<u>CORONER'S CONCERNS</u>** 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. – • The results from audits of compliance with safe discharge arrangements using a discharge stamp, including the recording of the Early Warning Score on discharge are unsatisfactory

	• The improved recording and communication of the EWS from Health Care assistant, to Nurse, to doctor as necessary, is not evident throughout the Hospital • The medical staff involved in this Inquest do not agree with the SUI author, that an ECG was indicated during Mr Robinson's admission. There are no clear guidelines to assist medical staff with this clinical decision making when a patient presents with acute breathlessness. An audit to monitor the threshold for performing an ECG has shown this is still not reliably performed when clinically indicated • The risk of there being no one available to provide senior medical review when a registrar is absent remains an 'extreme risk' • The iHospital which undoubtedly will assist in improving EWS recording, is not yet in place. Implementation is planned for June 2015, and there is potential for delay. Interim plans for a 'At a glance Board' are not clear, with confusion as to where the EWS will be recorded.
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 the 12th May 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] (Widow, and Next of Kin) 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	**13th March 2015** **Dr E A Didcock**