Regulation 28: Prevention of Future Deaths report

Margaret Emily TUCK (died 26.10.15)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Medical Officer** **Barts Health** **Royal London Hospital** **Whitechapel Road** **London** **E1 1BB**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 3 November 2015, one of my assistant coroners, Jacqueline Devonish, commenced an investigation into the death of Margaret Emily Tuck, aged 88 years. The investigation concluded at the end of the inquest earlier today. The jury made a determination at inquest that Margaret Tuck's death was caused by a combination of accident and illness.
4	**CIRCUMSTANCES OF THE DEATH** Already diagnosed with multiple myeloma, Margaret Tuck fell on 13 October 2015 in her home and again on 15 October 2015 in the Royal London Hospital.

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.

(I appreciate that the trust has attempted to deal with some of these issues already, most particularly by way of new documentation and training. However, I think that they nevertheless bear articulating, most especially in the context of the concerns as yet unaddressed.)

1. Although a falls risk assessment was conducted upon Margaret Tuck's admission to hospital, when it demonstrated an increased risk of falling no falls prevention care plan was drafted.

   And, whilst most of the preventative measures that would have been detailed on such a care plan were implemented in any event, Mrs Tuck was described on the risk assessment as having no walking aids. In fact, she had a zimmer frame, and it was while reaching for this zimmer frame that she fell on the acute admissions unit.

2. There was confusion about which nurse had primary responsibility for Margaret Tuck. Recourse was had to the bed diaries, but there was further discussion in court about whether the nurses had been sharing care. Such a lack of clarity seems undesirable.

3. After her fall, Mrs Tuck was seen by a junior doctor who examined her thoroughly and filled in the medical portion of the post falls checklist. However, the nursing aspect of this form was never completed.

   The FY1 had wanted a neurological observation to be undertaken in addition to the protocol neurological observations of every 30 minutes, but her note was not wholly clear, and could have been interpreted as seeking only one neurological observation in total.

   In fact, no neurological observations at all were conducted on the day that Mrs Tuck fell, nor the day after.

   The FY1 doctor had wanted to speak to the primary nurse before leaving the bedside, but had been unable to find her. The twin nursing failures of documentation and observation might have been avoided if such a conversation had been mandatory, and there had been a simple way of achieving this.

4. Mrs Tuck had been alert and orientated upon admission on 13 October, and remained so until the afternoon of 16 October, despite her persistently low sodium. When a haematology registrar found her to be confused however, an assumption was made that this confusion was the result of low sodium.

   It may be that this doctor was unaware of the falls and as a consequence did not consider the possibility that the confusion had been caused by a bleed, but this was the time when a CT scan was indicated.

5. The consultant in charge of Mrs Tuck's care did not learn of the 15 October fall until 17 October. It seems that the junior doctors on her ward did not bring this to her attention.

   Mrs Tuck's nephew, however, was gravely concerned to find his auntie unable to communicate and brought this to the attention of the consultant. The consultant asked him "What do you want me to do, scan her brain?" and he replied "I think that would be a very good idea". Hence a CT scan was conducted on the afternoon of 17 October.

6. I heard at inquest that agency nurses are unable to input into the trust reporting system (Datix). Bearing in mind that at times 50% of the ward staff are agency nurses, the matron who gave evidence suggested that agency nurses could be given a card similar to that given to locum doctors, so that they would not have to trouble their colleagues to help them make such reports.

   She was unsure whether this idea was going to be taken forward.

7. The hospital investigation into the circumstances surrounding the death was conducted by a ward manager. The thinking behind having a senior nurse explore questions of nursing care is obvious. However, the report also commented on aspects of medical care that the report author freely admitted in court were outside her area of expertise. In terms of learning lessons for the future, this seems sub optimal.

   Clinicians giving evidence disagreed with some of the report's conclusions, but I was not able to explore those areas with the true originator, because the views had come from a consultant who the author had consulted informally.

   The report was not recorded as being co-authored, and the doctor who had been asked for his view was not an oncologist. The author thought on reflection that an oncologist would have been better placed to comment on the medical management.

6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 26 September 2016. 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • Care Quality Commission for England • [redacted], nephew of Margaret Tuck • [redacted] locum consultant in care of the elderly • [redacted], foundation year 1 doctor • [redacted] AAU ward manager • [redacted], ward manager and investigation report author • [redacted] matron 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 26.07.16