REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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<tr><td></td><td>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

John Goulston
Chief Executive
Croydon University Hospital & NHS Trust
London Road
Croydon
CR7 7YE</td></tr>
<tr><td>1</td><td>CORONER

I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London</td></tr>
<tr><td>2</td><td>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.</td></tr>
<tr><td>3</td><td>INVESTIGATION and INQUEST

On 22nd February 2016, 16th to 18th & 21st March 2016 I heard the inquest touching the death of Laxmi Himatlal THAKKER.

Medical Cause of Death

1 (a) Multiple Organ Failure

(b) Acute limb ischaemia and infarction (operated 21.09.14 & 28.09.14)

(c) Left humerus fracture (operated 25.09.14)

II. Osteoporosis
Acute lung injury

How, when and where and in what circumstances the deceased came by her death:

On 24/09/2014 Mrs Thakker fell at home sustaining a fracture of the left humerus. She was admitted to Croydon University Hospital and a hemiarthroplasty performed on 25/09/2014. She began to deteriorate overnight and especially throughout the morning of the 26/09/14 and collapsed at approximately 2pm. The deterioration was not recognised in part due to lack of</td></tr>
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bedside observations. The "site team" were not informed. No bedside senior assessment was undertaken. The diagnosis of post-surgical complications of bleeding and vascular injury were missed despite her haemoglobin having fallen to half its admission level and evidence of acute kidney injury. She did not receive blood until approximately nine and a half hours after her collapse. The care at Croydon University Hospital during the 26/09/2014 until the involvement of senior team members late evening was consistent with neglect. She was transferred in a critical condition to St George's Hospital at approximately 01.00 on 27/09/2014. She was resuscitated and investigated but not admitted to ITU for pre-surgical optimisation. Surgical revascularisation and investigation was delayed until 18.30 hours on 27/09/2014. This was not successful and she continued to deteriorate. She returned to theatre in the evening of 28/09/2014 for amputation of her arm. However, she continued to decline and died on 29/09/2014 at 09.41 in ITU.

Conclusion as to the death

Accident contributed to by neglect

4 **CIRCUMSTANCES OF THE DEATH**

1. The evidence was that at the time of Mrs Thakker's admission, Croydon University Hospital (CUH) had recently moved to a fully computerised medical records system. Patients' observations were no longer recorded on an end of bed chart in graphic form but instead were recorded by a Health Care Assistant (HCA) in numerical form on a computer some distance from the patient. The senior registrar was not aware of this change. In order to access and review these observations, clinicians had to log onto a computer remotely sited from the patient and specifically look them up. It was clear, from the evidence of numerous witnesses that the ability of clinicians to make accurate assessments of Mrs Thakker's medical condition was hindered by this system. Expert evidence was taken that in another hospital this system had been trialled and withdrawn within hours due to the lack of bedside patient display.

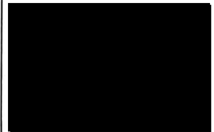
2. The evidence was also that the HCA failed to escalate Mrs Thakker's observations despite the fact that they were abnormal and consistent with deterioration in her condition.

3. 1 and 2 above compounded each other making it harder for reviewing clinicians to correctly diagnose the underlying problem.

4. The court heard that there are now several computers on wheels (COWS) on each ward that can be moved around on ward rounds and taken to the bedside, but still no end of bed permanent display, despite the re-instatement of such a chart being a recommendation of the hospital's own internal inquiry following Mrs Thakker's death.

5. It would appear form the evidence that none of those caring for Mrs Thakker at Croydon University Hospital contacted the "site team" (AKA the critical outreach team) in relation to her care despite a deterioration in her "Views" score to 5 or 6. This was against the hospital's own policy. CUH provided evidence that in more than 40% of cardiac arrests that occur there, this score is 5 or more in the preceding 2 hours. This raises questions about staff training.

	6. When Mrs Thakker collapsed at CUH at approximately 2 pm, she was assessed on the ward by a junior doctor who then attempted to contact the SR of Mrs Thakker's surgical team. No contact was effected as the SR was in fracture clinic where there was reduced telephone coverage. 7. Despite the cause of the collapse at CUH being due low haemoglobin, no blood was started until nine and a half hours later, by which time Mrs Thakker was in a critical condition. When she reached St Georges Hospital she required resuscitation with O negative blood. 8. No expert or senior advice was given at the bedside in relation to Mrs Thakker's care until 10- 11pm, some 8 to 9 hours after her first collapse at CUH. This collapse at 2pm at CUH had been mis-diagnosed as vaso-vagal rather than post-surgical complications and by the time she was eventually seen and appropriately diagnosed and treated and transferred to St George's Hospital, she was in a critical condition.
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. Lack of bedside observation chart hinders rather than assists clinical assessment of patients. This represents a real step- back in the provision of patient care. 2. Lack of training at CUH in the nursing staff in relation to the existence of and when to call the "site" or "critical outreach team". 3. Problems with telephonic communications on the CUH site. 4. Problems with systems in place for the administration of blood at CUH. 5. Lack of escalation of clinical concerns from junior to senior staff at CUH, and in particular that a patient could collapse, be seen by a junior from another treating team and the patient's own senior team not be promptly informed, as well lack of escalation of clinical issues within the same team.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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. 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 : Miles Scott Chief Executive St George's Hospital Blackshaw Rd London SW17 0QT  I have also sent it to the following persons or organisations who may find it useful or of interest: Simon Stevens Chief Executive NHS England PO Box 16738 Redditch B97 9PT 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	**28th April 2016** **Dr Fiona J Wilcox** **HM Senior Coroner** **Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED**