REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Alwen Williams, 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 East 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 28th August 2015 I commenced an investigation into the death of Mrs Catherine Dinnen. The investigation concluded at the end of the Inquest on the 26th August 2016. The conclusion of the Inquest was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Dinnen was admitted to the Royal London Hospital on the 21st August 2013. She was admitted with left-sided weakness and a stroke was suspected. On the 23rd August 2013 she was transferred from the hyper acute stroke unit at the Royal London Hospital to Heather Ward at Newham University Hospital. Prior to transfer she had begun to suffer from gastro-intestinal symptoms of vomiting and diarrhoea. Mrs Dinnen was admitted on to Heather Ward at 18:20 on Friday the 23rd August 2013 and it is noted that the ward was understaffed during the period of her admission. There is a conflict of evidence as to when the family first noted deterioration in Mrs Dinnen's condition. The family's evidence is that they noticed Mrs Dinnen having difficulties in breathing on the 24th August 2013. This was reported to the nursing staff who confirmed that they had requested a medical review. The evidence from the family indicates a delay in obtaining a medical review and confirmed that a nurse was trying very hard to obtain the required review. The medical record indicates that the nursing staff were informed by the family, of concerns with Mrs Dinnen's breathing on the 25th August 2013. The records confirm that the on-call doctor was informed at 18:30 at 20:00 the doctor had still not attended. The doctor attended at 23.15 on the 25th August 2013. Mrs Dinnen was suspected to be suffering from chest or abdominal sepsis and investigations were carried out. On the 27th August 2013 at around 6 pm, Mrs Dinnen suffered a cardio-respiratory arrest. She was pronounced deceased at 19:11 on the 27th August 2013.

	A post-mortem examination was carried out by [redacted] who gave a cause of death 1a Cardiorespiratory arrest due to 1b Gastroenteritis and 2 Cerebrovascular event (clinical history); degenerative and ischaemic heart disease, chronic obstructive pulmonary disease, hypertension and diabetes mellitus.
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. A number of concerns were raised in relation to the care of Mrs Dinnen whilst on Heather Ward, Newham University Hospital between the 23rd August to 27th August 2013. There have been a large number of internal investigations in relation to this case and many of the areas of concern have been addressed by the Trust. 2. The outstanding area of concern was in relation to provision of a timely medical review. The evidence provided by the family was that the nursing staff had a great deal of difficulty in securing a medical review. It would appear from the records that the on-call doctor was informed at 18:30 on 25 August, but did not attend until 23:15. The Trust had lost the observation records and these were not therefore available for review at the Inquest. One of the investigation reports however refers to the observations at 19:20 on the 25th August, triggering a review by an FY1 and discussion with an SPR, within 30 minutes. The consultant who gave evidence at the Inquest confirmed that there had been no changes to medical staffing since August 2013. She further confirmed that the medical staffing at weekends, bank holidays and out of hours is one FY1 and one SHO to cover all medical wards (7 or 8 of them). One medical registrar to cover emergency admissions to hospital, acute admissions unit and all patients on medical wards. One consultant on call. She described this cover as "not ideal, but the same as in other Trusts". The ward manager stated that the level of medical staffing out of hours can be a problem and is still a problem. He confirmed that nurses have to continuously bleep the medical team to come to review patients. The Trust legal representative confirmed that the Trust had not considered medical cover out of hours as part of their internal investigation.
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 **28th October 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 Chief Coroner and [redacted] (grandson) I am also forwarding a copy to the Care Quality Commission and to [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]** 2 September 2016 **[SIGNED BY CORONER]**