REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. THE DIRECTOR, MEDWAY NHS FOUNDATION TRUST** **2. MEDICSPRO**
1	**CORONER** I am Kate Thomas Assistant Coroner, for the coroner area of Mid Kent and Medway.
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 12th of February 2016 I commenced an investigation into the death of Denis Plater, Aged 70. The investigation concluded at the end of the inquest on the 10th of November 2016. The conclusion of the inquest was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Dennis Plater died on the 3rd of February 2016 at Medway Maritime Hospital. I recorded that Mr Plater died of natural causes, namely 1a Acute Kidney Injury 1b Neuropathic Sepsis 2 Metastatic Lung Adenocarcinoma By way of back ground: Mr Plater was 70 years of age at the time of his death. He had been diagnosed with adenocarcinoma of the lung in 2014 which did not respond well to treatment. Following chemotherapy and on the 27 January he stumbled and fell due to dizziness. He was admitted to Medway Maritime Hospital complaining of feeling unwell and with left-sided weakness. He was not dehydrated and his blood test markers were unremarkable and a working diagnosis was given of a possible stroke.

For this reason he was moved to Harvey Ward (stroke ward)

On 29th January Mr Plater developed diarrhoea which was a commonly recognised side-effects of chemotherapy treatment. By the 1st of February Mr Plater had developed sepsis and was recognised as having AKI. He was prescribed antibiotics and fluids namely 1000ml at a rate of 125 ml per hour.

Between 3pm and 9pm on 1 February Mr Plater was not recorded as having had those fluids. It could not be established at the Inquest as why this was the case or who had stopped the fluids.

Further, Mr Plater's urine output was not being recorded on the fluid balance chart thus making it an ineffective diagnostic tool.

On the night 1st February Mr Plater was handed into the care of an agency Nurse. She found that Mr Plater was not receiving his fluids, so restarted them at about 9.30pm. She undertook his observations and incorrectly calculated a NEWS score of 4 - it should have been 6. The Nurse was not aware of the detailed advice given on the reverse observation chart and was unsure of how to calculate the score properly.

Mr Plater's NEWS score had previously been a consistent 0 – 2 and therefore given this increase he should have been escalated. This was not done.

The Nurse undertook observations again at 12:10 am and although her calculation of the News score was correct she again did not escalate his condition when she should have done so. At 3am she again undertook observations and his NEWS score was correctly calculated as 6. Mr Plater's score had risen from midnight and accordingly there was a more urgent need to escalate his condition. This was not done. The Nurse did not know that she should have escalated the situation, nor did she know how to, save for ringing the hospital switchboard. (the bleep numbers were in fact on the reserve of the observations charts)

Of concern was the fact that notwithstanding it was evident the Mr Plater was deteriorating, the nurse did not undertake any further observations at all during her shift, and the next observations undertaken where at 11:05 am (some 8 hours later) by the Day Nurse whereupon Mr Plater's deterioration was finally picked up.

It was also clear that at some point on the morning of 2nd of February the fluids started by the Nurse at 9.30 pm had run out (a 1000 ml bag would have run out at approximately 5.10 am.) The charts indicated that a second bag was started. The fluid rate was set at 83 ml per hour which was not the prescribed rate. The Nurse could not recall starting a second bag but accepted the handwriting on the chart looked similar to hers.

At hand over, the Nurse did not convey adequately the deterioration in Mr

	Plater's condition in circumstances where it was reasonable to expect she should have. After 11 am on the 2nd of February Mr Plater was seen by and number clinicians and was eventually admitted into the HDU in the afternoon of the 2nd of February where he continued to deteriorate. He died shortly after 1 am on the 3rd of February. Upon considering the evidence as a whole however there was insufficient evidence to find that on the balance of probabilities the failures as outlined herein and above caused or contributed to Mr Plater's death.
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) There were incomplete records kept and especially in respect of the fluid balance chart thereby rendering it an ineffective diagnostic tool. 2) That a patient was placed in the care of Nurse who neither understood the NEWS scoring system, did not apply it correctly and failed to escalate patient's condition in circumstances where she ought to have done so. 3)That the Trust did not have in place a sufficiently rigorous or effective system for testing and monitoring the training, knowledge, understanding and compliance of agency staff.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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, namely by the 9th December 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 to the following Interested Persons : [redacted] 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	 **Kate Thomas** **Assistant Coroner** **Mid Kent and Medway** **21st November 206**