IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Annette KRASINSKY-LLOYD
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: Ms Paula Head, Chief Executive Royal Surrey County Hospital NHS Foundation Trust Egerton Road Guilford Surrey GU2 7XX
1	**CORONER** Mr Darren Stewart OBE, HM Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** On 21st April 2016, an investigation was commenced into the death of Annette KRASINSKY-LLOYD, an inquest was then opened on the 27th April 2016 which concluded at the end of the inquest on 13th December 2016.

	I found the medical cause of death to be: 1a. Hypovolemic Shock 1b. Retro-peritoneal Haemorrhage 1c. Pelvic Fracture II. Cerebral Infarction. She died at Royal Surrey County Hospital on the 20th April 2016 as a result of Hypovolemic Shock. I concluded with the short-from conclusion: Accident.
4	**CIRCUMSTANCES OF THE DEATH** Mrs KRASINSKY-LLOYD was a resident at Felbury House, Holmbury, St Mary Dorking, Surrey. She had been resident there since July 2014 following a brief stay at Milford Rehabilitation Centre where she had been admitted as a result of a fall at her home. Over the period 18/19th April 2016 Mrs KRASINSKY-LLOYD suffered an unwitnessed fall in her room at Felbury House which resulted in a fracture to her pelvis causing a retro-peritoneal haemorrhage (undiagnosed until 20th April 2016). She complained of groin pain on the evening of 19th April 2016 which was monitored by staff at Felbury House. Early on the morning of 20th April 2016 Mrs KRASINSKY-LLOYD appeared much worse, suffering from pain in her legs and stomach, slurred speech, she appeared yellow in colour, clammy to touch, low blood pressure and was panting for breath. She was transported by ambulance to the Royal Surrey County Hospital where she was admitted to the Accident and Emergency (A&E) Department at 0745 hours on the 20th April 2016. Following triage, Mrs KRASINSKY-LLOYD was moved to resuscitation within the A&E Department. She was assessed at 0845 by an SHO (FY2) who gained intravenous access and prescribed antibiotics and analgesia (morphine). Fluids were also administered. The initial working diagnosis was one of sepsis. Abdominal and chest x-rays were also ordered. These were performed at 1000 hours and on review of the imaging a consultant was called. Further investigation by the consultant by way of a bedside ultrasound (performed around 1030 hours) established a right-hand side mass in her abdomen. A CT scan was requested which was conducted between 1100 – 1130 hours. Following her return from the CT scan at 1130 hours, Mrs KRASINSKY-LLOYD's condition started to deteriorate with her blood pressure and heart rate rising rapidly. She went into shock at 1147 hours with heart spikes and a rapid fall in her blood pressure and a crash call was made. She was

	stabilised and given a blood transfusion for the first time following admission. The treating A&E clinicians were unaware that Mrs KRASINSKY-LLOYD had been taking anti-coagulation therapy (low molecular weight Heparin injections). Mrs KRASINSKY-LLOYD's condition deteriorated further and assessment by surgeons resulted in a decision not to provide any invasive treatment due to her co-morbidities. She was stabilised in A&E and transferred to the care of the consultant on call for medicine. She was first seen by the consultant on call for medicine at 1330 hours at which point she appeared hypotensive, tachycardic, peripherally shutdown, agitated and suffering from delirium. Her cannula had fissured. The consultant on call for medicine addressed the poor intravenous access by way of a femoral line. He reversed Mrs KRASINSKY-LLOYD's anti-coagulation therapy and ordered a further blood transfusion. He was concerned with the deceased's kidney failure, high lactate levels and delirium. The on call consultant for medicine's assessment upon receiving Mrs KRASINSKY-LLOYD into his care was one of a poor prognosis pointing to the combination of low blood pressure, poor profusion to her vital organs and acute renal failure, all of which had limited reversibility. Mrs KRASINSKY-LLOYD's condition further deteriorated during the afternoon and she died at 1615 hours. The on call consultant for medicine assessed that this was the likely outcome for Mrs KRASINSKY-LLOYD irrespective of the course of treatment she received upon admission to A&E on 20th April 2016 given size of the Retro-peritoneal Haemorrhage and blood loss suffered by Mrs KRASINSKY-LLOYD.
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 could 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) It was clear from the evidence that the governance and rapidity of treatment in A&E was inadequate. The SHO who initially provided care to Mrs KRASINSKY-LLOYD was left un-supervised for an extended period resulting in a delay of 90 minutes before the relevant A&E consultant engaged in the care of the patient and

	appropriate investigations undertaken to establish the nature of the deceased's condition. (2) Notwithstanding (1) there were additional delays in obtaining results of tests and the conduct of an appropriate assessment of the deceased's condition. This in turn led to delays in reversing the deceased's anti-coagulation therapy and administering blood transfusions. (3) At the time the on call consultant for medicine received Mrs KRASINSKY-LLOYD into his care, she had further deteriorated, including the fissuring of her cannula leading to poor intravenous access. Between the end of the crash call at 1147 hours and when Mrs KRASINSKY-LLOYD was transferred from the A&E department (around 1330 hours), the monitoring of Mrs KRASINSKY-LLOYD by the A&E department was inadequate giving rise to the complication relating to poor intravenous access.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 2nd June 2017. 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 this report to the following: 1. See names in paragraph 1 above 2. [redacted] 3. [redacted] 4. The Chief Coroner In addition to this report, I am 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	**7th April 2017**	**Darren Stewart OBE**