	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Newmarket Community Hospital.** **2. The Rookery Medical Centre, Newmarket.** **3. [redacted] Consultant Physician, West Suffolk Hospital**
1	**CORONER** I am Dr Peter Dean, senior coroner for the coroner area of Suffolk
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** At the conclusion of the inquest into the very sad death of DAPHNE JOAN PENN, I recorded a narrative conclusion that 'Mrs Penn died from pneumonia occurring against a background of pre-existing significant natural disease and possibly due to aspiration in the final deterioration. Her last illness leading to her hospital admission was likely to have been multifactorial and contributed to, at least in part, by an inadvertently rapid reduction in the dose of her long term steroid therapy'. The cause of death was found to be: 1a Pneumonia.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Daphne Penn had been transferred from West Suffolk Hospital to Newmarket Community Hospital for rehabilitation and sadly died following her subsequent readmission to West Suffolk Hospital, her condition having deteriorated at Newmarket Community Hospital. She suffered from various pre-existing significant natural disease processes for which she took medication, including long term steroids, and there were problems associated with the provision of these steroids while she was a patient at Newmarket Community 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 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. – The inquest heard that, as well as the significant benefits that long term steroids can clearly bring to some conditions, there are also well recognised and significant potential risks including side effects such as (i) gastro intestinal bleeding; (ii) suppression of normal steroid production necessitating, when prescribed doses have to be reduced medically, slow and gradual dose reduction and the avoidance of sudden drops in the dose of steroids given; and (iii), because of the long term suppression by prescribed long term steroids of the glands producing steroids in patients naturally, the need for prescribed doses to be increased where there is intercurrent illness, known as the 'Sick Day Rules'. The inquest also heard that a more rapid steroid reduction rate than that suggested by the original consultant was initiated, although the clinical reasons for this were given by the second consultant in respect of the need to balance benefits against the risk of further gastro-intestinal bleeding here; that there was a delay transmitting to relevant

	medical staff concerns about her condition expressed to healthcare staff by Mrs Penn's very supportive family, who clearly understood the issues related to steroids well; and that there was also an inadvertent additional decrease in the steroid dose prescribed following a prescribing error by a general medical practitioner who misread the intended steroid dose when rewriting the drug chart.
6	**ACTION SHOULD BE TAKEN** There was a significant medical history and multiple factors likely to have been involved in the tragic death of Mrs Daphne Penn but the inadvertently rapid reduction in the dose of prescribed steroids, on the balance of probabilities, is likely to have contributed to the death. In view of this, and the other factors noted, I would wish to draw attention to: 1) The need to flag up notes in significant and/or long term conditions where the patient might be at risk if those conditions are not given adequate consideration. 2) The importance of recording and transmitting family concerns to all relevant clinical staff. 3) Consider a safer system of prescribing, for example electronic, to reduce the risk of transcription and prescribing errors and also to ensure that all prescribing entries are clear and legible, and 4) To ensure that staff are aware of the 'Sick Day Rules' in respect of long term steroid use.
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 24th of August 2018. 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: Mrs Penn's family. Similarly, you are 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.
9	**Dr Peter Dean** PD Dean **29-6-18**