Regulation 28: Prevention of Future Deaths report

Flora Marion BABER (died 22.02.18)

	THIS REPORT IS BEING SENT TO: **1. Professor Stephen Powis** **Medical Director** **Royal Free London NHS Trust** **Royal Free Hospital** **Pond Street** **London NW3 2QG** **2. [redacted]** **Registered Manager** **Compton Lodge Care Home** **7 Harley Road** **London NW3 3BX** **3. [redacted]** **Adelaide Medical Centre** **111 Adelaide Road** **London NW3 3RY**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 28 February 2018, one of my assistant coroners, Richard Ian Brittain, commenced an investigation into the death of Flora Marion Baber, aged 92 years.

	The investigation concluded at the end of the inquest yesterday. I made a determination that Flora Baber died from a combination of accidental falls and frailty of old age. I recorded a medical cause of death as follows. 1a aspiration pneumonia 1b traumatic left sided chronic subdural haematoma with re-bleeding 2 thrombocytopenia, aortic valve disease, general frailty and dementia.
4	**CIRCUMSTANCES OF THE DEATH** Dr Baber was admitted to the Royal Free Hospital from Compton Lodge Care Home on 25 January 2018 with increased confusion, slurred speech and difficulty in breathing. She died there a month later.
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. **Royal Free Hospital** 1. Whilst record keeping showed Dr Baber as having been given appropriate food and drink whilst on the ward in hospital, I heard that sometimes her nearest fluid was out of her reach on a bedside table too far from the bed. Also, she did not always receive appropriately pureed food or the assistance that she needed to eat. 2. There was a delay in referring Dr Baber to the speech and language team and in treating her oral thrush. Most significantly, I heard evidence that it was only when family members pointed out a problem such as pain on swallowing, that staff acted to deal with this. 3. Family members told me that at one point, they found the member of staff allocated to Dr Baber's bay sitting in a chair apparently asleep.

	4. Dr Baber was noted in the medical records as being doubly incontinent. However, family members told me that she was not incontinent. Rather, when she asked for assistance to go to the toilet or to use a bedpan (she had poor mobility), a healthcare assistant told her that staff were busy, she was wearing an incontinence pad, and she should use that instead. I was shocked to hear this. **Royal Free Hospital, Compton Lodge and Adelaide Medical Centre** 5. Dr Baber had a sensitivity to opioids, such that her family noted a direct correlation between episodes of sickness and vomiting, and the administration of opioid medication. This had been recognised and recorded during earlier admissions to the Royal Free, and family had discussed with staff at the care home. However, it was not recorded as an alert on her hospital notes, or on her general practitioner notes, or on the care home notes. At the very end of Dr Baber's life, the benefit of pain relief was thought to outweigh the side effects of opiates, but before then her sensitivity was simply not recognised. This caused her discomfort and distress, and in another case could have fatal consequences.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 by 15 October 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • Care Quality Commission for England • [redacted], daughter of Flora Baber 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 13.08.18