ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Dr Yvette Oade, Chief Medical Officer, Leeds Teaching Hospitals NHS Trust, Trust Headquarters, Beckett Street, Leeds, LS9 7TF**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner for the coroner area of West Yorkshire (Eastern)
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 13 December 2017 I commenced an investigation into the death of Theresa Maria BUTTON aged 65. The investigation concluded at the end of the Inquest on 25 September 2018. The conclusion of the Inquest was **Natural Causes**.
4	**CIRCUMSTANCES OF THE DEATH** On 21 August 2017 the deceased underwent a liver transplant. She remained in hospital for some 15 weeks during which time she suffered multiple complications including a stroke. She developed pneumonia and died on 7 December 2017. The deceased's family contended that her death was contributed to by the deficiencies in nursing care which arose due to insufficient nursing staff being available at certain times on Ward J83 at St James's University Hospital, Leeds.
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. The staffing levels on Ward J83 should be reviewed, notwithstanding that they may currently meet the minimum levels prescribed. The ward handles a challenging cohort of patients with liver disease who have complex needs which merit close nursing attention. 2. Evidence taken at the Inquest revealed concerns that treatment plans instituted by clinicians were not always fully or effectively implemented as the staff were often too busy, particularly at night. Example included not hoisting an immobile lady out of bed onto a chair before mealtimes and then having time to encourage her to eat. 3. In this case the deceased was frail and losing weight due to not eating. A family

	member witnessed her food being left on her tray whilst she was laid flat and hence unable to access it with the result that it went cold and she did not eat, despite the concern relating to her nutritional condition. 4. Insufficient time was available for the nursing staff and clinicians to explain treatment decisions to family members. An example given at the Inquest related to a decision to prescribe anti-depressant medication without the family being informed of any psychiatric involvement. 5. Contemporaneous nursing records were not always maintained; for example relating to food and fluid intake (even though nutrition was a matter of concern to the treating clinicians).
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 **28 November 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: [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	**Date: 3 October 2018** **Signed by:** Kevin McLaughlin