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. Chief Executive, Calderdale and Huddersfield NHS Foundation Trust**
1	**CORONER** I am MARY BURKE, Assistant Coroner for the Coroner area of West Yorkshire (Western)
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 22nd April 2014 an investigation was opened into the death of Ruth Hilda Smith and an inquest was concluded on the 14th October 2015. The conclusion of the inquest was a narrative: *Ruth Hilda Smith died on 16 April 2014 on Ward 3, Huddersfield Royal Infirmary due to a haemothorax which occurred as a result of the necessary insertion of a central venous access line required to facilitate treatment of her underlying condition.* The cause of death was established as: 1(a) Haemothorax 1(b) Central line insertion 11. Sepsis, altered liver function and pneumonia.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Smith had a medical history of peripheral vascular disease, chronic kidney disease, chronic obstructive pulmonary disease, hypothyroidism and hiatus hernia. In May 2013 she had been diagnosed with colon cancer and underwent a colectomy with ileostomy in June 2013. Mrs Smith experienced a difficult post operative period, developing significant wound infection and high stoma output. She was eventually discharged from hospital but had 3 more hospital admissions between September 2013 and December 2013, for recurrent problems of high stoma output and acute kidney symptoms. Mrs Smith was readmitted to Calderdale Royal Hospital again on the 28th December 2013 with problems with her stoma. During this admission she was noted to have symptoms of necrosis and leg rest pain and as a result Mrs Smith was transferred to Huddersfield Royal Infirmary under the care of the vascular team. Investigations were undertaken which revealed that she had bilateral common iliac occlusion for which she underwent an elective vascular procedure on the 24th February 2014. Following a period in intensive care Mrs Smith's condition

	appeared to stabalise, however her condition subsequently began to deteriorate, she developed poor urine output and respiratory symptoms and showed signs of sepsis. Mrs Smith also developed severe abdominal pain an MRCP revealed ascites and generalized oedema. Mrs Smith's treating clinicians were endeavouring to provide her with full medical support but difficulties were encountered in cannulating her so as to ensure she received intravenous antibiotics and fluid support. As a result a decision was taken for Mrs Smith to have a central venous line inserted. This was undertaken on the 15th April 2014. The procedure was uneventful and a check chest x-ray revealed that the central venous access was in the correct position. During the early evening Mrs Smith's condition began to steadily deteriorate. She was reviewed by a number of doctors and nursing staff, culminating in being reviewed by a Registrar at 3.25 now the 16th April, who confirmed that Mrs Smith appeared to be pre-moribund and advised her family that no direct intervention was likely to resolve Mrs Smith's presentation. Mrs Smith died a few hours later, her death being confirmed at 6.30 hours on 16th April 2014. Mrs Smith subsequently underwent a post-mortem examination by [redacted], who concluded that the medical cause of Mrs Smith's death was due to 1(a) Haemothorax due to 1(b) central line insertion and 2. sepsis altered liver function and pneumonia.
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. – **Nursing Care** At 22.05 Mrs Smith was found to have an elevated MEWS score and as a result a request was made for an FY 1 Doctor to review. Evidence was given by a senior charge nurse(who provided an overview of nursing care to Mrs Smith, but who was not directly involved in her care) that following this Mrs Smith should have undergone hourly observations. This did not happen. There was reference to observations being undertaken at 00.30 but these were not recorded. Further observations were incomplete The FY1 Doctor did not attend the ward until 00.30. There was no record within the notes to suggest that enquiries were undertaken between 22.30 and 00.30 to chase up the attendance of the FY 1 Doctor. I have the following concerns: 1. No attempts were made to ensure a doctor attended and reviewed Mrs. Smith

between 22.30 and 00.30.
2. The level of nursing monitoring (hourly observations) taking place for much of the period between 22.30 on the 15th April and 03.25 on the 16th April.
3. The standard of the nursing record keeping.

On the 16th April a red incident incident investigation was undertaken but none of the above matters were included in the report although I heard evidence from one of the authors of the report that "a number of issues" had been identified and fed back to the Legal Services department. I received no written communication of this, nor whether any steps or measures had been implemented as a result, hence the reason why I am making this report.

Medical Care

A doctor attended at 18.40 upon Mrs Smith but did not make a full record within the medical records.

Nursing staff requested a doctor review at 22.30 hours. No doctor attended until 00.30 hours.

When a doctor did attend a fluid challenge was implemented. The doctor did not return to review Mrs Smith or put in place arrangements for another doctor to review.
At 2.00 hours an FY2 doctor attended following a request by nursing staff. The FY2 doctor determined that Mrs Smith's bloods and blood gases should be checked. I heard evidence that nursing staff advised the FY2 doctor that Mrs Smith needed more senior medical review by a registrar.
The FY2 made no entries within Mrs Smith's medical records.

I have the following concerns:

1. The 2 hour time lapse between a request for a doctor review and a doctor attending upon Mrs.Smith.
2. No review was put in place following the implementation of the fluid challenge.
3. The standard of record keeping and lack of records being made by the doctors who attended up Mrs. Smith on the evening of the 15th April and early hours of the 16th April up until the Registrar's involvement at 03.25 a.m. on the 16th April.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 9th February 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	**15th December 2015** **M. T. Burke, Assistant Coroner**