MR G IRVINE
ACTING SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Ministerial Correspondence and Public Enquiries Unit, Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU [redacted] **And** • [redacted], Chief Medical Officer, Barts Health NHS Trust, The Royal Hospital, Whitechapel Rd, London E1 1BB [redacted]
1	**CORONER** I am Graeme Irvine, acting senior coroner, for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 22nd April 2021 I opened an investigation touching upon the death of Margaret Rose Toye, aged 81 years old. I opened an inquest on the 5th May 2021. The inquest concluded on the 21st December 2021. The conclusion of the inquest was Natural Causes, the record of inquest stated: *"On the 10th April 2021 Mrs Margaret Rose Toye sustained an unwitnessed fall in the community and suffered a left neck of femur fracture. Following surgery to repair the fracture on 12th April 2021 Mrs Toye received ward based care and on 20th April she died following a cardiac arrest."*

	The cause of death was recorded as; 1a Cardiac Failure 1b Ischaemic Heart Disease 1c Coronary Artery Atherosclerosis II Fractured Left Neck of Femur
4	**CIRCUMSTANCES OF THE DEATH** Following a fall in the street on 10th April 2021, Mrs Toye was taken by ambulance to hospital where she underwent a surgical repair of the fracture on 12th April 2021. Despite recovering from surgery well, whilst care for on the ward Mrs Toye sustained a cardiac arrest on 20th April 2021.
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. Following admission, Mrs Toye was not assessed for risks of malnutrition by use of the MUST score system. Such an assessment was required for all patients. Erroneously, her notes recorded that she scored 0 on the MUST scale which meant that no other staff members began an assessment throughout her admission. It is likely that during admission Mrs Toye would have scored 4 on a MUST assessment, as such a number of mitigations would have been introduced to maximise her nutritional intake. 2. Contemporary audits of compliance of Must scoring on the ward in question demonstrate that one in ten patients are not being assessed for risks of malnutrition.
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 **17th February 2022**, 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, the family of Mrs Toye, the Care Quality Commission. I have also sent it to the Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest.

	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	**[DATE] 23rd December 2021 [SIGNED BY CORONER]**