VERONICA HAMILTON-DEELEY, LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove

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CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	THIS REPORT IS BEING SENT TO: **1. Brighton and Sussex University Hospitals NHS Trust**
1	**CORONER** I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove
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 9th August 2016 I commenced an investigation into the death of **Diana Maxine RITCHIE.** The investigation concluded at the end of the inquest on 9th August 2016. The conclusion of the inquest was Narrative Conclusion.
4	**CIRCUMSTANCES OF THE DEATH** See Record of Inquest
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) Mrs Ritchie was recovering from major surgery and on her second day post operatively was suspected of having an Ileus. Overnight on the 5th and 6th

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March she deteriorated quite substantially and a doctor was called to see her in the early hours of the 6th at that time there was no suspicion that she was suffering from a bronchopneumonia but the evidence at the Inquest indicated that this was the start of the that infection. The differential diagnoses at that stage were Pulmonary Embolis or the effects of Ileus.

(2) That there were missed opportunities to escalate Mrs Ritchie's treatment arising from raised NEWS scores where there was no report of those raised scores either to the doctors on the ward or to the critical care outreach team. There were eight different NEWS scores taken between 06.30 on the 6th and 11.15 on the 6th.
On two of them the scoring was inaccurate (one was scored 2 points too high and the other was scored 2 points too low). One of them scored at 4 but the remainder scored at 5 and above. As I say, none of them resulted in a call to critical care outreach or to the ward SHO.

(3) If care had been escalated there would have been at least 4.5 extra hours from the earliest NEWS chart for Mrs Ritchie to have been assessed by an independent clinician who may well have taken different action to the action that was taken to her.
If care had been escalated it may well have been that she may not have suffered the cardiac arrest which occurred around about 12.20 hrs on the 6th.
It is possible that the outcome might have been different.

(4) The other area of concern I have is that the observations were not taken more regularly during the night of the 5th/6th March when it was clear that Mrs Ritchie's condition was deteriorating – it should not have needed any form of direction from the doctors attending for these observations to be taken more regularly. The Nurse in charge of the ward should have been informed and should have made a direction for the appropriate timing of these observations.

(5) It was also suggested to me that the observations taken at 11 o'clock, 11.05, 11.10 and 11.15 were not in fact taken at those times but were taken later, after the first relatively short lived loss of consciousness which occurred at around 11.15. If this is correct then this is really an extremely worrying use of this assessment tool.

(6) Finally this is not the first time I have had to write a Regulation 28 Report to this Trust which involves abuse of or failure to use NEWS properly at all. It is in my view necessary for there to be substantial and immediate training on proper use of NEWS throughout the Trust.

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	I am told that there are electronic hand-held 'smart' pieces of equipment which can be used to take and record NEWS and which then omit a warning signal if the NEWS is raised. This should be considered at this hospital. I understand that Worthing Hospital (recently rated excellent by the CQC) has this handheld equipment and uses it to good effect.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND 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 7th November 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 1. Clinical Quality Commission 2. Clinical Commissioning Group – Soline Jarram 3. Secretary of State for Health, Department of Health 4. Simon Stevens – Chief Executive NHS England 5. National Patient Safety Agency 6. [redacted] – Medico Legal Services Manager I have also sent it to:- 1. [redacted] Who may find it useful or of interest. 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.

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9	**Date:** **18th August 2016** **SIGNED BY:** V. Hamilton-Deeley. **Senior Coroner Brighton and Hove**