REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Dr Gillian Fairfield Chief Executive Royal Sussex County Hospital Eastern Road Brighton BN2 5BE
1	**CORONER** I am Karen Harrold, Assistant Coroner for the coroner area of West Sussex.
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 http://www.legislation.gov.uk/uksi/2013/1629/made
3	**INVESTIGATION and INQUEST** On 20th April 2015 the Senior Coroner, Penny Schofied, commenced an investigation into the death of Jean Stockley aged 84 years old. The investigation concluded at the end of the inquest on 2 August 2016. I recorded a conclusion of Accidental Death and the medical cause of death as: 1a) Respiratory failure; 1b) Bilateral pneumonia; 1c) Traumatic spinal fractures; 2) Asthma, Elevated right hemi-diaphragm.
4	**CIRCUMSTANCES OF THE DEATH** Jean Stockley was admitted to the Royal Sussex County Hospital in Brighton on 17th March 2015 following an unwitnessed fall at her son's home when she fell down 13 stairs landing on her back and neck. The immediate focus was on establishing any orthopaedic problems and after MRI/CT scans it was confirmed that she had one fracture in her neck and three in her thoracic spine. She was admitted to an orthopaedic ward and her management was referred to a neurological registrar who confirmed that surgery was not felt to be appropriate and that initially, a brace and collar was the preferred treatment. Due to breathing difficulties, treatment of the spinal injuries was changed to conservative management. Mrs Stockley had pre-existing COPD/asthma and used an inhaler. During her stay in hospital the plan to manage her respiratory condition included treatment and therapy from physiotherapists; active monitoring of her oxygen saturation levels and medication including Salbutamol to relieve her breathing difficulties and help clear any secretions. She was also monitored for signs of any chest infection and given antibiotics when needed. Throughout her time in hospital her NEWS score remained steady so there was no sudden deterioration in her condition. By 26 March, Mrs Stockley was transferred to the

	Princess Royal Hospital in Haywards Heath for further rehabilitation and to be closer to one of her sons address. It was noted that the amount of air reaching the side of her right lung was reduced and a chest XR was ordered. She continued to have chest physiotherapy, saline nebulisers and antibiotics. Between 1-3 April there was a period of stability as noted in the NEWS records and Mrs Stockley was using less pain relief. However, by 8 April, the breathing difficulties resurfaced and without oxygen her saturation levels dropped but rose again after receiving oxygen. A chest x-ray suggested a raised right hemidiaphragm and some fluid was collecting at the base of both lungs. A specialist respiratory review was conducted during the afternoon of 9 April and concern expressed that the hemidiaphragm may be paralysed. An ultrasound scan was recommended and new targets for maintaining oxygen saturation levels between 88-92% were set to be monitored every 2 hours. Arterial blood gas tests were carried out followed by a further review by the critical care outreach team who did not make any changes to the respiratory registrar's plan. These were repeated again that evening by a junior doctor and he requested the nursing staff to carry out observations throughout the night. Mrs Stockley was monitored every 2 hours and at 6.35 a.m. her NEWS score was 4 but doubled to 8 by 7.20 due to a raised respiratory and heart rate. Nursing staff contacted the same junior doctor but he did not review Mrs Stockley on the ward. Later the same day her condition deteriorated rapidly and she descended into respiratory failure which required transfer to intensive care for eventual intubation on 10th April. An ultrasound confirmed consolidation and collapse of the right lower lobe with minimal diaphragmatic movement. Between the 10th April and her eventual death on 20th April efforts were made to wean down her ventilator setting and reduce her sedation to allow her to do more of her own breathing. This did not work as she become agitated and on one occasion tried to remove her tube. Further ventilation was discussed but eventually she was placed on an end of life pathway until she died on 20th April at 02.28.
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. On 9 April, Mrs Stockley's respiratory condition was clearly deteriorating necessitating critical care review who recommended careful and consistent observation of principally her oxygen saturation levels. The NEWS score was a vital tool to alert clinical staff to an acute change yet despite the fact the score went from 4 to 8, the junior doctor did not review the patient. I heard evidence from nursing staff that the doctor felt the patient may simply have been anxious. This suggests a potential training need for doctors and/or nurses. 2. Further, although the nurse quite rightly telephoned a doctor it was far from clear whether the right doctor had been contacted. The national NEWS forms were in use at the time of Mrs Stockley's death to record observations but the policy that governed their use was the 2012 MEWS Escalation Policy and the two policies were different. From evidence heard from both doctors and nurses, it suggests the need to revisit how the NEWS policy is applied locally especially around which doctor should be contacted when there is an acute change. 3. The nurse who had monitored Mrs Stockley throughout the night and contacted the junior doctor when the NEWS score spiked handed over to the day nurse shortly after her conversation with the doctor. From evidence heard at inquest, there may

	still be reluctance for nursing staff to contact doctors at a more senior level if a junior doctor does not take appropriate action such as a patient review. 4. Finally, during the inquest I heard from an independent expert that some hospitals use an automated electronic NEWS system which may have avoided the difficulties encountered in Mrs Stockley's case.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 7th September 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] [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: 12th August 2016** pp KFBurbeck Karen Harrold Assistant Coroner West Sussex