REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

This report is made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

Recipients

This report is being set to:

- Mrs L Boswell, Chief Executive, Royal Cornwall Hospitals NHS Trust, Bedruthan House, Truro, Cornwall, TR1 3LJ
- [redacted] – the parents of Karen Peters

Coroner

I am ANDREW JAMES COX Assistant Coroner for the area of Plymouth, Torbay and South Devon.

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.

Investigation and Inquest

On 9 April 2013 I commenced an investigation into the death of Karen Lesley Peters, then aged 49. The investigation concluded at the end of the inquest on 14 – 16 April 2014 inclusive.

The cause of death was found to be:

1a Subdural and Subarachnoid Haemorrhage, Cerebral Contusion
1b Fall

The conclusion of the inquest was that Karen died from the effects of a head injury sustained in a fall. There was a failure to provide appropriate nursing care and timely medical intervention.

Circumstances of death

Karen Peters suffered a fall and head injury in Royal Cornwall Hospitals Trust at 14:00 on 28 March 2013. She was placed on hourly neurological observations with medical guidance to obtain a CT Scan in the event of reduced levels of consciousness. At 20:00 her GCS was reported at 14. At midnight there was a further reduction in GCS to 13. At 22:00 or sometime thereafter she was administered Dalteparin, an anticoagulant. This was contra-indicated and is likely to have made the bleeding worse. At 06:00 on 29 March Karen was found unresponsive and at 06.15 her GCS was assessed at 6. She underwent a CT Scan which confirmed an acute subdural haemorrhage. Arrangements were made to transfer Karen to the Neurosurgical team at Derriford Hospital in Plymouth. There were delays in the transfer. It took 5 ¾ hours to complete. By the time Karen arrived at Derriford Hospital her neurological status had deteriorated further and nothing could be done for her. She died later that day at 18:30.

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 fall into two broad areas, namely Nursing and Medical. I am quite content for you to pass this letter to (who gave evidence at the Inquest) to deal with Nursing matters and equally, it is appropriate for you to ask the Medical Director to deal with the following Medical issues. I have seen, however, your letter to the family of 5 December last year and I am aware of the personal interest you have taken in this death which is the reason this correspondence is addressed to you.

Nursing Matters

In his review found four areas of concern.

1. Staffing levels in MAU as a whole;
2. Deployment of Agency Staff;
3. The quality of handover between Nurses;
4. The quality and accuracy of Neurological observations, in this instance, done by measurement of GCS.

I endorsed these findings and will deal with each of these matters in turn.

1. Staffing Levels

[redacted] was able to tell me at Inquest that additional nursing and healthcare resources have been allocated to the Medical Admissions Unit. There are no further steps for you to take.

2. Deployment of Agency Staff.

On the night of 28 March 2013, Nurse A from Plan B Nursing Agency had been asked to provide cover. She started her Night Shift working in the back area of A & E. A Sister in that department was then contacted by the Site Co-ordinator and, as a consequence, Nurse A was then moved to cover a Bay in MAU. Subsequently, another nurse within MAU became ill and had to go home. Nurse A was then additionally asked to look after that further Bay. At 23:15 hours Karen was then moved into one of the Bays for which Nurse A was responsible.

My concern is whether it is appropriate to put Agency Nurses in such demanding positions ahead of nurses already employed by RCHT. I would welcome your thoughts on this and whether any changes to practice have or will be implemented as a consequence.

3. The quality of handover information

I heard from two nurses, Nurse A and Nurse P. There was a clear conflict in their respective evidence as to what information was conveyed between them at handover. In particular, there was conflict as to whether Nurse A was advised of Karen's earlier fall and the need for hourly neurological observations.

[redacted] explained at Inquest that he had now directed that all nursing handovers must be undertaken by reference to the Nursing Record. One of my concerns arising out of this was that there was no entry in the Nursing record advising of the need for the patient to undergo a CT Scan if there was a drop in recorded levels of consciousness. That note was only to be found in the medical records and neither Nurse A nor Nurse P considered these. [redacted] explained to me that there will be an ongoing audit in relation to the quality and accuracy of nursing handovers. I would be pleased to learn from you the outcome of that audit.

4. Measuring and Recording GCS

After her fall at 14:00 hours an entry was made in the medical record that Karen was to have a CT scan in the event that her levels of consciousness fell. At 20:00 hours Nurse P noted a 1 point reduction to 14. At midnight a further set of observations (performed by an unidentified nurse) noted a further reduction to 13. On neither occasion was Karen sent for a CT scan nor was her treatment otherwise escalated.

accepted at Inquest the need for continued education and training. I would be pleased to hear from you of the outcome in this regard.

Medical Matters

1. Following Karen's fall at 14:00 hours, the medical staff should have directed that Karen was not to receive any further anticoagulation medication until staff were satisfied that her neurological status was stable. The entry in the notes failed to do this.

   At Inquest, a Consultant Neuro-Surgeon from Derriford, indicated that the administration of anticoagulation treatment to a patient under observation for a possible neurological injury was absolutely contra-indicated.

   Would you please let me know how you propose to ensure a similar oversight will not happen again in the future.

2. At 06.15 hours on 29 March, Karen was found to have a GCS of 6. She was sent for an immediate CT Scan and this was completed within 45 minutes, which I found to be commendable.

   I heard evidence, however, from a who was the F1 doctor who took Karen to the CT scanner. He told me that no airway support was available to him at that time. He felt exposed and it was plain that Karen was similarly exposed. Fortunately, there were no complications during the course of the Scan, but it is easy to see that in similar circumstances, a problem could develop that the Junior doctor looking after the patient would be unable to resolve.

   I would be grateful if you could let me have your thoughts as to how you propose to address this difficulty.

3. Transfer of time critical patients

   I heard from at Inquest who had been tasked to conduct a review of out of Hospital transfer from RCHT. On this occasion he found two factors that delayed the team:

   (a) Equipment was stored in a general cupboard and it took time to identify the right leads and other apparatus that was required;

   (b) Karen was intubated and ventilated in Theatre which threw off the relevant staff as they were not accustomed to dealing with patients in this way.

   I heard from that since this incident, all of the transfer equipment has been replaced. There is no further action for you to take in this regard.

I also heard that, where possible, patients will now be prepared for transfer in the Emergency Department. I would like to know whether that is, in fact, working. Over the past year, how many patients have been prepared for time critical out of Hospital transfer other than in the Emergency Department? Why has this occurred and what can be done to address the issue?

I also heard evidence from Paramedics who attended to carry out the transfer. They were unaware that RCHT had replaced its transfer equipment. It seemed to be that the efficacy of transfers could be improved if the service between Hospital Clinicians and Paramedics could be better joined up. Are any joint drills run? Is it known for certain that the new transfer equipment (attached to a specific stretcher) will fit in all of the ambulances available to South West Ambulance Trust? Is there a need for a particular type of Ambulance to be identified at the time that the doctor calls an ambulance?

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.

Your response

You are under a duty to respond to this report within 56 days of the date of this report, namely by 12 June 2014. 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.

Copies and publication

I have sent a copy of my report to the Chief Coroner and [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.

A J COX **Date**
Assistant Coroner
Plymouth Torbay and South Devon area