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:

- [redacted] (Husband)
- [redacted] (Son)
- [redacted] Medical Director Plymouth Hospitals NHS Trust

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 12 October 2012 I commenced an investigation into the death of Audrey Christine DAWS, then aged 84 years. The investigation concluded at the end of the inquest on 2 July 2014.

The cause of death was found to be:

1a Peritonitis and Bronchopneumonia;

1b Perforated Gastric Ulcer (Treated).

The conclusion of the inquest was that Mrs Daws died from Natural Causes to which Neglect contributed.

Circumstances of death

Mrs Daws was admitted to the Emergency Department at Derriford Hospital at 12.38 on Friday 5 October 2012. She complained of chest pain, a burning sensation and feeling clammy.

At 14.30 hours she was examined by a Junior Doctor [redacted] who was concerned to exclude an acute coronary syndrome as a cause of her symptoms. She took a sample of blood so that Mrs Daws' troponin levels could be checked. She did not order a chest X-ray.

[redacted] noted that Mrs Daws was tender in the upper abdomen. She admitted Mrs Daws into the Medical Assessment Unit.

At 18.15 hours Mrs Daws was examined again by another doctor [redacted] in the MAU. She did not believe there was a cardiac cause to Mrs Daws' symptoms but accepted that it was necessary to exclude this. She took a further sample of blood as the first one had broken down and was not suitable for testing.

She also ordered the patient's old medical notes and records. She wanted to see if the left bundle branch block found on ECG had existed at the time of any earlier ECG.

[redacted] requested a chest X-ray.

At 19.04 hours Surgeon [redacted] examined Mrs. Daws. In evidence he said that he would have expected an X-ray result to have been available within two to four hours of having been requested. It was not available at the time of his Ward round.

[redacted] and Surgeon [redacted] completed their shifts and left the Hospital. The results of the X-ray were not to hand. Indeed, Mrs Daws had not been for X-ray at that time.

It was not clear what information in relation to Mrs Daws was conveyed to the doctors coming on to perform the night shift on the MAU. In her evidence [redacted] said she would have expected to have told them that the results of the X-ray were still awaited. It appears as though nothing was done to chase the X-ray during the entire course of the night shift. Shortly after midnight, I understand

that Mrs Daws was moved to a Ward in the Hospital. I heard no evidence as to what, if any, information was exchanged during the transfer.

At 11.19 hours on Saturday 6 October Mrs Daws underwent her chest X-ray.

She was reviewed by another junior doctor, [redacted] approximately 10 minutes later. He checked the image system but the result was not then available.

In his evidence, [redacted] said that he was not clear whether the X-ray still needed to be requested. The reason for his apparent confusion was that while his junior colleague, [redacted] had suggested this when she saw Mrs Daws at 18.15 there was nothing in the notes from the Senior Review conducted by [redacted] to indicate whether or not he confirmed this approach.

[redacted] appears not to have asked the patient whether she had gone for an X-ray and further appears not to have checked the position with any seniors on duty during the course of that shift.

A further point to come out of [redacted] evidence was that he did not receive a formal handover in respect of Mrs Daws from the night shift.

[redacted] reviewed Mrs Daws at 16.49 the same day. She had presented as much improved but as she had vomited he decided that she should remain in Hospital for further observation.

[redacted] said that he did not then check the imaging system to see whether the results of any X-ray were to hand. He explained this by saying that he had asked nursing staff whether Mrs Daws had been off the Ward. When they told him she had not (incorrectly) he did not believe that it was necessary to look for the result of the X-ray.

No one from the night shift appears to have checked whether the results of the X-ray had come back.

On Sunday 7 October Mrs Daws suffered a fall. She was then examined by medical staff as her condition had deteriorated. It was only at approximately midday that the result of the X-ray was discovered. It showed air under the diaphragm indicating a perforation.

Subsequently, Mrs. Daws underwent surgery but her condition deteriorated and she died.

<u>Coroner's concerns</u>

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. Handover of Information. The need for Mrs Daws to undergo a chest X-ray and for the result to be checked appears to have been lost as medical staff have changed at the end/start of consecutive shifts. You may wish to consider whether there needs to be a formal handover in respect of every patient where outstanding investigations are highlighted.

2. A chest X-ray should have been ordered at the time of Mrs Daws admission into the emergency department.

   One was ordered approximately four hours later but it was not performed for nearly 17 hours. This was described as "inexplicable" during the Inquest hearing. It is plainly undesirable for an investigation that is considered urgent to be delayed for so long without anyone identifying the issue.

   Related to this issue is that once the X-ray was performed, the result was not seen by medical staff for over 24 hours. No satisfactory explanation was put forward as to why this occurred.

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. I heard in evidence that if an X-ray had been taken within two to four hours of Mrs Daws admission into Hospital then it was more likely than not that she would have survived.

In relation to the X-ray result not being reviewed for 24 hours, is it possible for the X-ray to be sent with some form of read receipt? Is it possible to set up a process so that if no receipt is sent within a suitable period, an alarm is then raised for the X-ray to be reviewed by a member of medical staff.

Your response

You are under a duty to respond to this report within 56 days of the date of this report, namely by 8 September 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 to the following Interested Persons [redacted], [redacted] 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 9 June 2014**
Assistant Coroner – Plymouth Torbay and South Devon area