ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Marianne Griffiths**, Chief Executive, Western Sussex Hospitals NHS Trust, St Richards Hospital, Spitalfield Lane, Chichester, West Sussex PO19 6SE
1	**CORONER** I am Michael Kendall, 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.
3	**INVESTIGATION and INQUEST** On 20th May 2014 I concluded the inquest into the death of Denise PRIOR, born 18th February 1943 (aged 60 years) who died on 6th November 2013. Mrs Prior had died as a result of (1a) Global hypoxic ischaemic injury to the brain (1b) Hypoxia (1c) Facial injuries sustained in a witnessed fall (29/10/13) (II) Debridement and closure of facial laceration. MUA plus oris of fractured nasal bones. Closure of intra oral laceration (successful 30/10/13). I determined that "The deceased died from a cardiac arrest following a fall caused by her underlying medical condition."
4	**CIRCUMSTANCES OF THE DEATH** Denise Prior died from the consequences of a cardiac arrest following a fall, which in turn had been caused by her underlying medical condition. During the inquest considerable attention was given to the concerns of Mrs Prior's family arising from the records of Mrs Prior's treatment at St Richards, which is part of the West Sussex Hospitals NHS Foundation Trust. In particular the records of her oxygen levels on 30th and 31st October 2013 were examined at length. I heard evidence from several witnesses employed by the Trust, and concluded that there was conflicting evidence as to the precise reason for her cardiac arrest but no evidence to support a finding that on the balance of probabilities her cardiac arrest had been caused by any failure by the Trust or its employees to administer oxygen or any other treatment required by her condition.

	Nevertheless I expressed serious concerns about the standard of record-keeping on the Middleton Ward of St Richard's hospital. I found that the evidence showed particularly in respect of the Patient Observation Charts and the application of the 'National Early Warning Score' ('NEWS') system (i) that the 'O2 SATS' entries had been completed in the wrong line on four occasions on 30th October; (ii) that the total score of Mrs Prior's readings had been incorrectly calculated on five occasions on 30th October; (iii) that on three occasions on 30th October the patient's total 'NEWS' score amounted to 5, while individual scores of her oxygen levels were at '3' on one occasion on 30th October, and that according to the notes about the 'NEWS' system any total of 5 or individual score of 3 required monitoring to be increased in frequency "to a minimum of 1 hourly" and for a "trained nurse to urgently inform the medical team caring for the patient" and for an "urgent assessment within 1 hour by a clinician with core competencies to assess acutely ill patients." There was no record that these steps were taken nor of the outcome, nor alternatively that any reasons existed why they should not be taken, nor that any assessment had been made that Mrs Prior's "normal parameters" would have allowed a more relaxed monitoring regime or application of the 'NEWS' system; (iv) that while nurses were expected to use their experience in assessing the condition of patients and the course of action required, including any departure from the 'NEWS' system, the observation charts did not include any written record of such an assessment having been made, nor any cross-reference to any other records that might suggest that alternative courses of action were justified; (v) that the Prescription and Administration charts contained no record of oxygen being prescribed nor of the level of such prescription; (vi) that while supplementary evidence was given that steps had already been taken to introduce a computerised 'Patient Track' record system in the previous 2 years, and that such a system would ensure that observations were recorded correctly and that 'NEWS' score totals and alerts would be correctly indicated, that system had not been working on 30th and 31st October and on other occasions, during which the paper records already referred to were used instead, and would be used again in the future during any breakdown; moreover the computerised system did not in any event record the prescription of oxygen levels, and an oxygen administration audit had not yet been commissioned.
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. – That there is a risk of other deaths occurring in the future from the inadequacy of record-keeping practices at St Richards Hospital in the recording of oxygen levels and its prescription, and in the application or departure from the 'NEWS' system.
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 28th July 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] (daughter of the deceased) 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:02 June 2014 SIGNED : Michael Kendall, Assistant Coroner