REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. **Chief Executive, East Surrey Hospital**
2. **Medical Director, East Surrey Hospital**
3. **Chief Nurse, East Surrey Hospital**

CORONER

I am Karen HENDERSON, assistant coroner for the coroner area of Surrey

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 13th September 2012 I commenced an investigation into the death of Susanna Geraty, seventy five years of age. The investigation concluded at the end of the inquest on 19th September 2014. The medical cause of death given was:

1a. Hyperkalaemic Cardiac Arrest
1b. Acute kidney injury and compartment syndrome
1c Fracture of the right tibia and fibula (surgical repair)

2. -

My narrative conclusion was:

Mrs Geraty died from undiagnosed acute renal failure, which went unrecognised and consequently went untreated.

CIRCUMSTANCES OF THE DEATH

Mrs Geraty was a fit and well 75 year old woman who fractured her Tibia and Fibula after tripping over an object in the garden. Initial investigations on admission, prior to surgery, showed completely normal renal function. She had an uncomplicated intramedullary nailing operative procedure on 30th August 2012 to repair her fracture.

Five days later she suffered a fatal cardiac arrest on the post-operative ward from acute renal failure (serum potassium greater than12 mmol/l) from dehydration as a result of a lack of fluids in the post-operative period. Nursing records of the assessment of her fluid balance in the post-operative period were found to be inadequate and inaccurate. There was a record that that she was 'compliant' with eating and drinking but there was no evidence that this was the case and the fluid balance record was not completed and lasted for only one day. The 'wellness' chart filled in '3 hourly' by the nursing staff was 'routinely' ticked without good reason. No post-operative blood tests were carried out until shortly before her death, when it was deemed too late.

The family's concerns to the nursing staff on the evening before she died that she was not well and appeared to be jaundiced (I heard evidence that she did have liver failure and it is associated with renal failure) were not acted upon in a timely fashion, nor highlighted at any time to the clinicians. Shortly before her cardiac arrest the on call doctor failed to recognise gross and obvious signs of hyperkalaemia on an ECG and left Mrs Geraty to attend to another emergency, although I heard evidence that by that time her death was inevitable.

The SI report failed to consider lack of fluids as a cause of her underlying acute renal failure despite expert evidence that it was the only credible cause. Furthermore on direct questioning at inquest this was not acknowledged by the author of the report who could give no alternative cause of the acute renal failure.

In summary, this previously completely fit and well lady died from acute renal failure from a lack of appropriate

assessment and management of her fluid intake in the post operative period.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise for concern. In my opinion there is a risk that future death 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. Failure to assess, monitor and record post operative fluid balance.
2. Inadequate nursing records
3. Inadequate fluid balance charts
4. Failure to respond to legitimate concerns raised by the family
5. Failure to recognise an acutely unwell patient
6. Failure of the SI report to consider or acknowledge dehydration as a possible cause of acute renal failure

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation: East Surrey Hospital 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. I, the coroner, may extend this 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] – Expert Report
[redacted] – East Surrey Hospital
[redacted] – East Surrey Hospital
[redacted] - Matron

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.

DATE: 27/1/15 **SIGNED:** DR KAREN HENDERSON