REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive/Medical Director, The Dudley Group NHS Foundation Trust**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 9 January 2018, I commenced an investigation into the death of Mrs Christine Withers. The investigation concluded at the end of the inquest on 23 April 2018. The conclusion of the inquest was a short form conclusion of Natural Causes. The cause of death was: 1a Carcinomatosis b Small Cell Carcinoma of Bronchus
4	**CIRCUMSTANCES OF THE DEATH** i) Mrs Withers was a 72 year old lady with a medical history including a diagnosis of small cell carcinoma of the lung. She was receiving second line chemotherapy with palliative intent. She also had leg cellulitis. ii) Blood tests ordered by her GP on the 15 November 2017 confirmed she had low potassium levels and was admitted to Russells Hall Hospital on the 16 November 2017. iii) She was initially treated with intravenous potassium replacement for hypokalaemia (level 2.2). Initially she made some good progress but later in the evening her condition declined rapidly and she became more agitated and distressed. iv) An emergency call was issued around 11.15pm for a suspected fluid overdose. Furosemide was administered to try and correct the overload. Despite further treatment her condition continued to decline rapidly and sadly she passed away on the 17 November 2017 and was treated with anticipatory medication for end of life care.
5	**<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. Evidence emerged during the inquest that no repeat blood tests were performed to measure the potassium levels despite this being recommended by the Consultant at the ward round in the morning. 2. There was inadequate communication by nursing staff with the family who expressed concerns about the decline in Mrs Withers.
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. 1. You may wish to consider further reviewing the guidance on managing patients with hypokalaemia and monitoring of potassium levels. 2. You may also wish to consider reviewing the communication and training issues identified during the course of the inquest.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 26 June 2018. 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; Family. 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	**1 May 2018** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**