M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

8th June 2018 REF: 7089

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Robert Woolley - Chief Executive** **University Hospitals Bristol NHS Trust** **Trust Headquarters** **Marlborough Street** **Bristol** **BS1 3NU**
1	**CORONER** I am Robert Sowersby Assistant Coroner for **Area of Avon**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 12th July 2017 an investigation commenced into the death of Graham William FOX. The investigation concluded at the end of the inquest on 8 June 2018. The conclusion of the inquest was that he died of (Ia) chronic obstructive pulmonary disease and pneumonia, and (II) left hip fracture (operated) and ankle fractures. My narrative conclusion included the following: His condition deteriorated, and overnight from 25 June hospital staff did not correctly implement the standardised method of assessment and referral ['NEWS'] that was in use at the time, which meant that he was not seen by a doctor as he should have been, and the seriousness of his condition was not recognised until 26 June, when he was admitted to the Critical Care Unit in which he subsequently died.
4	**CIRCUMSTANCES OF THE DEATH** Mr Fox had a history of alcohol misuse and had had a fall in the community in which he broke both ankles. He was admitted to hospital and was being monitored using the NEWS system. He had been "re-triggered" by the hospital's doctors, so that although *normally* an oxygen saturation, or a blood pressure reading, below a certain level would add points to the NEWS total, in Mr Fox's case points would *not* be added unless his score dipped below the new revised ("re-triggered") level.

	Mr Fox's 'normal' NEWS was 5, after which he was reviewed, "re-triggered", and when later assessed his score was 5 again (using the new re-triggered means of NEWS assessment). That represented a real-world deterioration in his condition, but because the number itself did not go up, the nursing staff were relatively unconcerned. The NEWS of 5 was in due course relayed to the on-call doctor, but the doctor did not attend, even though she was on the same ward seeing another patient that evening. Mr Fox then had a series of inadequate observations taken overnight (which were not sufficient to enable any calculation of his NEWS total). By the time his NEWS total *was* properly calculated in the morning it was 9: he was then admitted to the Critical Care Unit, where his condition deteriorated and he sadly died.
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. – (1) The standard NEWS documentation contains a list of scores on the left, and corresponding clinical responses in a column on the right. My understanding of the system was that when the relevant score was reached, the corresponding clinical response was mandatory. The impression I gained from listening to the majority of the nursing staff was that there was an element of discretion / clinical judgment to be applied in determining whether the clinical responses that were 'required' when the relevant score was reached were *actually* necessary. The more senior nursing staff were clear that the relevant responses *were* mandatory, but that was not the impression given by the more junior staff. This evidence (which gave the impression that staff discretion could be applied to the clinical responses) was given *after* the staff had, apparently, been given additional NEWS training following Mr Fox's death. (2) I did not have the benefit of any expert evidence about the process of "re-triggering" patients under NEWS, and I am therefore unable to comment on whether it is clinically appropriate. I did hear evidence that the practice was commonplace within the hospital.

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 17th August 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 – the family of Mr. Fox. 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	22/06/2018 Signature R. C Robert Sowersby Assistant Coroner **Area of Avon**

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