REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **CHIEF EXECUTIVE** **QUEEN ELIZABETH HOSPITAL KING'S LYNN** **NHS FOUNDATION TRUST** **GAYTON ROAD** **KING'S LYNN** **NORFOLK** **PE30 4ET**
1	**CORONER** I am JACQUELINE LAKE, Senior Coroner, for the Coroner area of NORFOLK
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 21 February 2017 I commenced an investigation into the death of KIRSTY ELIZABETH TOLLEY, AGED 28 YEARS. The investigation concluded at the end of the inquest on 8 MAY 2018. The conclusion of the inquest was Medical Cause of Death: Unascertained. Conclusion: Open.
4	**CIRCUMSTANCES OF THE DEATH** Miss Tolley had a number of issues of ill-health. On 10 February 2017 she was admitted to Queen Elizabeth Hospital with leg pain and high temperature. Her haemoglobin level on entry was 77 g/l which dropped to 61 g/l by 16 February 2017. Ferinject treatment was started. Miss Tolley was reviewed by a number of specialities. She was being considered for discharge home. On 19 November 2017 Miss Tolley was found unresponsive in her bed. Despite resuscitation she was declared dead.
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) Miss Tolley had a history of anaemia and had received a blood transfusion in 2016. On admission the Care Plan required blood tests to be taken daily to check haemoglobin levels. These were carried out on 10th, 13th, 14th and 16th (not daily) and showed decreasing levels. Ferinject was administered on 16th February. No blood tests to check haemoglobin levels were carried out after that date (except whilst in cardiac arrest). Blood tests were not carried out daily as required in the Care Plan, despite the requirement for monitoring, her history, the decreasing level of haemoglobin, and Ferinject being administered. There is no reason given in the Care Plan. Evidence was heard with regard to a Regulation 28 Report, that haemoglobin levels are not checked in the few days after Ferinject is administered as its effect is not seen straight away. This was not raised as a reason for not carrying out blood tests in evidence at the inquest. This was not recorded as a reason in the medical records.

	Sadly, not only did this not give treating Doctors a picture of Miss Tolley's anaemia during her lifetime but has also meant there is a vaccum of evidence with regard to the medical cause of death. (2) Early Warning Scores (EWS) are required to be assessed and recorded 3 times per day. This was not done at lunchtime on 11 February nor evening time on 17 February 2017. No reason has been given for this. (3) Evidence was heard that if EWS reaches 3, then this should be escalated to a doctor who should review the patient and set a plan. Observations should be increased to 4 times per hour with further review. The EWS reached 3 on 4 occasions (including the occasion when the EWS was not completed in the records – 17 February) and there is no evidence that any additional action was taken. In particular on the 17 February no observations/EWS for over 17 hours.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 4 July 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:- [redacted] (Parents) I have also sent it to the Department of Health, HSIB and Healthwatch, Norfolk who may find it useful or of interest. 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	**9 May 2018** ..... **[SIGNED BY CORONER]** **Norfolk Coroner Service** **Carrow House,** **King Street** **Norwich NR1 2TN**