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.** Ms Miller, Chief Executive, Dorset County Hospital, Williams Avenue, Dorchester, DT1 2JY
1	**CORONER** I am Brendan Joseph Allen, Assistant Coroner, for the Coroner Area of Dorset
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 23rd January 2018, an investigation was commenced into the death of Rosemary Scott, born on the 30th April 1932. The investigation concluded at the end of the Inquest on the 23rd May 2018. The Medical Cause of Death was: 1a Bronchopneumonia 1b Rib fractures 1c 2 Cardiac failure, Atrial Fibrillation The conclusion of the Inquest was that Rosemary Scott died as a consequence of an accident.
4	**CIRCUMSTANCES OF THE DEATH** Overnight on 8th to 9th December 2017, Rosemary Scott suffered a fall at her son's address, where she was staying at the time. She injured her back. On 9th December, Mrs Scott became a resident at Nazareth Lodge Residential Home in Sturminster Newton. Whilst there, she complained of back pain. Mrs Scott was admitted to Dorset County Hospital on 14th December with breathlessness, confusion and drowsiness. She was found to have a chest flail segment and pneumonia. She required positive end-expiratory pressure (PEEP) and was given a bi-level positive airway pressure machine ("BiPAP"), which she tolerated well.

	Mrs Scott was discharged to Nazareth Resindetial Care Home on 22nd December, but was re-admitted to Dorset County Hospital on 25th December. Mrs Scott was suspected to have sepsis, so the "Sepsis Six Pathway" was completed. Venous blood gases were not measured on admission, or at any stage until shortly before her death. There appeared to be no reminder system in place to alert the treating doctors that this had not been done. Mrs Scott was assessed by a consultant on 28th December. He noted that Mrs Scott "needs PEEP – highflow or CPAP". The next entry in the records indicated that at 13.30 the Charge Nurse "was unable to source any means to provide PEEP". All High flows and BiPAPs were in use. There were no continuous positive airway pressure machines ("CPAP") in respiratory medicine. By 20.45, Mrs Scott was provided with a high flow machine. Mrs Scott deteriorated overnight on 29th to 30th December and died at Dorset County Hospital on 30th December.
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. During the inquest evidence was heard that: i. Venous blood gases were not measured on the second admission (25th December to 30th December), in accordance with the Sepsis Six Pathway. There appeared to be no reminder system in place to address this omission. I heard evidence that measuring the carbon dioxide levels would have assisted in determining whether the high flow machine was providing the level of respiratory support Mrs Scott required. ii. There were initially no means to provide PEEP to a patient that was deemed to need it, due to all machines being in use, or there simply being no machine in respiratory medicine. 2. I have concerns with regard to the following: i. Due to the lack of a reminder system in relation to measuring venous blood gases it was not known whether the respiratory support being provided to Mrs Scott should have been escalated to a BiPAP or CPAP. I request that a review is undertaken to assess whether there should be a system installed to ensure the staff caring for patients where venous blood gases should have been measured are "reminded" of the need to do so.

	ii. The insufficient number of machines to provide PEEP to patients who require it.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or your organisation 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, 1st 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: (1) [redacted] (2) (3) 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	**Dated** **5th June 2018**	**Signed** **Brendan J Allen**