	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • **University Hospitals Birmingham NHS Foundation Trust**
1	**CORONER** I am Miss Emma Brown, Area Coroner for **Birmingham and Solihull**
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 27 March 2018 I commenced an investigation into the death of Kathleen Margaret Allen. The investigation concluded at the end of an inquest on 27 June 2018. The conclusion of the inquest was Natural causes contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased died at the Birmingham Heartlands Hospital on the 20 March 2018 due to the effects of aspiration pneumonia caused by small bowel obstruction. She had been admitted at 15:12 on 18 March 2018 with a history of vomiting and was diagnosed with gastroenteritis. An abdominal x-ray was requested at 20:07 to exclude bowel obstruction but was not carried out until many hours later as the correct procedure was not followed simultaneously the severity of her condition was not identified because she was not reviewed by a Senior Doctor and her observations and modified early warning score were not being monitored frequently enough. The gravity of her condition was identified when her MEWs was taken at 12:40 on the 19 March 2018 prompting senior medical review and x-ray resulting in the diagnosis of small bowel obstruction secondary to a femoral hernia and surgery was undertaken at 06:20 but the Deceased was too poorly to benefit from the surgery. With prompt diagnosis, intervention and treatment Mrs Allen's death was preventable. Following a post mortem/Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: 1a) MULTI ORGAN FAILURE 1b) OBSTRUCTED RIGHT FEMORAL HERNIA (OPERATED)
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 Mews Chart contained within Mrs Allen's A and E records was the Heart of England NHS Foundation Trust 'Adult MEWS Observation Chart'. The Escalation Pathway was clearly set out

	providing that for a MEWs of between 1 and 3 there should be consideration of increasing frequency of observations and "Inform Nurse in Charge". 2. The evidence of the staff nurse caring for Mrs Allen during the evening of the 18 March was that he did not alert the Nurse in Charge when Mrs Allen's MEWS went up to three (having gradually risen from 0 at the time of arrival) because A and E nurses had been told that this part of the escalation pathway did not apply in A and E. He did not consider increasing the frequency of her observations at the time but on reflections said they should have been hourly, he could not explain why he hadn't done this. He went on to explain that since Mrs Allen's death he has been told that he should escalate to the Nurse in Charge a patient with a MEWS between 1 and 3. 3. Evidence was provided from an ED Senior Sister that there is a Trust Standard Operating Procedure (SOP) for MEWS Triggers in the Emergency Department which is different to the Trust wide SOP. The rationale behind having a different Procedure in ED was said to be because Doctors are more widely available in ED than on the wards. Within this SOP a MEWS of between 1 and 3 is not escalated to the Nurse in Charge. It was accepted by the witness that the rationale for a different procedure based on Doctor availability does not explain why the Nurse in Charge is not informed for a patient with a MEWs of 1 to 3. It was suggested that the explanation for this may in fact be because so many ED patients have a MEWS of between 1 and 3 the Trust wide MEWS SOP would be unworkable. A copy of this Procedure was not put before the inquest but was said to still be in operation at Birmingham Heartlands Hospital. 4. It therefore appears that there is not a consistent approach to MEWS SOP in Birmingham Heartlands ED: members of staff are being told different things and there appears to be a different procedure in operation to that set out in documents within patient records. There is a risk that staff within ED will not be taking a consistent, evidence based approach to MEWS and also that non ED based clinicians, reviewing patients in ED will not be aware of the difference in MEWS procedure operating in ED and therefore will expect a different escalation pathway. This could put lives at risk.
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 28 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 next of kin of Mrs Kathleen Allen. I have also sent it to NHS England 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	04/07/2018  Signature Miss Emma Brown Area Coroner **Birmingham and Solihull**