IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Rita Taylor
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: 1. **Chief Executive, Epsom General Hospital** 2. **Royal College of Physicians** 3. **Care Quality Commission**
1	**CORONER** Dr Karen Henderson, HM Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** On 23rd May 2018 I commenced and concluded an investigation into the death of Rita Taylor, 80 years of age. The medical cause of death given was: 1a. Pneumonia 1b. Central Pontine Myelinolysis 1c 2. - My narrative conclusion was: **Mrs Taylor died as a result of sub-optimal care contributed to by neglect**
4	CIRCUMSTANCES OF THE DEATH

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	Mrs Taylor, 80 years old, was admitted into Epsom General Hospital on 31st July 2017 following a collapse with confusion at the Meadows Hospital. She had been admitted there on 7th July 2017 for treatment of psychosis thought to be secondary to hydrocortisone therapy for a pituitary adenoma, which was under review by the endocrinology department at St George's hospital. Mrs Taylor had been previously admitted to Kingston Hospital on the 4th June 2017 with signs of confusion and paranoia. At that time, this was thought to be related to a urinary tract infection which was treated. She was also noted to be hyponatraemic which was corrected. At the same time, she was diagnosed with diabetes insipidus and prescribed desmopressin in addition to her hydrocortisone for her pituitary adenoma. On admission to Epsom hospital A&E department Mrs Taylor was found to have a GCS 14/15 with some confusion. She was haemodynamically stable. Investigations revealed a serum sodium of 111 mmol/l. She was given 1 L normal saline and desmopressin was withheld as it was known to cause hyponatraemia. She was admitted under the care of the on call medical physician. Mrs Taylor was seen by the on call consultant physician at or around 6 pm on the 31st July 2017. No treatment was instituted to monitor or treat the hyponatraemia. There was no documentation from the consultant with regard to that consultation. On the 1st August, Mrs Taylor was reviewed by a consultant emergency care physician with a specialist interest in endocrinology. Mrs Taylor's serum sodium was noted to have increased to 129 mmol/l by 11.00 am but there is no evidence that the rapid rate of increase was understood to be beyond the recommended national guidelines and no steps were put in place to regularly assess serum sodium levels as recommended by national guidelines. The management plan was to continue to withhold desmopressin, to provide potassium replacement through intravenous fluids and to contact St George's hospital for advice. This was attempted but it was not successful. Mrs Taylor was incontinent. Urinary catheterisation was considered but not undertaken preventing any fluid balance assessment which, in any event, was not requested despite a diagnosis of diabetes insipidus.

Mrs Taylor was not reviewed following the consultant ward round. Documentation was minimal and no plan was made with regard to ongoing supervision and treatment.

On the 2nd August Mrs Taylor was reviewed by another consultant emergency care consultant physician with a specialist interest in endocrinology. Mrs Taylor was sitting out of bed, alert and eating breakfast. Her serum sodium was within normal limits, but no plans were put in place to assess serum sodium as recommended by national guidelines. There was no consideration of resuming desmopressin and no consideration was made or documented to manage the consequences of untreated diabetes insipidus. Potassium replacement therapy was initiated with intravenous normal saline and 40 mmol/l of potassium chloride despite being able to eat and drink at that point. St George's hospital was not contacted. Documentation was minimal.

On the 3rd August Mrs Taylor was reviewed by another consultant emergency care physician who felt that she was ready for discharge planning. Mrs Taylor's sodium level had increased to 146 mmol/l having increased from 134 mmol/l the previous day. No thought was given to this rise and no plans were considered or implemented to assess serum sodium as recommended by national guidelines. There was no consideration of resuming desmopressin or to assess fluid balance and no plan was put in place to manage the consequences of untreated diabetes insipidus. St George's hospital was not contacted. Documentation was minimal.

On the 4th August, Mrs Taylor was transferred to the care of the elderly medical ward under the care of a geriatrician although it had been proposed for her to be transferred to a specialist endocrine ward. She was reviewed by a Specialist Registrar who noted Mrs Taylor was very drowsy. She vomited and was thought to have aspirated. Her serum sodium was found to be 164 mmol/l. After consultation with the consultant geriatrician and the consultant who reviewed her on the 2nd August, intravenous normal saline was replaced by dextrose saline. It is unclear what further management was instituted although desmopressin recommenced on 5th August.

It is unclear how Mrs Taylor was managed until the evening of the 6th August when the intensive care specialist registrar was contacted because of concerns of increasing oxygen requirement. Mrs Taylor was assessed and found to be in a minimally conscious state. Her serum

	sodium level was elevated at 152 mmol/l. The Intensive care consultant considered the acute deterioration of Mrs Taylor was a consequence of rapid changes in serum sodium secondary to omission of desmopressin and untreated diabetes insipidus. Mrs Taylor was transferred to the high dependency unit. Radiological examination confirmed the diagnosis of central pontine myelinolysis. Despite optimal treatment from that point, Mrs Taylor showed no signs of recovery and she died on the 15th August 2017. It was accepted in Court that Mrs Taylor died as a direct consequence of the failure, from admission until the 6th August 2017 to appropriately assess and manage hyponatraemia and diabetes insipidus, arising from a pituitary adenoma.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise for concern. In my opinion there is a risk that future death 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 failure to appropriately manage Mrs Taylor's hyponatraemia by the on call consultant physician on the 31st July 2017 on the grounds that it was not his sphere of expertise. No contact was considered or made to someone who may have been able to assist leaving Mrs Taylor to languish overnight with no management plan in place and a lack of any meaningful documentation in her hospital notes. 2. The failure, at any time between the 31st July 2017 and 5th August 2017 to follow the national recommended guidelines for the management and treatment of hyponatraemia, in particular the need to measure serum sodium regularly and to limit the rate of rise of serum sodium to prevent complications. 3. The failure, at any time between the 31st July 2017 until the 6th August 2017 to create a coherent plan for the management of Mrs Taylors medical problems resulting in the failure to assess fluid balance or to reintroduce desmopressin, given a known diagnosis of diabetes insipidus on a background of a pituitary adenoma.

	4. The apparent lack of understanding of the appropriate management of hyponatraemia by consultants whose care Mrs Taylor was under, despite two emergency consultant physicians having a specialist interest in endocrinology. Whilst some attempt was made to contact St George's hospital this was not successfully followed through to assist them in their management. 5. The failure of an emergency consultant physician with an interest in endocrinology to understand that giving intravenous fluids with potassium is not an appropriate method to increase serum potassium levels, more so as Mrs Taylor at that time could eat and drink normally. 6. The documentation throughout Mrs Taylor's admission until transfer to the high dependency unit was inadequate with no record of assessment or a coherent management plan in place to ensure appropriate care and continuity of that care for succeeding physicians to consider or to follow. 7. As was acknowledged in Court, the SI report did not fulfil its obligations and it was agreed that it would be extensively re-written and re-presented to HM Coroner's Court to more accurately reflect the circumstances of Mrs Taylor's death and the learning points required to assist in preventing any future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the following:

1. See names in paragraph 1 above
2. [redacted] (husband)
3. [redacted]
4. [redacted]
5. [redacted]
6. [redacted]
7. [redacted]
8. [redacted]
9. General Medical Council
10. The Chief Coroner

In addition to this report, I am 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 at the time of your response, about the release or the publication of your response by the Chief Coroner.

Signed:

Karen HENDERSON

DATED this 12th June 2018