VERONICA HAMILTON-DEELEY DL, LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove

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CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	THIS REPORT IS BEING SENT TO: **1. Marianne Griffiths, Chief Executive, Brighton & Sussex University Hospitals NHS Trust, Royal Sussex County Hospital, Eastern Road, Brighton.**
1	**CORONER** I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove
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 16th October 2018 I commenced an investigation into the death of **Kalma RAM-HENMAN**, **otherwise Kamla otherwise Kamala**. The investigation concluded at the end of the inquest on 16th October, 2018.The conclusion of the inquest was a **NARRATIVE CONCLUSION** as per the attached sheet.
4	**CIRCUMSTANCES OF THE DEATH** See Record of Inquest
5	**<u>CORONER'S CONCERNS</u>** 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) This lady arrived in A&E in a "precarious" state as the blood test results revealed and there were several failings:-

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The attending Doctor required an accurate fluid chart. This was started. It was incompletely filled out and showed no output and no attempts were made to measure any output. As a result, Doctors and Nurses were unaware of just how dehydrated Mrs RAM-HENMAN was becoming.

(2) An ECG was ordered which showed abnormalities likely associated with her low potassium level. This was not seen by the doctor who requested it. The signature on it is illegible.
A second ECG should have been requested. It was not.
She was written up for potassium in A&E as well as intravenous fluids but was given no potassium and only half a litre of intravenous fluids in her entire 24 hour admission.
It was the view of the Doctors giving the evidence that she should have received at least four litres to deal with her depleted state. So instructions given within three to four hours of her arrival in A&E (at 12.12pm on 6/6/2018) were not implemented.
Why not?

(3) Opportunities to realise that sodium and fluids had not been administered were missed overnight when Mrs RAM-HENMAN was transferred from A&E to Bristol Ward and was seen in the early hours of the 7th. It seems her notes were not read so the failure to give fluids and potassium was missed.

(4) On the morning of the 7th at around 10.30 am. the attending Doctor wanted Mrs RAM-HENMAN to be given Cyclazine, intravenous fluids and for her to have a CT scan. None of this was achieved before her death two hours later.
She should have at least received the intravenous fluids and the Cyclazine. Again it seems that at this stage there was a failure to realise that she had not been given the Potassium she had been written up for in A&E.

(5) Mrs RAM-HENMAN only had one set of bloods done. At Inquest I was told that she should have had more bloods for comparison. These would undoubtedly have shown her deteriorating condition and would have acted as an additional reminder of the failings in her care.

(6) It may be that her transfer from A&E to Bristol Ward at around 5.30 – 6.30pm on the afternoon of the 6th June (a Thursday) coincided with a time of hiatus on the ward but there should not have been an assumption that she should simply be put in a bed and left until the morning ward round and as I say it seems there was an opportunity missed when she deteriorated in the night and a doctor was asked to see her.

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	(7) It transpires that Mrs RAM-HENMAN had a large gastric ulcer which perforated. This in itself is a life threatening emergency and her presentation was unusual. From the evidence I heard it was clear that although there is no guarantee that she would have survived the perforation, had she been optimised in terms of fluids and Potassium her cardio vascular reserve would have been considerably better.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND 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, namely by **15th January 2019**. 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. [redacted] Acute Medical Consultant, Royal Sussex County Hospital 3. [redacted], Consultant in Diabetes and Endocrinology, Royal Sussex County Hospital 4. [redacted] Medico-Legal Services Manager, Royal Sussex County Hospital 5. [redacted] Brighton and Hove Clinical Commissioning Group 6. [redacted] Care Quality Commission 7. Secretary of State for Health, Department of Health 8. Simon Stevens, Chief Executive, 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.

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9	**Date: 23rd October 2018 SIGNED BY:** **HM Senior Coroner Brighton and Hove**