




M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

11th January 2019

REF: 10404

| | |
|---|---|
| | <p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>NHS Improvements Wellington House 133-155 Waterloo Road London SE1 8UG</p> |
| 1 | <p>CORONER</p> <p>I am M E Voisin Senior Coroner for Area of Avon</p> |
| 2 | <p>CORONER'S LEGAL POWERS</p> <p>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.</p> |
| 3 | <p>INVESTIGATION and INQUEST</p> <p>On 19/04/2018 I commenced an investigation into the death of Elizabeth Rose CURTIS. The investigation concluded at the end of the inquest 24th October 2018.</p> <p>The conclusion of the inquest was Elizabeth Curtis was admitted into the Royal United Hospital, Bath on 17th March 2018 with a urinary tract infection and delirium; she was treated and prescribed antibiotics to treat the infection and Haloperidol to treat the delirium. She should have been prescribed 0.25mg but in fact was prescribed 2.5mg. of Haloperidol. The drug error was noted and the drug was stopped. Mrs. Curtis had a number of comorbidities including the fact she was 90, that she was frail, had chronic kidney disease, Crohn's disease and had a swallow problem. Mrs. Curtis developed aspiration pneumonia on 26th March and died on 31st March 2018 at Royal United Hospital Bath</p> |
| 4 | <p>CIRCUMSTANCES OF THE DEATH</p> <p>Mrs Curtis died from aspiration pneumonia contributed to by a number of factors including: her age and frailty; her pre-existing underlying medical conditions; a problem with her swallow, an infection and delirium which required treatment with haloperidol. The drug haloperidol may also have had a minimal impact on her developing pneumonia.</p> |
| 5 | <p><u>CORONER'S CONCERNS</u></p> <p>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion</p> |

| | |
|--|--|
| | <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>A patient's mobility became an issue at the inquest and how this can help with assessing a patient's wellness.</p> <p>I was advised by [REDACTED] at the Royal United Hospital, Bath, who gave evidence at this inquest that she was introducing to the hospital a mobility scale due to the impact that mobility or indeed frailty has on assessing well-being of patients when in hospital.</p> <p>[REDACTED] has indicated that this is a simple scale noting a patient's best mobility in the previous 24hrs. and is recorded alongside the NEWS score. Often mobility is the first symptom demonstrating a decline in health. I am told that the Royal United Hospital have adopted this scale.</p> <p>For further details in relation to this I would suggest that you contact [REDACTED] Consultant Geriatrician, at Royal United Hospital NHS Foundation Trust her email is [REDACTED]. I have also suggested that she write to you to outline her "mobility scale", hence I have copied her into this report.</p> |
|--|--|

| | |
|---|---|
| 6 | <p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p> |
| 7 | <p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th March 2019. I, the coroner, may extend the period.</p> <p>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.</p> |
| 8 | <p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the chief coroner and to the following interested persons –</p> <p>The family of the deceased Royal United Hospital, Bath Avon & Wiltshire Mental Health NHS Partnership Trust</p> <p>I am also under a duty to send the chief coroner a copy of your response.</p> <p>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.</p> |
| 9 | <p>11/01/2019</p> <p>Signature  M E Voisin Senior Coroner Area of Avon</p> |