Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

MS CAROLINE SHAW
CHIEF EXECUTIVE
QUEEN ELIZABETH HOSPITAL
GAYTON ROAD
KING'S LYNN
NORFOLK
PE30 4ET

1 CORONER

I am Yvonne BLAKE, Area Coroner for the Coroner area of NORFOLK

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 28/03/2018 I commenced an investigation into the death of William Clifford ATHERTON aged 92. The investigation concluded at the end of the inquest on 12/12/2018. The conclusion of the inquest was:
Medical Cause of Death
1a Intestinal Obstruction
1b Intra-Abdominal Adhesions including a Constricting Band
1c Previous repair of Abdominal Aortic Aneurysm

Conclusion: A Narrative Conclusion (a copy of which is attached).

4 CIRCUMSTANCES OF THE DEATH

Mr Atherton was admitted to the Queen Elizabeth Hospital (QEH) on 29 May 2017 with abdominal pain and nausea, urinary retention and a distended abdomen. He was assessed in the ED and was thought to have a bowel obstruction. Investigation there showed a distended bladder and a plain x-ray did not show any definite signs of a bowel obstruction. Blood tests demonstrated poor kidney function and a raised CRP.A catheter was inserted. On admission to the ward he was assessed by the surgical registrar who found him to be a poor historian and he was seen the next day by two Consultants, one general surgical, the other a Urologist. They believed he had urinary retention secondary to constipation and an enema was ordered. This worked well, and the plan was for blood tests and discharge. Bloods were taken and showed some improvement in renal function but were reviewed by a junior doctor. A third set of bloods were taken apparently in error and the results of these showed worsening renal function and a general deterioration in his condition. These too were seen by a junior doctor. No senior review of Mr Atherton took place after the morning ward round. He was left on the ward for several hours waiting for discharge and transport, no further observations were taken and no doctor reviewed him prior to actual discharge. He went home, his family reported that he had severely deteriorated and were generally alarmed at his condition.

It was decided the GP would see him the next day. In any event he became severely unwell on 31st with vomiting of faecal matter, a distended abdomen and severe pain. He was taken to QEH Emergency Department and died the same day of bowel obstruction.

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 CONCERNS are as follows: That no medical review of Mr Atherton took place after the ward round on 30th. That his worsening condition was not recognised by the junior doctor reviewing the blood results. That no nursing observations were carried out in the several hours whilst he waited to go home and that potential warning signs of a bowel obstruction were not recognised and acted upon. His documentation was incorrectly filled in (early warning scores EWS) and thus the proper escalation of treatment which this should have triggered did not take place. That the different department at QEH appear to complete EWS differently results in inconsistent scoring and the potential to not escalate treatment of a patient who needs it.

6 ACTION SHOULD BE TAKEN

In my opinion 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, namely by 15 February 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:-

[REDACTED] – daughter of Mr Atherton
[REDACTED] - son of Mr Atherton

I have also sent it to the Department of Health, HSIB and Healthwatch, Norfolk 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 Dated: 21/12/2018

…………………………………………………………….

Yvonne BLAKE
Area Coroner for Norfolk
Norfolk Coroner Service
Carrow House
301 King Street
Norwich NR1 2TN