REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. Chief Executive of University Hospitals Plymouth NHS Trust

1 CORONER

I am Deborah Archer assistant coroner, for the coroner area of Plymouth , Torbay and South Devon

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. [HYPERLINKS]

3 INVESTIGATION and INQUEST

On 16th April 2018 an inquest was opened into the death of Terence Bradfield age 70 (dob 09.07.43). The investigation concluded at the end of the inquest on 1st March 2019. The conclusion of the inquest was that Mr Bradfield died from 1a Small intestinal infarction

2 Pulmonary Sarcoidosis, Hospital acquired pneumonia, duodenal ulcer.

4 CIRCUMSTANCES OF THE DEATH

On 1st December 2013 Mr Bradfield entered Derriford hospital with Gastric bleeding. He had been taking steroid medication prescribed for Sarcoidosis for over 20 years. Mr Bradfield died on 17th December 2013 primarily from the consequences of his GI bleed but during his inpatient stay there were occasions when his steroid dose was either not given or adequately managed.

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 could 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) They are:

- 1. Mr. Bradfield was not given his steroids on 2.12.13
- 2. Mr. Bradfield was not prescribed intravenous hydrocortisone on 4th and 5th December 2013 when Mr. Bradfield had reported vomiting
- 3. Mr. Bradfield was not put on a stress dose of steroids whilst in Derriford hospital
- 4. The awareness and training of staff on the issue of steroid management.

- 5. The lack of a policy on the administration of steroids generally and their use in situations where a number of co morbidities are present despite this death having arisen in 2013.
- 6. The training and awareness of staff on the meaning of "Nil by Mouth "in patients who are suffering from a number of co –morbidities and are on important prescribed medication which needs to be taken regularly notwithstanding any planned necessary procedures.

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. I ask you to review my concerns and report on any action taken to address those concerns.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th May 2019. I, the coroner, and 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:

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 [DATE] 11th March 2019 DEBORAH ARCHER