for Bedfordshire & Luton

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **Mr Stephen Conroy** **Chief Executive** **Bedford Hospital – South Wing** **Kempston Road** **Bedford MK42 9DJ**
1	**CORONER** I am Ian Pears, Assistant Coroner for Bedfordshire & Luton
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 04 July 2018 I commenced an Investigation into the death of **Gwyneth Ann EDWARDS** aged 73. The Investigation concluded at the end of the Inquest on 31 January 2019. The Conclusion of the Inquest was that she died from natural causes and the cause of death was aggravated by neglect.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was under Section 3 of the Mental Health Act with known schizophrenia, diabetes insipidus, panhypopituitarism and suspected malignancy of left kidney. She had been referred by her general practitioner with increased confusion, urinary incontinence, constipation and reduced mobility. She was admitted to Bedford Hospital on the 7th December 2017 complaining of abdominal distension, muscle weakness and unsteady gait; she was treated for sepsis of unknown origin and petechial rash. The deceased was reliant upon Desmopressin for her diabetes insipidus and on Hydrocortisone for her panhypopituitarism. The Hydrocortisone was not dispensed on 10th December 2017.

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	Also, the Desmopressin was not dispensed on 10th, 11th & 12th December 2017. Her sodium levels were very high (above 180 in comparison to 144 on the day of admission) over the weekend, as were her National Early Warning Scores (NEWS). She continued to deteriorate and was put on end of life care, dying on 14th December 2017. The cause of death being: Ia Bronchopneumonia and Hypernatraemia Ib Failure to administer Desmopressin and failure to maintain appropriate fluids II Panhypopituitarism
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 CONCERN** are as follows: (1) The Serious Incident Investigation Report (SIR) addressed the issue of transfers from out of the Acute Assessment Unit (AAU), but the current solution does not include weekend transfers, which is when the deceased was transferred. (2) The SIR recommended that laminated cards be given to staff with National Early Warning Score (NEWS) scoring and response guidance. It is clear from the evidence of the nurses at the Inquest that the NEWS scoring was being recorded, but not actioned in accordance with the NEWS Protocol. This would suggest that the SIR recommendations to re-inforce learning is not effective. (3) During the SIR Investigation it became clear that the Mobile Medic System had registered a request for a review due to raised NEWS at 19.48 hours on 10th December 2017. The Mobile Medic System was marked as complete at 20.54 hours, but there is no record of the Mobile Medic having attended. It is of concern that this request can be marked as complete when it was not. (4) Desmopressin tablets are kept in the fridge, but the staff were not familiar with the drug to know that. There appears to be no warning on the drug charts that this is the case. (5) Witnesses who had not recorded their actions or who had not undertaken NEWS scoring, explained that they were too busy, and indicated there was not enough staff. It is of concern that monitoring, as envisaged by NEWS, cannot take place if there is insufficient staff and it is of concern

	that proper and crucial notes are not being made due to staffing pressures.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 21 March 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] (husband of the deceased) I have also sent it to Bedfordshire Clinical Commissioning Group 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 5th February 2019** ..... **Ian PEARS** **Assistant Coroner** **for Bedfordshire & Luton**

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