Regulation 28: REPORT TO PREVENT FUTURE DEATHS

.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

Chief Executive Officer
Norfolk and Norwich University Hospital
Colney Lane
Norwich
NR4 7UY

1. CORONER

I am Jacqueline LAKE, Senior Coroner for the 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 25/04/2019 I commenced an investigation into the death of Sarah Nadine Louise GIBBS aged 38. The investigation concluded at the end of the inquest on 26/10/2020. The medical cause of death was:

1a) Aspiration of Gastric Contents
1b) Vomiting
1c)
1d)
2 Acute Peritonitis Following Recent Insertion of PEG tube to Assist Nutrition (in patient with learning disabilities and epilepsy)

The conclusion of the inquest was: Sarah Gibbs died shortly after returning home following a medical procedure.

4. CIRCUMSTANCES OF THE DEATH

Sarah Gibbs had learning disabilities, lacked mental capacity and had difficulty feeding. She underwent a PEG operation on 16 April 2019. Sarah was discharged home on 17 April 2019. The result of an earlier blood test was not known and she was not seen by a Doctor immediately prior to discharge. Later that day, Sarah became unresponsive and emergency services were called. A defibrillator was not able to be accessed. Sarah was pronounced dead at the scene.

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:

Concerns were raised during the inquest with regard to communication between teams, particularly to the staff on duty at night as to what information was handed over. Evidence was heard of an easy to use form of communication tool which enables information to be transferred accurately, especially at handover time, between nurses and clinicians, known as SBARD. This helps in reducing the likelihood for errors in communication information.

It was not known whether this tool is in use although it was "hoped" it is being used. This is some eighteen months following Miss Gibbs's death.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 24 December 2020. 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:

Mr and Mrs Gibbs, (Parents)

I have also sent it to:
Department of Health
Care Quality Commission
HSIB
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: 29 October 2020

Jacqueline LAKE
Senior Coroner for Norfolk
Norfolk Coroner Service
Carrow House
301 King Street
Norwich NR1 2TN