REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. [redacted] Chief Executive Frimley Health NHS Foundation Trust Frimley Park Hospital Portsmouth Road Frimley Camberley Surrey GU16 7UJ 2. The Right Honourable Sajid Javid MP Secretary of State for Health and Social Care House of Commons LONDON SW1A 0AA
1	**CORONER** I am Mrs Heidi J. Connor, senior coroner for the coroner area of Berkshire.
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** I conducted an inquest into the death of Angela Margaret O'Donnell at Reading Town Hall on 15th October 2021. I recorded a conclusion of natural causes.
4	**CIRCUMSTANCES OF THE DEATH** The family asked me to refer to the deceased as Angela during the inquest. I will respect that wish in this report. Angela was born on the 26th July 1951. She was diagnosed with advanced lung cancer in October 2019. She underwent treatment for this, but the cancer continued to spread and she was admitted to Wexham Park Hospital in Berkshire on the 8th January 2022 with symptoms of confusion and pain. We heard evidence about the completion of a NEWS (National Early Warning Score) chart by an agency nurse on the night of 13th/14th January 2020. Angela was noted to have an unrecordable blood pressure on 6 occasions. Some parameters were not completed at all. There were numerous missed opportunities for her care to be escalated as her condition deteriorated. It is sadly not uncommon to see NEWS charts which are incomplete. This is far from the first time this issue has arisen, but this example was particularly stark. Angela died in hospital on 14th January 2020. The hospital trust produced a very candid investigation report, fully accepting the errors made. They have put a lot of work into awareness around recognising and managing deteriorating patients and will be moving towards electronic NEWS scoring

next year. For this reason, my report does not contain questions about NEWS scoring and recognising deteriorating patients.

On the very specific facts of this case, I did not find that the failure to recognise her deterioration caused Angela's death.

Despite the extensive work carried out by the trust in raising awareness of NEWS scoring and recognising deteriorating patients, the fact that the nurse in question was an agency nurse was, in my view, a key point. Agency nurses are of course qualified, and the purpose of this report is not to criticise agency nurses generally. It is fair to say, however, that they would not be receiving the refresher training, newsletters etc, circulated by the trust, nor would they be attending meetings where these issues are discussed and awareness is raised.

Wexham Park Hospital, along with many hospitals nationally, has a serious problem with staffing shortages in many areas, including nursing. As such, they have little choice but to use large numbers of agency nurses to fill those gaps in the short term. This is a picture which is reflected up and down the country.

As set out in the case of R (Dr Siddiqui and Dr Paeprer-Rohricht) -v- Assistant Coroner for East London, the issuing of a Regulation 28 Report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature.

This is a complex and national issue, but it is the important responsibility of coroners to highlight matters of concern, where we believe there is a risk of future deaths.

Concern about the use of agency staff is by no means new information. This report does not tell the hospital anything they do not already know. It is difficult even for the senior managers within the trust to identify the cause or causes of these national shortages. Coroners are under a duty to flag up concerns where there is a risk of future deaths - even where the solution to that concern is not clear.

I have heard in evidence on more than one occasion that recruiting more nurses is difficult - not because the trusts are not trying to recruit them, but simply because there are insufficient nurses out there to recruit.

Given the fact that this issue is a national one, and the root cause of it is nursing staff shortages, I have considered it necessary to include the Secretary of State for Health and Social Care, to add my voice to this ever-increasing national concern.

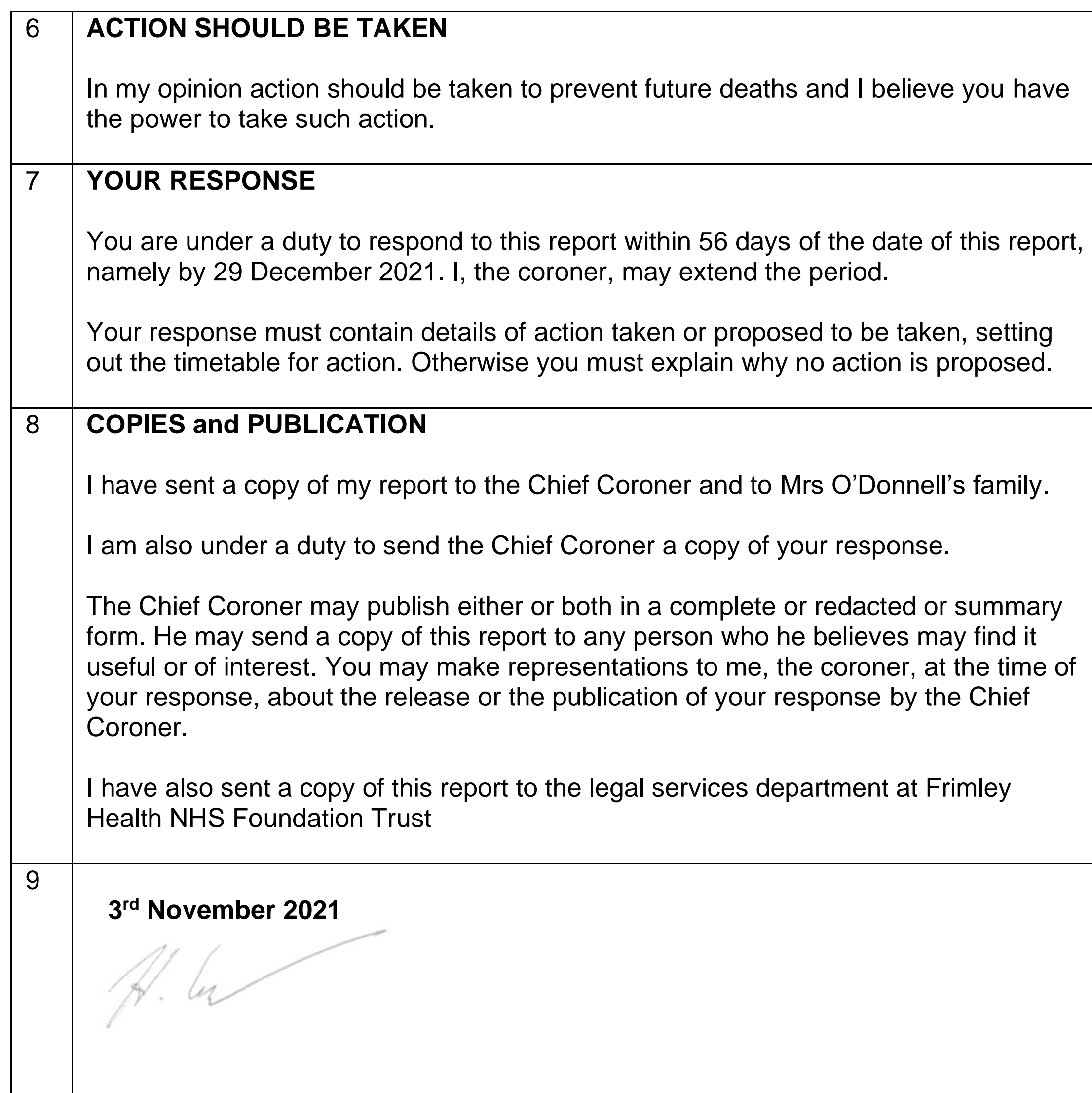
5 **CORONER'S CONCERNS**

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) Is the trust able to carry out any steps to reduce their reliance on agency nursing staff – for instance, by using nurses from a smaller pool of their own bank staff who receive the same training as permanent staff, or any other similar measures? This question is for the hospital trust.

(2) What plans are there nationally to reduce the shortage of nursing staff going forward? This question is for the Secretary of State.



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 29 December 2021. 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 Mrs O'Donnell's family. 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. I have also sent a copy of this report to the legal services department at Frimley Health NHS Foundation Trust
9	**3rd November 2021**