Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. **The Chief Executive**
   Queen Elizabeth Hospital
   Gayton Road
   King's Lynn
   PE30 4ET

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 10/01/2020 I commenced an investigation into the death of Margaret Lilian SALES aged 89. The investigation concluded at the end of the inquest on 02/10/2020. The medical cause of death was:

1a) Aspiration Pneumonia

1b)

1c)

2 Cerebellar Cerebrovascular Accident

The conclusion of the inquest was: Mrs Sales died from Aspiration Pneumonia, the cause of which is not clear from the evidence.

4. CIRCUMSTANCES OF THE DEATH

Mrs Sales had a number of comorbidities including a stroke for which she had a PEG fitted, had a number of recent chest infections and was generally frail. On 13 December 2019 Mrs Sales was admitted to Queen Elizabeth Hospital with hyperglycaemia and suspected chest infection. On 24 December 2019 conflicting evidence was heard as to whether Mrs Sales had been given breakfast, despite being "Nil by mouth". Mrs Sales general health deteriorated and she died on 4 January 2020.

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. Evidence was heard that Records were not always completed as required. It is understood clinical teams have been notified of this and the records are being audited. There was no evidence as to the outcome of those audits and any further action taken.
2. Nurses had difficulty in contacting front line on call medical staff on two occasions. Several members were contacted before anyone attended. Bleeps are now to be provided to all on call medical staff. However, some of the team had bleeps and still did not respond to the requests to attend the patient.
3. On a previous discharge from hospital, it was noted Mrs Sales had been referred to the Home Enteral Nutrition service for monitoring and follow up and that in situations such as this, requests will be placed with the GP. However, no such request had been placed with the GP. The Discharge Letter in fact stated: "Actions for the GP: No recommendations". As a result, the GP did not monitor Mrs Sales' capillary blood glucose following discharge.

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 7 January 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 the following Interested Persons:

[redacted] (son)

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: 11 November 2020

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