MR G IRVINE
ACTING SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 13171727

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], Chief Executive, The Barking Havering and Redbridge University NHS Trust, Queen's Hospital, Rom Valley Way, Romford, Essex RM7 0AG [redacted]
1	**CORONER** I am Graeme Irvine, acting senior coroner, for the coroner area of East London
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 1st April 2021 this Court commenced an investigation into the death of Elizabeth Margaret Mills age 71 years. The investigation concluded at the end of the inquest held on the 12th November 2021 and 16th May 2022. I made a determination of a Narrative conclusion; "*Mrs Elizabeth Margaret Mills was admitted to hospital with abdominal pain on 25th March 2021. Mrs Mills was diagnosed as suffering from a perforated pyloric ulcer and underwent surgery. Following surgery, a chest infection developed requiring increasing levels of oxygen therapy through nasal cannulae.* *On 31st March 2021 Mrs Mills suffered a desaturation requiring an increased volume of*

	oxygen therapy to be administered through a mask. Due to concerns regarding Covid 19, Mrs Mills was transferred to a side ward. The deceased did not tolerate the use of the mask and repeatedly removed the apparatus. *Mrs Mills was supported by [redacted] who attempted to reassure and encourage [redacted] in the use of the mask. [redacted] Mrs Mills were unattended in the side ward by clinical staff without any specific advice to follow. Mrs Mills removed her mask and [redacted] replaced the mask with nasal cannulae. [redacted] did not know that the nasal cannulae were no longer connected to an oxygen supply. The interruption of oxygen treatment in concert with Mrs Mills' pneumonia caused a respiratory arrest which caused her death."* The medical cause of death was: 1a Healthcare Associated Pneumonia 1b Perforated Gastric Ulcer (Laparotomy and repair of Ulcer 26.03.2021) II Liver Cirrhosis
4	**CIRCUMSTANCES OF THE DEATH** See narrative conclusion above
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. The poor standard of medical record-keeping and documentation did not allow a clear understanding of whether the Trust policy on "Do not attempt CPR" orders was followed properly. Family members assert that the process was not properly engaged and their views were not explored. 2. During the final hours of her life, Mrs Mills required increasing levels of oxygen therapy. Mrs Mills was agitated and repeatedly removed a venturi mask. Medical and nursing staff left Mrs Mills in a side ward in the care of her husband, relying upon him to ensure her mask remained in place. 3. Unexpected events that impacted upon Mrs Mills' care were not investigated by the Trust in the form of a Serious Incident Investigation.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 **21st July 2022**. 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] • The Care Quality Commission. • The Nursing and Midwifery Council • The General Medical Council • The Secretary of State for Health and Social Care, 39 Victoria St, Westminster, London SW1H 0EU I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE] 25/05/2022 [SIGNED BY CORONER]**