*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Medical Director, Royal Cornwall Hospital**
1	**CORONER** I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 25/1/23, I concluded an inquest into the death of Felice Eileen Grace Banfield who died in RCHT on 22/10/21. . The medical cause of death was recorded as: 1a) Chronic Obstructive Pulmonary Disease and Sarcoidosis 1b) 1c) II) I recorded a Conclusion of Natural Causes. I considered adding a rider of neglect but did not do so on the basis that the shortcomings identified – and accepted – were not gross in the sense they were not total and complete. Nevertheless, I felt the circumstances gave rise to a concern and engaged my statutory duty to make this PFD report.
4	**CIRCUMSTANCES OF THE DEATH** Ms Banfield had a past medical history that included COPD ([redacted] felt this was actually Obesity Hypoventilation Syndrome) chronic kidney disease (stage 3) and type 2 diabetes. She used non-invasive ventilation (NIV) at home and brought her machine into RCHT with her when admitted. Her presenting complaint was a painful knee, and the initial differential diagnoses were gout, septic arthritis or a flare of osteo arthritis. Her need for NIV was recognised but following her admission to MAU at 22:20 on 17/10/22, there was a lack of clarity about if and where NIV could be undertaken. As respiratory consultants do not provide an on-call service, it appears to have been decided to leave the issue until the following day when the evidence suggested the matter was simply forgotten. Although presenting with a respiratory element to her condition, her admission was not brought to the attention of respiratory clinicians. On 21/10/21, a respiratory nurse became aware of her presence and took bloods that revealed a mixed respiratory and metabolic acidosis that had caused an AKI. Despite treatment, Ms Banfield deteriorated and died. It was accepted in evidence that this was an avoidable death. The structured judgment review conducted found a poor level of care. There was discussion about the cause for the AKI. While the failure to provide NIV was accepted, it was felt in evidence that the more likely significant driver was a failure to provide adequate fluid and food. Charts to evidence this were not completed. [redacted] accepted this had been a problem in MAU for years where there is a rapid turnover of patients and a lack of continuity in medical and nursing care.

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. - A lack of clarity about if and when NIV can be offered to admitted patients. - A patient admitted into RCHT with a respiratory element to her underlying condition was not brought to the attention of the respiratory team. The presenting complaint was not of a respiratory nature and so the challenge appears to be to identify those patients with multiple co-morbidities, one of which has a respiratory component, particularly where the patient is not on a respiratory ward. - A failure to recognise a deterioration in the presentation of a patient which could have triggered a request for repeat bloods and revealed the worsening acidosis before an AKI developed. There appear at least two elements to this: i) the use of food and fluid charts to make sure a patient is not becoming dehydrated and is having adequate calorific intake; ii) for patients who stay on AMU longer than usual, ensuring there is some continuity in medical or nursing care, so a deterioration in presentation can be recognised promptly. Would there be value, for example, in requiring a patient who is on AMU for longer than say, 48 hours, to become the responsibility of a single, named consultant who will be responsible for regular review starting at the 48 hour mark?
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 28 March. 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] (daughters.) 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	**[DATE] 30.1.23** **[SIGNED BY CORONER]**