**M. E. Voisin**
**His Majesty's Senior Coroner**
**Area of Avon**

Date: 19 April 2023

[redacted]

**REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

**THIS REPORT IS BEING SENT TO: Chief Executive, Royal United Hospital, Bath**

**CORONER**

1 I am Maria Eileen Voisin, Senior Coroner for the Area of Avon

**CORONER'S LEGAL POWERS**

2 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

**INVESTIGATION and INQUEST**

On 28 January 2022 I commenced an investigation into the death of Elizabeth Mavis HUTCHINS. The investigation concluded at the end of the inquest . The conclusion of the inquest was

Natural causes contributed to by neglect.

3 The medical cause of death was recorded as:

1a Cardiac arrest

1b Acute coronary syndrome, myocardial infarction

1c Coronary artery atherosclerosis

II Type 2 diabetes, hypertension, aortic stenosis

**CIRCUMSTANCES OF THE DEATH**

4 The deceased Elizabeth Mavis HUTCHINS died on 23 January 2022 at Royal United Hospital, Bath. She had been admitted unwell on 11th January 2022 after falling and breaking her arm. She suffered myocardial ischaemia and injury on the night of 13th /14th January which was not treated or managed in any way at all. She was not seen by a doctor again until she suffered a cardiac arrest on 18th January 2022.

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## 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.

On 13th January, at 23.15hrs a doctor reviewed Mrs Hutchins because she was complaining of being short of breath. She was alert but appeared to be very breathless, she was speaking with some difficulty. Mrs. Hutchins reported a one-day history of being short of breath with a productive cough and intermittent chest tightness. She was also nauseous. He sought advice from an SHO and documented the plan that she was for an ECG, blood test including a troponin, CRP and oxygen.

The ward cover SHO for Medicine, said that he was called initially for advice on the blood tests he said in evidence that he considered a heart attack and pulmonary embolism so said Troponin and D-Dimer. He sought advice from the Registrar who said that the ECG trace was not normal.

The Registrar said that at the time she had raised CPR and that she had a productive cough and he considered that this was a pneumonia. He said that he considered Troponin but thought that it would not be a useful test in the circumstances. His plan at this time was to give antibiotics, IV fluids, to repeat her heart trace in half an hour and to increase her observations to 1 hourly.

It is known that the Troponin result was returned at 01.35hrs on 14th January and that it was raised at 358.

The SHO saw Mrs Hutchins at 04.57 that morning, he had noted the raised Troponin, he made a plan for the day team to review her and for bloods to be done to include a serial Troponin level. He also recalls that he gave a handover and spoke to the nurses. He said he expected her to be reviewed.

Mrs Hutchins did not have a medical review on 14th or 15th or 16th or 17th .

On 18th January at 06.45 Mrs Hutchins was admitted to the intensive care unit. That she had suffered a cardiac arrest on Pierce ward, she had felt light-headed whilst sitting on the commode and the nursing staff helped her back to bed; where it was noted her blood pressure was low and heart rate fast around 30 minutes before she suffered a cardiac arrest. It was estimated that the cardiac arrest lasted for around 15 minutes. I was told that the arrest call was put out at 04.41hrs and CPR started in 4 minutes.

An urgent angiogram found multivessel coronary artery disease including a severe stenosis in the right coronary artery. She was assessed for neurological function after the cardiac arrest which unfortunately showed seizure activity. This is associated with a poor outcome. She remained deeply unconscious and died on 23rd January 2022.

A Consultant Cardiologist based at the RUH provided his opinion having reviewed the medical records. He had not been involved with Mrs Hutchins care. He confirmed that:

- She had chest pain an abnormal ECG and an elevated Troponin.
- Her heart was under strain and she was not treated at the time
- She was not seen by a doctor for 4 days, she should have been. He would expect all patients to be seen on a working day. A medical patient not seen for 4 days is not right.
- She had an elevated risk profile due to the cardiac stenosis but also her hypertension, diabetes, her age – she was in a higher risk group.

- In the daytime there should be a review and then a discussion with the cardiologist team.
- He said that her episode of chest pain and breathlessness on 13th/14th together with an ischemic ECG and elevated Troponin would be compatible with myocardial ischaemia and injury. That he would have commenced her on standard therapy for ACS antiplatelets and an anticoagulant. That patients with suspected or confirmed ACS should have cardiac monitoring. The ideal pathway would be transfer to a monitored area such as the coronary care unit or cardiac ward; a cardiology review, repeat echocardiography and inpatient angiography.
- It was accepted that this may not have all happened but she should have been reviewed by cardiology; had ACS treatment; monitored carefully; the risk of a second event is reduced by the ACS treatment, it might have made a difference. If treated she may still have suffered a cardiac arrest.
- If she'd had the senior review and suffered the cardiac arrest in a different place she would have been treated more promptly.

The Registrar said if he'd been aware of the raised Troponin his threshold to treat her for a heart attack would have been lower. He agreed with the cardiologist's view about how Mrs Hutchins should have been treated.

The **MATTERS OF CONCERN** are as follows. –

I was told that there have been a number of changes following this death at the RUH. However that there were two areas which remain outstanding:

(1) The hospital at night team, to assist with management of the hospital at night, take calls from wards, log and triage the calls, coordinate the night team, send clinicians tasks – this is still to be put into place, funding has not been secured for this.

(2) The acute cardiac syndrome (ACS) specialist nurse practitioner role – this is not in existence at this time which I am told would be an excellent compliment for the teams and support staff during the daytime hours.

**ACTION SHOULD BE TAKEN**

6 In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

**YOUR RESPONSE**

You are under a duty to respond to this report within 56 days of the date of this report, namely by
7 14th June 2023. 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.

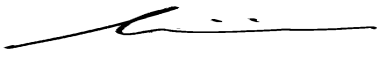
**COPIES and PUBLICATION**

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons – family of the Deceased.

8 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.

19 April 2023

9 Signature 

M. E. Voisin, H. M. Senior Coroner, Area of Avon