Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 The Medical Director – Milton Keynes University Hospital** **2 [redacted] – Chief Inspector of Hospitals at the Care Quality Commission** **3 [redacted] – Chief Medical Director, Bedfordshire, Luton, and Milton Keynes Integrated Care Board** **4 The General Medical Council**
1	**CORONER** I am Sean CUMMINGS, Assistant Coroner for the coroner area of Milton Keynes
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 20 July 2022 I commenced an investigation into the death of Alexander Shone BLEWITT aged 48. The investigation concluded at the end of the inquest on 21 March 2023. The conclusion of the inquest was that: Alexander Shone Blewitt died at the Milton Keynes University Hospital on the 11th July 2022. He had attended on the 9th July 2022 after visiting the nearby Urgent Care Centre (UCC) and being referred to ED by the GP there. He was provided with a printout of his consultation with her. She was worried about him. That communication detailed his complaint of loose stools and abdominal pain. The triage nurse did not record the content of the UCC letter accurately and took that letter from Mr Blewitt. He later saw the ED doctor who did not see or read the UCC letter or attempt to source it. The ED doctor did not record any questions relating to bowel habit on his contemporaneous note, but sometime subsequent to Mr Blewitt's death wrote a statement in which he identified that he had and that there were no bowel complaints. This was despite several days of being faecally incontinent at home and highlighting this to the UCC doctor. The ED doctor sent him home with a diagnosis of a possible resistant or recurrent urinary tract infection even though the MSU taken by his GP a few days earlier and available to the UCC doctor showed no growth. Mr Blewitt, even though he was sent home with a diagnosis of a possible resistant urinary tract infection on the 9th July 2022, was told to continue the original antibiotics his GP had started him on and then to start the new ones the next day. Mr Blewitt spent a difficult two days with faecal incontinence and abdominal pain before returning on the 11th July 2022 to the ED. At this visit a possible acute abdomen was diagnosed and CT scanning confirmed this. He was taken to theatre and suffered a cardiac arrest before surgery and died the next day on ITU. It emerged in evidence that there were no reliable records of any fluid resuscitation in the ED available for examination. This is because the computerised system records the prescription of IV fluids but unless the prescription is signed, that prescribed item is erased. The best information I received was that he had received two litres of an unknown fluid at some point during his time in the ED. It seems that doctors were not as a routine signing the prescriptions and so no reliable record was retained. I was told that doctors had been reminded on the need to sign prescriptions but no audit of this had been

	carried out since Mr Blewitt's death.
4	**CIRCUMSTANCES OF THE DEATH** Alexander Shone Blewitt died at the Milton Keynes University Hospital on the 11th July 2022. He had attended on the 9th July 2022 after visiting the nearby Urgent Care Centre (UCC) and being referred to ED by the GP there. He was provided with a printout of his consultation with her. She was worried about him. That communication detailed his complaint of loose stools and abdominal pain. The triage nurse did not record the content of the UCC letter accurately and took that letter from Mr Blewitt. He later saw the ED doctor who did not see or read the UCC letter or attempt to source it. The ED doctor did not record any questions relating to bowel habit on his contemporaneous note, but sometime subsequent to Mr Blewitt's death wrote a statement in which he identified that he had and that there were no bowel complaints. This was despite several days of being faecally incontinent at home and highlighting this to the UCC doctor. The ED doctor sent him home with a diagnosis of a possible resistant or recurrent urinary tract infection even though the MSU taken by his GP a few days earlier and available to the UCC doctor showed no growth. Mr Blewitt, even though he was sent home with a diagnosis of a possible resistant urinary tract infection on the 9th July 2022, was told to continue the original antibiotics his GP had started him on and then to start the new ones the next day. Mr Blewitt spent a difficult two days with faecal incontinence and abdominal pain before returning on the 11th July 2022 to the ED. At this visit a possible acute abdomen was diagnosed and CT scanning confirmed this. He was taken to theatre and suffered a cardiac arrest before surgery and died the next day on ITU. It emerged in evidence that there were no reliable records of any fluid resuscitation in the ED available for examination. This is because the computerised system records the prescription of IV fluids but unless the prescription is signed, that prescribed item is erased. The best information I received was that he had received two litres of an unknown fluid at some point during his time in the ED. It seems that doctors were not as a routine signing the prescriptions and so no reliable record was retained. I was told that doctors had been reminded on the need to sign prescriptions but no audit of this had been carried out since Mr Blewitt's death.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) [1] At the time of Mr Blewitt's death there was no effective, reliable recording of intravenous fluids administered to patients in the emergency department. That in my view has potential to represent a threat to the safety and lives of patients suffering with a wide variety of different conditions. The author of the SI report who attended to give evidence did not, at the time of Inquest 8 months later, was unable to demonstrate that the Trust had remedied that. [2] Despite the 8 month interval between Mr Blewitt's death and the Inquest the issues of concern had not been brought to the attention of hospital authorities. [3] On arrival at the ED a triage nurse summarised the communication from the urgent care centre. The triage nurse missed important points during the transcription. The attending doctor did not concern himself to look at the communication himself. [4] I was concerned that the treating doctor made a contemporaneous note on the 9th July 2022 at Mr Blewitt's first presentation which failed to record the major presenting symptom, diarrhoea with faecal incontinence, which Mr Blewitt had communicated to the urgent care doctor who in turn had included that in her notes and letter to the ED. The treating doctor did record a flatly contradictory note to the effect there was no change in bowel habit. [5] The Incident Investigation Report which is in part designed to assist with learning from adverse events was of a generally poor standard. There was a failure to consider issues in

	detail; there was a failure to challenge the statements of clinicians where there were obvious contradictions between statements made and the medical record; there was a failure to put in place measures to correct and monitor prescribing clinicians failure to sign off on IV fluid prescriptions so that the contemporaneous record would be available for clinicians coming after them and they could see whether a patient had satisfactory or unsatisfactory fluid management. The only record in the case was a typed note by a junior doctor to the effect that it was thought Mr Blewitt had received 2 litres of fluid since arrival.
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 July 24, 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] I have also sent it to who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 06/06/2023** **Sean CUMMINGS** **Assistant Coroner for** **Milton Keynes**