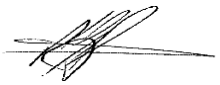
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT DATED 15 SEPTEMBER 2023 IS BEING SENT TO:** [redacted] **Interim Chief Executive** **Royal Devon University Healthcare Foundation Trust.**
1	**CORONER** I am Philip SPINNEY, HM Senior Coroner, for the coroner area of Exeter and Greater Devon.
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 November 2020 an investigation was commenced into the death of Geoffrey Robin Brooks. The investigation concluded at the end of the inquest held on 14 September 2023. The conclusion of the inquest was as follows: *Geoffrey Robin Brooks died due to complications of nephrogenic diabetes insipidus on a background of poor fluid intake.*
4	**CIRCUMSTANCES OF THE DEATH** Geoffrey Robin Brooks suffered with nephrogenic diabetes insipidus diagnosed in 2013. In 2020 Mr Brooks's health declined and he had multiple admissions to hospital. In August 2020 he was admitted to the Exmouth Community Hospital. Due to his diabetes insipidus Mr Brooks required monitoring of his blood sodium to ensure that he was maintaining the correct balance of fluid intake to remain stable. On admission his blood sodium was low, and he was on a restricted fluid intake; during his admission his condition improved, and he was moved from a restricted fluid intake to a daily target level of fluid intake of 2.5 to 3L per day. On 25 September 2020 Mr Brooks was discharged to the Barton Place Nursing Home. The discharge summary did not clearly set out Mr Brooks's fluid requirements and the nursing home staff believed Mr Brooks was to be restricted to no more than 2.5 -3L per day rather than that figure being a target to aim for; the nursing home were advised it was a target on 9 October 2020 after Mr Brooks became unwell; the

	target level of 2.5 to 3L was not achieved during his stay in the nursing home. On 18 October 2020 Mr Brooks' health deteriorated and was admitted to hospital where despite treatment he sadly died on 12 November 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) During his evidence the consultant physician with the responsibility for the care and treatment of Mr Brooks acknowledged that the discharge summary was ambiguous and did not make it clear that the 2.5 – 3L was a target fluid intake; he agreed that it could be interpreted that Mr Brooks should be restricted to no more than 2.5 to 3L of fluid a day. As a consequence, the nursing home staff were unaware of the needs of Mr Brooks. The target fluid intake was not met in the period that Mr Brooks was in the nursing home, which contributed to his death.
6	**ACTION SHOULD BE TAKEN** (1) **Consideration should be given to reviewing the process of discharging patients to ensure that all discharge documentation includes an accurate summary of the ongoing care needs of the patient.** In my opinion action should be taken to prevent future deaths and I believe you and 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 23rd November 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 family of Mr Brooks. The Chief Coroner

	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	**SIGNED:**  **Mr Philip C Spinney** **HM Senior Coroner** **Exeter and Greater Devon**