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 Resuscitation Council UK** **2 Northampton General Hospital Trust**
1	**CORONER** I am Hassan SHAH, Assistant Coroner for the coroner area of Northamptonshire
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 13 October 2021 I commenced an investigation into the death of Miss C, aged 36. The investigation concluded at the end of the inquest on 24 August 2023. The conclusion of the inquest was that: Miss C died at Northampton General Hospital on 5th October 2021. The primary underlying causes are recent weight loss with nutritional deficiencies and interstitial pneumonia. On 4th October 2021 during her deterioration, a doctor should have reviewed but did not do so until later. A review before the cardiac arrest would have provided a chance for enhanced supportive care and an early peri-arrest call might have been activated which could have had a favourable effect on the outcome. There was therefore a missed opportunity in the medical care.
4	**CIRCUMSTANCES OF THE DEATH** Miss C died at Northampton General Hospital on 5th October 2021. The primary underlying causes are recent weight loss with nutritional deficiencies and interstitial pneumonia. On 4th October 2021 during her deterioration, a doctor should have reviewed but did not do so until later. A review before the cardiac arrest would have provided a chance for enhanced supportive care and an early peri-arrest call might have been activated which could have had a favourable effect on the outcome. There was therefore a missed opportunity in the medical care. Although ultimately determined to be non-causative of the death, the management of the cardiac arrest which occurred around 7 hours before Miss C passed away was scrutinised. During the cardiac arrest, an arterial blood gas showed metabolic acidosis, hyperkalaemia, increased lactate, hyponatraemia, and hypoglycaemia. Calcium gluconate (dose not known) and 20% glucose were administered. Administering calcium gluconate (medication used to manage hypocalcaemia) is not the Hospital Trust's policy for the treatment of hyperkalaemia in cardiac arrest. There were conflicting amounts of dextrose recorded as given in the clinical notes compared to what was signed on the drug chart. The drug chart states that only 500mls of 5% glucose was commenced at 17:20 hours, however the clinical notes state that the following was given: • 20% 100mls,

	• 3 bags of 5% Dextrose. Insulin was not given. The Hospital Investigation Panel concluded that dextrose and insulin would be administered to treat hyperkalaemia however, as Miss C was hypoglycaemic (blood sugar of 0.9mmol/l) and this would have further reduced her blood sugar, this was the rationale for not administering insulin at that time. Return of spontaneous circulation was achieved after ten minutes.
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) Resuscitation Council UK and NGH NHS Trust should consider a review of their policy in relation to the out of hours availability of Resuscitation Officers.
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 October 19, 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 **The family of Miss C.** 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: 25/08/2023**  **Hassan SHAH** **Assistant Coroner for** **Northamptonshire**