MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON
Coroner's Court, 124 Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive Officer, Barts Health NHS Foundation Trust** [redacted]
1	**CORONER** I am Nadia Persaud, Area Coroner for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 4 November 2022 I commenced an investigation into the death of Margaret Ann Waylett age 78. The investigation concluded at the end of the inquest on the 15 December 2023. The conclusion was a narrative conclusion: *Mrs Waylett died as a result of acute cardiac failure following a necessary surgical procedure. Post operative care was not provided in accordance with clear policies and expected standards of practice. Her death was contributed to by neglect.*
4	**CIRCUMSTANCES OF THE DEATH** Mrs Waylett suffered a humerus fracture in early October 2022. She consulted with orthopaedic surgeons and it was decided that surgery would be appropriate to maintain her levels of independence. She underwent surgery on the 13 October 2022 and the

	orthopaedic outcome was satisfactory. Post-operatively, Mrs Waylett's recovery was complicated by ongoing low blood pressure and intermittent oxygen requirements. From the early hours of 17 October 2022, she required a medical assessment, with medical intervention to address a likely pulmonary oedema and likely urinary tract infection. She did not receive the necessary medical intervention and on the 19 October 2022, she suffered a cardiac arrest on the ward. Resuscitation was provided and she was admitted to the intensive care unit. Sadly, she did not recover and she passed away at Whipps Cross Hospital in the early hours of the 20 October 2022. Had Mrs Waylett received the necessary medical intervention from the 17 October 2022 or even on the morning of the 19 October 2022, it is likely that her death would have been avoided.
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 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: (1) The inquest heard that nursing staff requested reviews by the on-call orthopaedic doctors on multiple occasions, without the doctors attending to carry out a review. A junior doctor described the junior orthopaedic staffing levels in the hospital as "dangerous". (2) The inquest heard that the NEWS charts were not available on the ward rounds. The consultants did not therefore review the charts and were unaware of the frequently raised NEWS scores. The inquest heard that laptops on the ward were unwieldy and time consuming. There were no iPads or vital packs available for the ward round team to easily access the NEWS scores. (3) The inquest heard that there was confusion between the doctors as to who was responsible for the patient, in light of her dual orthopaedic and medical needs. Orthogeriatricians were aware of Mrs Waylett's desaturation on 19 October 2022, but appeared to have considered it necessary for them to receive a referral from the orthopaedic team before they could carry out a review.
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 **13 February 2024**. 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, to the family of Margaret Waylett, to the Care Quality Commission, and the local Director of Public Health 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 other 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.
9	**19 December 2023**