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:** **Chief Executive** **Norfolk and Norwich University Hospital** **Colney Lane** **NORWICH** **NR4 7UY**
1	**CORONER** I am Samantha GOWARD, Area Coroner for the coroner area of Norfolk
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 May 2022 I commenced an investigation into the death of Jeanine Maria HUGGINS aged 68. The investigation concluded at the end of the inquest on 25 January 2024. **The medical cause of death was:** 1a) Coronary Artery Atheroma 1b) 1c) 2) Diffuse Large B Cell Lymphoma on treatment **The conclusion of the inquest was:** Natural causes
4	**CIRCUMSTANCES OF THE DEATH** 1. Mrs Jeanine Huggins had a background medical history including hypertension, sclerosis and Raynaud phenomenon and a diagnosis in 2019 of diffuse B-cell lymphoma. 2. Jeanine was cared for by the Royal Free Hospital in relation to the sclerosis and Raynaud phenomenon and this condition appeared to have been well controlled with treatment and improved her symptoms. 3. The lymphoma was treated at the Norfolk and Norwich University Hospital (NNUH) and Jeanine responded well to treatment and went into remission in 2021, but sadly in March 2022 there was a relapse and chemotherapy commenced. 4. Jeanine was admitted to NNUH on 3 May 2022. She had presented to ED with fever, vomiting and diarrhea and was dehydrated and with poor urine output. She had recently undergone chemotherapy. A provisional diagnosis of neutropenic sepsis was made pending blood results and she was given antibiotics and IV fluids and investigations were ordered. Blood tests later confirmed the diagnosis and she was given injections to stimulate white cell growth and a platelet transfusion.

Blood results also indicated an acute kidney injury (AKI).

5. Jeanine was reviewed by the Renal team in relation to the kidney injury. They agreed the AKI was likely due to dehydration and sepsis and arranged some further tests. The injury may also have been linked to one of the necessary chemotherapy treatments recently received.

6. Jeanine remained under review and treatment and on 5 May microbiology results confirmed a pseudomonas infection in her blood and antibiotics were appropriately adjusted as a result.

7. Reviews by the Haematology and Renal teams showed signs of improvement over the following days and by the morning of 9 May Jeanine had been apyrexial for several days, her oxygen saturations were good, she did remain tachycardic but her blood pressure and physical examination were good and she no longer appeared dehydrated. Her renal function, while still severely impaired, had stabilised. Her neutrophil count was back in the normal range. Discussions were had with Microbiologists about the continuation of antibiotics for the bacterial infection with a plan to make arrangements for Jeanine to be managed safely at home.

8. A treating Consultant described the position at that point as her clinical trajectory being one of cautious improvement. She described her death as unexpected from a Haematology point of view.

9. Jeanine was reviewed by a Haematologist at 0910 hours on 9 May and her NEWS2 score was 5. This was largely due to fluctuation in the ongoing tachycardia. She confirms that Jeanine was not hypotensive, had a normal temperature and improving oxygen saturations on a small amount of oxygen.

10. Jeanine was being nursed in a side room due to being neutropenic previously and having diarrhea.

11. Over the night of 9 May, medications were given around 19:30 hours and then the nurse saw Jeanine again around 21:23 hours and states that medication was given and her buzzer was left within easy reach. Her NEWS score was 5 and was the same again at 23:00. This was not escalated to medical staff nor did it lead to hourly observations in accordance with Trust guidelines. Evidence was heard from a Ward Sister at the Trust regarding concerns over poor documentation and the failure to follow Trust guidelines with regard to action in response to raised NEWS scores. While expert evidence suggested this was not causative, evidence was heard regarding training and education at the Trust to address this concern.

12. When Jeanine was next checked at around 02:00 she was not breathing and had vomited. Despite appropriate attempts, Jeanine could not be resuscitated and was sadly declared deceased at 02:56 hours.

13. A Post Mortem gave cause of death as (1a) coronary artery atheroma (2) Diffuse large B cell lymphoma on treatment.

14. Independent expert evidence of a Consultant Cardiologist was that on the balance of probabilities, Jeanine had an arrhythmic sudden cardiac death and deterioration would have been rapid, a matter of minutes.

15. While, based on expert evidence it was not felt to be causative, one of the other issues upon which evidence was heard related to Jeanine's ability to use her call bell due to her underlying sclerosis, which her family advised made it difficult for her. While it was found in evidence that Jeanine had on other occasions used her bell, it was accepted that no one checked during the evening of 9 May whether her

	bell was in a suitable position to enable her to use it. Evidence was also heard that while in the side room, Jeanine could not be seen by nurses or HCAs unless they specifically went into her room. The only method for patients in such side rooms to contact staff in the event of an emergency is therefore by the call bell. 16. Evidence was given by a Ward Sister on the use of side rooms and call bells. She agreed that the room Jeanine was in, and indeed many side rooms, mean that the patient within them is not visible to the nursing & HCA team unless they go in the room. That means that, if they are not able to mobilise, whether due to their condition or a sudden event, the only way for them to attract the attention of staff is to use their call bell. It was accepted that this means it is extra important to ensure that these patients are able to use their call bell. The Inquest was told that there is no risk assessment carried out before someone is placed into a side room. It was fully accepted that there are many reasons why a side room is necessary, including cases like Jeanine where the patient is vulnerable and at risk of infection, so a ward bay would not be appropriate. However, if there is no risk assessment, then this may pose a risk if they are unable to communicate with or be seen by staff. This makes ensuring the call bell can be used more important. Evidence was seen of a document in the notes that is completed when HCAs/nurses complete intentional rounding & this asks for it to be ticked to confirm that the "call bell is within reach & patient shown how to use and is able to use". This is ticked on each occasion for Jeanine on all dates. However, evidence was that on 9 May it was not checked whether she could in fact use it (we do not know for other dates). There was no documentation regarding any difficulties she had, as there was no formal risk assessment required.
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. There is no requirement for a risk assessment to be carried out before a patient is placed in a side room (other than for risk of falls), so as to identify if they will have any risks and difficulties associated with communicating their needs to staff in an emergency situation. 2. There is no formal requirement to ensure that a patient is risk assessed with regard to ability to use a call bell and, if they are unable, to consider suitable alternatives, especially when in a side room and there is no other way to attract staff attention.
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 March 22, 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 and to the following Interested Persons [redacted] **– husband** [redacted] **– son** [redacted]**– Family Legal Representative** [redacted] **– Norfolk & Norwich University Hospital Legal Representative** [redacted] **– CQC Inspector** I have also sent it to **Care Quality Commission** **Department of Health** **Healthwatch Norfolk** **HSIB** **NHS ENGLAND (NHS IMPROVEMENT)** 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: 26/01/2024**  **Samantha GOWARD** **Area Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH