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** **Queen Elizabeth Hospital** **Gayton Road** **King's Lynn** **Norfolk** **PE30 4ET**
1	**CORONER** I am Yvonne Kathleen Blake, 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 27 October 2022 I commenced an investigation into the death of Kim Georgina STROUD aged 65. The investigation concluded at the end of the inquest on 14 February 2024. **The medical cause of death was:** 1a) Idiopathic Pulmonary Fibrosis 1b) 1c) 2) Bladder Cancer, Covid Pneumonia **The conclusion of the inquest was:** Natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Stroud was admitted to hospital on 4 August 2022 for a transurethral resection of bladder tumour which had been cancelled 5 times. She became unwell on 15 August 2022 with a chest infection against a background of severe interstitial lung disease and chronic type 1 respiratory failure. She tested positive for covid on 10 September 2022. Despite being on multiple antibiotics for chest infections and all other treatment she remained on high oxygen demand and was episodically confused. She died suddenly on 11 October 2022.
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) Mrs Stroud's care appears to have been non-compliant with both hospital policies and the Nursing and Midwifery Council regulations for the administration of medication. Mrs Stroud's relatives found pots with tablets in on several occasions just left on their mother's bedside table. These had been signed for as given. On one occasion Mrs Stroud had

	concealed 9 tablets inside her incontinence pads because she thought she was being poisoned, clearly not supervised in taking those either. It was extremely unsafe to leave tablets in this way. Mrs Stroud had delirium and could not be left to take them herself. There were other confused and mobile patients on the same ward who could have picked them up. On several occasions Mrs Stroud was found in her bed so soaked in urine (I have seen photographs of this) that the urine was dripping off the edge of the bed and the family had to wash and change her themselves. Also wash faeces from her body.
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 April 18, 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] (Daughter) The Nursing and Midwifery Council I have also sent it to Department of Health Care Quality Commission HSIB Healthwatch Norfolk NHS England and 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: 22 February 2024**  **Yvonne K Blake** **Area Coroner for Norfolk.** County Hall Martineau Lane Norwich NR1 2DH