Kally Cheema LLB | Senior Coroner | Cumbria

Fairfield, Station Road, Cockermouth, Cumbria CA13 9PT

Tel: [redacted] | **Email:** [redacted]

Case Ref: [redacted]

8 August 2024

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: North Cumbria Integrated Care NHS Trust
CORONER

1 I am Robert Cohen HM Assistant Coroner for Cumbria

CORONER'S LEGAL POWERS

2 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

INVESTIGATION and INQUEST

On 22 June 2023 I commenced an investigation into the death of Daphne Gillian AUSTIN. The investigation concluded at the end of the inquest on 8th August 2024. The conclusion of the inquest was a narrative.

3 I found that the medical cause of death was:

1a Urosepsis and Acute Kidney Injury

1b

1c

II Right cerebral Infarct

CIRCUMSTANCES OF THE DEATH

4 Ms Austin was 71 years old. She suffered from diabetes. On 22nd May 2023 Ms Austin was admitted to the Cumberland Infirmary, Carlisle. She had had a stroke. Whilst in hospital, Ms Austin's glucose levels were poorly controlled. She also became dehydrated. Ms Austin's fluid balance was not monitored in an effective manner. On 14th June 2023 it became apparent that Ms Austin had sustained an acute kidney injury. Blood testing was not carried out on 15th or 16th June, it is more likely than not that this was because of

industrial action by junior doctors. On 17th June 2023, Ms Austin's condition deteriorated and it became apparent that she had developed sepsis. Despite treatment, Ms Austin died as a result of that condition on 18th June 2023.

Neglect (being the ineffective monitoring of Ms Austin's fluid balance and the fact that blood testing was not carried out on 15th or 16th June 2023) contributed to Ms Austin's death.

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. –

5 (1) I received evidence of the planning that had gone into preparing the trust for strikes. However, there was evidence from one of the Trust's consultants that on the day of the strike she had to "look after nearly 25 patients" and that "due to the junior doctor's strike on 14/06/2023, Mrs Austin did not receive any medical input that day". Another consultant gave evidence that despite being listed as one of the consultants covering the unit (in the contingency planning evidence) he was probably dealing with other duties on that day. In the circumstances I am concerned that the planning that seeks to ensure safe levels of cover during periods of industrial action was insufficient to meet need and that this gave rise to a risk of future deaths.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you North Cumbria Integrated Care NHS Trust have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report,
7 namely by 8th October 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the family of Ms Austin. I have also sent it to the Secretary of State for Health and the British Medical Association who may find it useful or of interest given the potential national aspects of these concerns.

8 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.

13 August 2024

9 

Signature

Robert Cohen HM Assistant Coroner for Cumbria