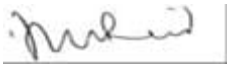
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive, Worcestershire Acute Hospitals NHS Trust, Charles Hastings Way, Worcester WR5 1DD;
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
2	**CORONER'S LEGAL POWERS** 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 21 February 2024 I commenced an investigation and opened an inquest into the death of Kelly Marie STEVENS. The investigation concluded at the end of the inquest on 24 September 2024 The conclusion of the inquest was that Ms. Stevens *"Died from complications associated with an excessively low, and unrecognized, sodium level while in hospital. Her death was contributed to by neglect."*
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where and how did Ms. Stevens come by her death?", I recorded as follows: *"On 28.12.23 Kelly Stevens, who lived with profound learning and physical disabilities, and received all nutrition, hydration and medication via a percutaneous endoscopic gastrostomy (PEG) tube, was admitted to Worcestershire Royal Hospital with abdominal distension and concern about her PEG tube. She was diagnosed with a likely pseudo-bowel obstruction and a plan was made for her to undergo endoscopic investigation. In the meantime, she was prescribed intravenous fluids but her intake of these was not properly recorded, and her electrolyte levels were not monitored. On the morning of 3.1.24 she suffered a seizure during which she aspirated some vomit. This seizure was caused by an excessively low sodium level which had not been recognized. She went on to develop aspiration pneumonia and, despite treatment, declined and died in hospital later that night."*
5	**<u>CORONER'S CONCERNS</u>** 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. – 1) Despite being under the care of the medical team, Ms. Stevens did also receive input from the surgical team. Her situation was further complicated by the fact that for most of her admission she was placed as a medical outlier on

	a surgical ward. In the event, no one consultant was in overall charge of her care, which meant that the issues identified in this case were not picked up on. I heard evidence that there was no policy in place at the Trust to give guidance as to how this sort of situation should be resolved, but instead that it was expected that consultants would liaise with each other in order to do so. That did not happen in this case; 2) No doctor providing care for Ms. Stevens followed the established principle that the prescription of intravenous fluids for a patient must be accompanied by regular testing of electrolytes. In Ms. Stevens' case, this was particularly important because her baseline sodium level was low anyway, so the overprescription of fluids put her at greater risk of hyponatraemia; 3) There was no proper recording of Ms. Stevens' fluid intake and output on fluid balance charts for most of her hospital admission. For the reasons set out at 2) above, this was vitally important in her case; 4) Ms. Stevens' hospital notes revealed evidence of the routine "copying and pasting" of out-of-date care plans by previous doctors. This meant that the next person reading her notes would be left with an erroneous view of her current care plan.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of Worcestershire Acute Hospitals NHS Trust, 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 **19 November 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: (a) [redacted], Ms. Stevens' mother; (b) Dimensions UK, who run the supported living accommodation where Ms. Stevens' lived; (c) The Care Quality Commission. 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.
9	**24 September 2024**  **David REID** **HM Senior Coroner for Worcestershire**