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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>[redacted], Chief Executive, Worcestershire Acute Hospitals NHS Trust, Charles Hastings Way, Worcester WR5 1DD; |
| 1 | **CORONER**<br><br>I am David Donald William REID, HM Senior Coroner for Worcestershire. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br><br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 25 March 2024 I commenced an investigation and opened an inquest into the death of Teresa AURIEMMA. The investigation concluded at the end of the inquest on 14 November 2024<br><br>The conclusion of the inquest was that Mrs. Auriemma *"Died as the result of an over-prescription of supplementary potassium, due to a failure properly to monitor potassium levels in her blood. Mrs. Auriemma's death was contributed to by neglect."* |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>In answer to the questions "when, where and how did Mrs. Auriemma come by her death?", I recorded as follows:<br><br>*"On 18.2.24 Teresa Auriemma was admitted to the Alexandra Hospital, Redditch after becoming unwell at home, and treated for aspiration pneumonia, dehydration and acute kidney injury, and deranged electrolytes. When reviewed in hospital on 15.3.24 she was given further intravenous potassium, a decision which was based on an out-of-date and inaccurate blood test. After the provision of that intravenous potassium, a blood test should have been carried out to check Mrs. Auriemma's potassium levels, but was not, and she was given further intravenous potassium on 16.3.24. She then collapsed suddenly on the ward on 17.3.24, and was confirmed deceased a short time later. A blood test which had been taken very shortly before she died confirmed a fatally high level of potassium. Had Mrs. Auriemma's potassium level been checked on 14 or 15.3.24 and again on 16.3.24, it is likely that her death would have been prevented."* |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>1) None of the doctors caring for Mrs. Auriemma from 11.3.24 onwards appear to have heeded the guidance of policy WAHT-PHA-020 for the treatment of |

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| | hypokalaemia, and in particular that daily monitoring of urea and electrolytes ( U&E ) was required until the patient's potassium levels had returned to normal levels. Mrs. Auriemma had been prescribed an oral potassium supplement from 11.3.24. A junior doctor assisting the consultant on the ward round on 15.3.24, when asked what Mrs. Auriemma's potassium level was, gave the last reading taken on 11.3.24; that junior doctor appeared therefore not to have understood the need for daily U&E monitoring. The consultant accepted he should have checked the date of the reading given, but did not and instead assumed it was up-to-date. The consultant then proceeded to prescribe intravenous potassium on 15.3.24;<br>2) Once the intravenous potassium had been given on 15.3.24, further U&E monitoring should have been carried out before any more intravenous potassium was given. That U&E monitoring was not done, and instead further intravenous potassium was given on 16.3.24. No clear reason was provided to the inquest as to why the junior doctor responsible had not checked Mrs. Auriemma's potassium levels before prescribing further intravenous potassium;<br>3) This is not the first inquest which has found shortcomings in the Trust's monitoring of patients' electrolyte levels. Only 2 months ago, this court heard evidence in another inquest concerning the death of a young woman at Worcestershire Royal Hospital in January 2024, who had died because staff at the hospital had failed to recognize and act upon an excessively low sodium level. In that case, like this, I found that there was a failure by doctors to ensure proper monitoring of electrolytes by checking blood results before prescribing IV fluids.<br>4) I am therefore concerned that the Trust has not ensured that its doctors:<br>(a) understand the importance generally of U&E monitoring before prescribing intravenous fluids; and<br>(b) are aware of, and comply with specific policies concerning this issue, such as that relating to the management of hypokalaemia ( WAHT-PHA-020 ). |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by **9 January 2025.** I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following:<br><br>(a) [redacted] and [redacted] ( Mrs. Auriemma's daughters );<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 |

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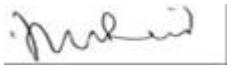
| | your response, about the release or the publication of your response by the Chief Coroner. |
| 9 | **14 November 2024**<br>  <br>**David REID**<br>**HM Senior Coroner for Worcestershire** |