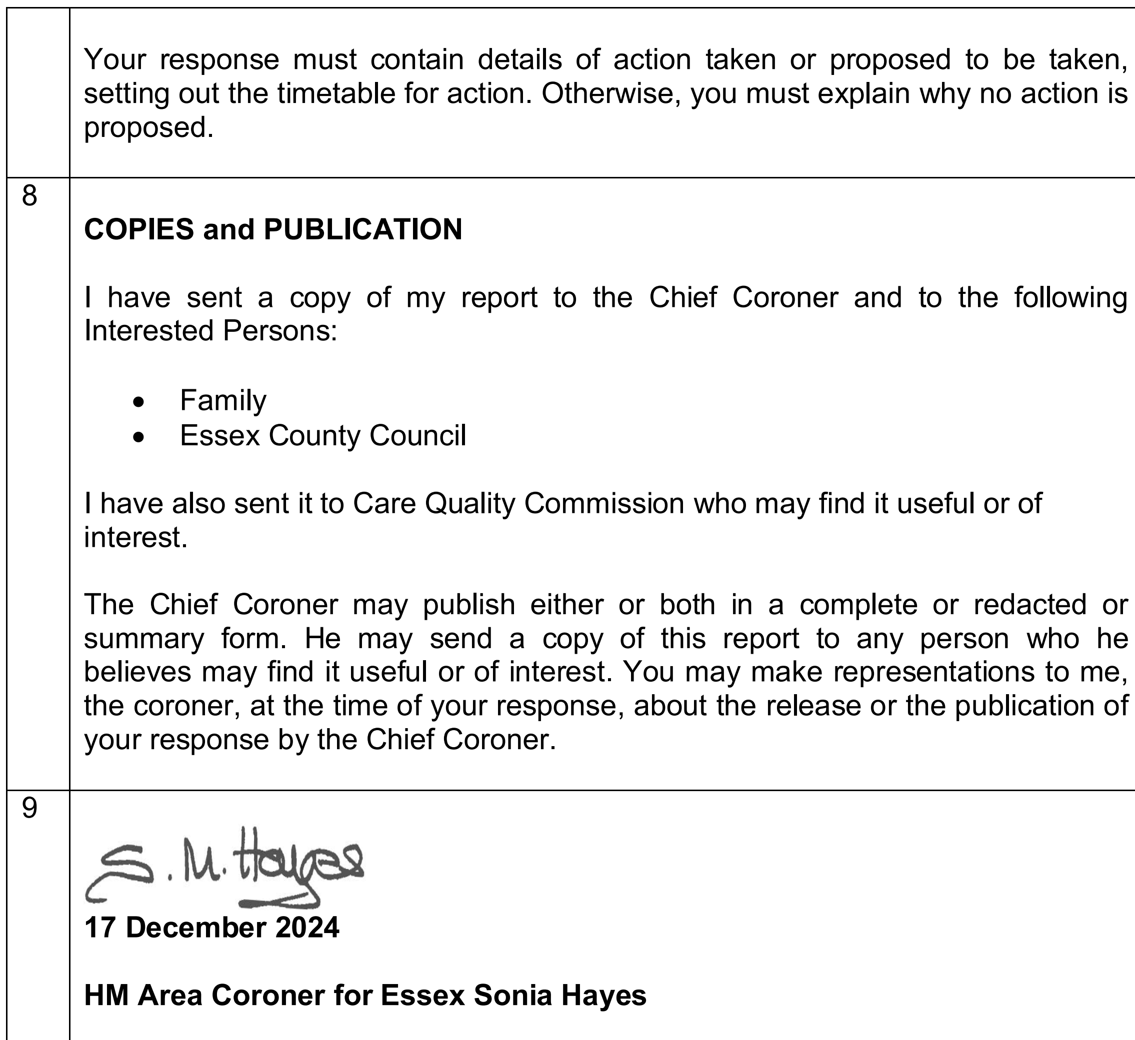
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of Mid & South Essex NHS Trust**
1	**CORONER** I am Sonia Hayes, Area Coroner, for the coroner area of Essex
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 1 September 2023 I commenced an investigation into the death of MARY MARGARET WHITLOCK, AGE 84. The investigation concluded at the end of the inquest on 17 December 2024. The conclusion of the inquest was Ia Aspiration of food contents Ib Fracture of Cervical Vertebra and Dementia Accident contributed to by neglect
4	**CIRCUMSTANCES OF THE DEATH** Mary Whitlock died at Broomfield Hospital on 23 August 2023. Mrs Whitlock sustained a fracture of her cervical vertebra when she tripped at her care home and struck her head against the wall on 21 August 2023. Mrs Whitlock was conveyed to hospital with neck pain. CT scan of her head revealed no bleed or infarct and Mrs Whitlock returned home that night; no imaging was completed of the neck. Mrs Whitlock was in pain and could not swallow paracetamol the next morning and was readmitted to Broomfield Hospital where further scans revealed cervical fractures at C1 and C2. Advice was that she was not suitable for surgical intervention and was for conservative treatment with a collar that was difficult to tolerate. Broomfield Hospital did not provide the collar clinically recommended until 23 August 2023. Swallowing problems were a known risk for Mrs Whitlock's injury and there was no plan for managing oral intake. Concerns about swallowing tablets and oral administration of analgesia were noted in the medical records overnight and not handed over to the day shift or reviewed in the ward round. Mrs Whitlock suffered aspiration following assisted feeding of

	her lunch on 23 August that was treated with suctioning and oxygen with improvement in her condition. Mrs Whitlock was required to be nil by mouth, undergo chest x-ray, a Speech and Language Team assessment, antibiotics and intravenous fluids. This information was not shared with all the ward staff due to staff shortages. Mrs Whitlock was fed some of her remaining lunch and suffered shortness of breath and oxygen desaturation that required a emergency medical call at approximately 13:00 hours and Mary was place on end-of-life care and died. Mrs Whitlock sustained a Fractured Cervical Vertebrae with Dementia that put her at risk of aspiration. and she was fed when experiencing swallowing difficulties.
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) Morphine in the form of 5mg Oramorph and then 2.5mg Intravenous morphine was administered for a patient where the medication record noted allergy to Tramadol, Codeine and Buprenorphine. Naloxone was required to reverse the effect. Whilst this die not cause or contribute to this death this matter was not part of the Trust review, and no safeguarding was raised. (2) Evidence of clinical witnesses is that Notley Ward was (at the time of this death) and remains understaffed despite escalation within Trust (3) No Discharge Summary or Safety Netting advice was provided by the Trust to the care home for a patient with dementia who was discharged from Accident & Emergency at night where she had undergone investigations for traumatic head injury
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 14 February 2025. 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: • Family • Essex County Council I have also sent it to Care Quality Commission who 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	S. M. Hayes **17 December 2024** **HM Area Coroner for Essex Sonia Hayes**