ANNEX A

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:** **Philippa Slinger, Chief Executive of Wexham Park Hospital Trust**
1	**CORONER** I am Peter James Bedford, Senior Coroner for the coroner area of Berkshire
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 17th August 2011 I commenced an investigation into the death of Edna Elsie Mary Eden, then aged eighty eight years. The investigation concluded at the end of the inquest on 20th November 2013. The conclusion of the inquest was a narrative verdict returned by the Jury and I attach a copy to this Report. The medical cause of death was Myocardial Infarction due to Coronary Atheroma on a background of Bronchopneumonia.
4	**CIRCUMSTANCES OF THE DEATH** (1) Mrs Eden was generally of good health for her age and had been living independently. On Friday 12th August 2011 she complained to her niece that she was feeling a bit poorly. She was seen by a GP and prescribed antibiotics for a chest infection but, following a further review the next day, a different GP admitted her to your Hospital being described as non-specifically unwell. The letter that accompanied her included the words "some right sided chest pain." (2) At Wexham Park Hospital, Mrs Eden remained in A&E for five hours under the care of nursing staff. A Doctor appears to have authorised an ECG and blood tests without actually seeing the patient. There was a signature on the ECG printout but the identity of the person, presumed to be a Doctor, has not been ascertained. The ECG is described as abnormal but was not escalated to any other Clinician. The blood tests appear not to have been reviewed by any Clinician. (3) Having arrived at A&E at 14.34 hours on 12th August 2011, Mrs Eden was transferred to the AMU at 19.45 hours. A nursing observation chart shows observations being documented at 15.10, 17.43 and 18.10 hours in A&E and 20.00 and 21.58 hours in AMU. There is a reference in the nursing notes of observations being done at 23.25 hours but these were not recorded on the chart. The chart included an EDOD score which, as accepted in evidence, was wrongly scored at three but should have been scored at four. This should have triggered a Doctor review within thirty minutes but this was not done.

	(4) The nurse responsible for Mrs Eden on AMU documented four attempts to contact a Doctor by bleep, all without success or response. The evidence was that Doctors were aware of Mrs Eden needing to be seen but it was a very busy weekend for patients and priority was being given to other more urgent patients. (5) The Doctors who made the decision not to prioritise Mrs Eden were not aware of the abnormal ECG or blood results. (6) Mrs Eden was not finally seen by a Doctor until 17.00 hours, some fourteen and a half hours after her arrival at the Hospital. Within minutes of being seen, she arrested and could not be revived. (7) An independent expert Consultant Cardiologist gave evidence that Mrs Eden's heart was sufficiently diseased that she would have died within hours in any event. However, from the evidence, it was recognised that there were missed opportunities to intervene with earlier care that may have prolonged her life for a number of hours which would have allowed Mrs Eden and/or her family to say goodbye.
5	**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. – (1) Mrs Eden was admitted having been prescribed antibiotics by her GP. She was not provided with further antibiotic cover pending being seen by a Doctor and that was unduly delayed meaning that she went fourteen and a half hours without her prescribed medication. (2) The nursing observation chart suggested infrequent observations for a patient who had not yet been clerked by a Doctor. The EDOD score was wrongly calculated which meant an escalation of Doctor review was not carried out. (3) Nursing staff were not able to make contact with Doctors to review Mrs Eden. When this continued, the problem was not escalated to more senior staff. (4) Clinicians were taking decisions over priority of seeing patients based only on a very vague description of Mrs Eden's condition. Information at handovers appeared very limited. (5) Junior staff on a very busy shift appeared reluctant, or ignorant of the procedures, to escalate concerns to more senior staff to address a significant backlog that had developed. (6) An elderly patient who was admitted with a covering letter describing recent chest pain was not seen by a Doctor for a total of fourteen and a half hours.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. At the Inquest, evidence was given by Doctor [redacted] about an action plan that had been put in place. However, there were clearly outstanding issues and matters that had still not yet been addressed which is why I bring all the issues arising at the Inquest to your

	attention.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 24th January 2014. 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. 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	**27th November 2013** **Peter J. Bedford** **H.M. Senior Coroner for Berkshire**