	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Nottingham University Hospitals NHS Trust**
1	**CORONER** I am HEIDI CONNOR, assistant coroner for the coroner area of Nottinghamshire.
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** I concluded an inquest into Mr Harold Elvidge (DoB 22.10.33 ; DoD 2.11.12) on 24th October 2013. I recorded a verdict of accidental death.
4	**CIRCUMSTANCES OF THE DEATH** (1) It was clear in evidence that a Staff Nurse on the Critcal Care Unit at Nottingham City Hospital had, on 6 October 2012, used the wrong type of fluid bag to keep an arterial line open. She used 5% dextrose instead of normal saline. This error was realised before Mr Elvidge died, and is consistent with the Trust's own SUI report. Mr Elvidge's blood sugar levels were misinterpreted as a result of this error, and drugs administered accordingly, resulting in brain damage, and his subsequent death, on 2nd November 2012. (2) I heard evidence during the inquest about changes made in the Critical Care Unit following Mr Elvidge's death, particularly in relation to how fluid bags are stored, with a view to reducing the risk of different types of fluid being confused. (3) The evidence of the Staff Nurse in question was that the two types of fluid (in the 500ml bags required for this purpose) were stored adjacent to each other in a fluid room / cupboard, as well as being available in the Omnicell cabinet. The nurse obtained the fluid from the fluid room/cupboard, rather than from the Omnicell cabinet. If she had obtained this from the Omnicell cabinet, she would have been prompted to confirm what fluid bag she intended to take out, and it is likely that the error would not have occurred.
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) It is clear that much work has been done by the Adult Critical Care team to learn from the mistakes made in this case. It is now not possible to obtain 500 ml bags of 5% dextrose fluid without the input of a pharmacist, and they are not stored in the same place as 500ml bags of normal saline. I also heard about further training, and that sharing of these events has taken place. (2) The evidence suggested that Omnicell cabinets may be available soon in E12 at the QMC. It was however clear that, although Critical Care at the City campus has Omnicell cabinets in place, this is not the case across the trust, nor even all all critical care areas in the trust. While a mistake in the context of intensive care and arterial lines may be more serious for some patients, there could be equally catastrophic outcomes for patients in non critical care settings, if there remains a risk of different types of fluids being mixed up. (3) Whilst mindful of the cost implications involved, I am concerned about the risk of

	future deaths occurring in other parts of the trust which may not have as robust a safety standard as Critical Care (certainly at the City Hospital campus) now appears to have. (4) It is not for me to make specific recommendations regarding the purchase of specified equipment, but a trust-wide review of policies for safe storage of different types of fluids would reduce the risk of a similar tragedy occurring in future. This would include issues such as where these fluids are stored, how they are packaged and labelled, who is entitled to change bags, what checks are in place, and how this is recorded.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and the 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 19th December 2013. 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	**24th OCTOBER 2013**