Regulation 28: Prevention of Future Deaths report

Paula Anne SPEIRS (died 28.08.20)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Executive** **Phoenix Hospital Group** **Weymouth Street Hospital** **42-46 Weymouth Street** **London W1G 6NP**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 6 October 2020, I commenced an investigation into the death of Paula Speirs, aged 77 years. The investigation concluded at the end of the inquest on 25 February 2021. I made a narrative determination at inquest, a copy of which I now attach.
4	**CIRCUMSTANCES OF THE DEATH** Paula Speirs died from the ingestion of benzodiazepines that were not prescribed for her, which she had taken in an attempt to deal with anxiety before she underwent submental recontouring and a mini face lift on 25 August 2020 at Weymouth Street Hospital. Her medical cause of death was:

	1a hypoxic brain injury 1b respiratory arrest 1c benzodiazepine toxicity 2 ischaemic heart disease, hypertension and type II diabetes
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. When Ms Speirs arrived at Weymouth Street Hospital early on the morning of her procedure, staff formed the view that she was intoxicated. Her surgeon and anaesthetist agreed that, as a consequence of this, they could not be sure that she consented to the procedure. Very properly, they cancelled it for that day. Ms Speirs was allowed to use her room to sleep off her intoxication. Her husband was informed of the cancellation and told that he would be telephoned when she awoke, so that he could then come to collect her. 1. However, in spite of her intoxication at 7am (from what was at the time an unknown substance, initially presumed to be alcohol), no formal observations were ordered or undertaken. Her room was easily accessible, but nobody was specifically tasked with monitoring her. No instructions were given as to how frequently she should be checked, or what that checking should involve. 2. The nurses looking after Ms Speirs were not given any instructions on how to avoid positional asphyxia. When I asked them about this at inquest, they explained that they had not previously heard of positional asphyxia. I have encountered positional asphyxia most frequently in a custodial setting. Detainees in police cells are now subject to very clearly laid down procedures that attempt to reduce the risk of positional asphyxia and to reduce drink and drug related deaths. It seems to me an omission that there is not a similar regime in a hospital, where one would expect the medical care to be of a higher standard.

6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 4 May 2021. 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 following. • [redacted], husband of Paula Speirs • [redacted], director of operations, Phoenix Hospital Group • [redacted], UCLH NHS Trust • Care Quality Commission for England • Royal College of Anaesthetists • HHJ Thomas Teague QC, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 04.03.21 *ME Hassell*