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, 5 Boroughs Partnership
1	**CORONER** I am M Jennifer Leeming H M Senior Coroner, for the Coroner Area of Manchester West
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 10th August 2012 I commenced an investigation into the death of Margaret Walker, who was 97 years of age. The investigation concluded at the end of the inquest on 14th March 2014. The conclusion of the inquest was that Margaret Walker died of natural causes. The medical cause of death was 1a) Acute Myocardial Ischaemia 1b) Coronary Artery Atheroma
4	**CIRCUMSTANCES OF THE DEATH** On the 4th August 2012 Margaret Walker, who was diabetic was admitted to the Sephton Unit at Leigh Infirmary as a detained patient under the terms of the Mental Health Act. At or about 6am on the morning of the 7th August 2012, Margaret Walker was found unresponsive in bed on the Sephton Unit. She was showing no sign of life. Cardiopulmonary resuscitation was commenced. A defibrillator was obtained but was not used prior to the arrival of ambulance personnel at or about 6.16am. Ambulance personnel continued resuscitation efforts and applied a defibrillator which did not reveal any heart rhythm. There is no evidence that the earlier use of a defibrillator would have prevented Margaret Walker's death. Margaret Walker was then taken by ambulance to the Royal Albert Edward Infirmary in Wigan where her death was diagnosed. Her diabetes care during the time that she was a detained inpatient on the Sephton Unit was inconsistent. The inconsistencies in her care did not cause or contribute to her death from Coronary Artery Disease.
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) Following Mrs Walker's admission to the Sephton Unit at Leigh Infirmary as a detained patient on 4th March 2012, details of her previous medication regime for her diabetes were not sought until the 6th August 2012. When these details were obtained on the 6th August 2012, information concerning the medication was passed to relevant clinical staff but information concerning what blood test results were acceptable for her was not so passed. (2) Information concerning Mrs Walker's medical condition and blood test readings was not appropriately recorded in her clinical notes. (3) When Mrs Walker was found unresponsive at approximately 6.00am on the morning of the 7th August 2012, cardio-pulmonary resuscitation was appropriately commenced and continued and a defibrillator was obtained. However the defibrillator was not applied prior to the arrival of ambulance personnel who then applied their own defibrillator, which did not reveal a heart rhythm suitable for a shock to be given.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 20th May 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 and to the following Interested Persons [redacted] (the grandsons of the deceased). I have also sent it to Care Quality Commission who may find it useful or of interest. 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	**Dated** **25th March 2014**	**Signed** **M Jennifer Leeming**