REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

DECEASED: CHRISTOPHER RICARDO WILLIAMS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive** **St Mary's Hospital** **Floyd Drive** **Warrington** **Cheshire** **WA2 8DB**
1	**CORONER** I am Alan Gordon MOORE Assistant Coroner, for the coroner area of Cheshire
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 11 November 2013 I commenced an investigation into the death of Christopher Ricardo WILLIAMS, then aged 50. The investigation concluded at the end of the inquest on 7 March 2014. The conclusion of the inquest was Natural Causes and the medical cause of death was Massive Pulmonary Embolism.
4	**CIRCUMSTANCES OF THE DEATH** (1) At the time of his death Christopher was detained under Section 37 of the Mental Health Act 1983. He was resident at Adams Ward, St Mary's Hospital, Warrington, Cheshire. Adams Ward is a medium secure unit. (2) On 5 November 2013 Christopher complained of shortness of breath during the previous few days. He had a past medical history of pulmonary tuberculosis. He was seen by the GP the same day. The GP diagnosed a chest infection and prescribed antibiotics. (3) Christopher was subject to Level 1 observations (every 30 minutes). Throughout the night, up to and including the check at 5.30 am on 6 November 2013, Christopher appeared to be sleeping in his bed, giving no cause for concern. At 6 am he was found to be out of bed, kneeling on the floor against the bed. He appeared to be 'snoring' but was unresponsive. An ambulance was called. (4) A defibrillator machine was brought from an adjacent ward. The defibrillator did not work. Staff changed the battery pack but the defibrillator still did not work. (5) A second defibrillator machine was sent for but by the time it had arrived the ambulance paramedics were already at the scene. (6) Christopher was pronounced dead at the scene at approximately 6.30 am.

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) The defibrillator machine did not work, even when the battery pack was changed. (2) The defibrillator had not been checked on 5 November, although there was a requirement for the equipment to be checked daily for serviceability by the nursing staff. (3) There was no 'cross-check' or 'double check' system in place. (4) There was no policy or protocol in place at the hospital for the management of sudden / unexpected deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and / or 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 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] I have also sent it to: (1) HM Inspectorate of Prisons (2) National Offender Management Service (3) Independent Advisory Panel on Deaths in custody 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	**19 March 2014** **A G Moore Assistant Coroner**