REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive, Stockport NHS Foundation Trust and to The Secretary of State for Health**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 **the 18th July 2012** I commenced an investigation into the death of **Gary Bradshaw** dob **15th March 1965**. The investigation concluded on the **7th May 2014** and I recorded a **Narrative Conclusion** . The medical cause of death was **1a Myocardial Infarction 1b Dystrophic myocardial calcification 1c Hypercalcaemia due to a tumour of the Parathyroid gland and 2 Bronchopneumonia.**
4	**CIRCUMSTANCES OF THE DEATH** **In May 2011 Mr Bradshaw attended Stepping Hill Hospital in Stockport reporting to the Accident and Emergency Department that he was suffering from right sided groin pain. By July 2011 an ultrasound scan had revealed that he was suffering from kidney stones. In April it was noted that he had high levels of calcium in his urine and in June 2012 he was reviewed by a urological surgeon who ordered serum calcium investigations to be carried out but put him on bendroflumethiazide in the meantime before the results of the blood test were known. At the end of June he again presented to the Emergency Department and this time he collapsed in the waiting area. On the 2nd July it was assessed that he was suffering from hyperparathyroidism. He then remained in hospital until his death on the 12th July. During the time before his admission to hospital and indeed during his last hospital admission, a number of opportunities were missed, some of which might have alleviated his level of suffering and others of which might have extended his life expectancy.**
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. **There was a considerable delay in the initial diagnosis that he was suffering with kidney stones, between May 2011 and March 2012.**(Stockport NHS Trust) 2. **At the consultation in March 2012 both blood and urine tests were ordered but apparently only the urine tests were done and /or reported, thus his**

hypercalciuria was seen but not his hypercalcaemia (Stockport NHS Trust)

3. The above blood tests were ordered but the patient was prescribed and administered Bendroflumethiazide before the results were known, something which the expert witness described as contra-indicated.(Stockport NHS Trust and The Secretary of State)

4. There was a misunderstanding or misreporting of the results to the General Practitioner as to whether these results related to blood or urine tests.(Stockport NHS Trust)

5. The patient was discharged from the hospital on the 27th June 2012 rather than being retained as an in-patient whilst full investigations were carried out; again a practice which the expert witness felt to be inappropriate (Stockport NHS Trust)

6. During the subsequent admission on the 29th June no consideration was given to referring Mr Bradshaw to an endocrine surgeon. (Stockport NHS Trust)

7. Fluid balance charts were not kept, or not kept properly, on various occasions during the in-patient stays (Stockport NHS Trust)

8. The hospital laboratory only 'flag-up' the blood results if the blood-calcium levels exceed 3.5mmol/l or more of serum calcium. The expert witness opined that this should occur at levels of 3.0mmol/l, and that this should be the National standard.(Stockport NHS Trust and The Secretary of State)

9. The system of escalation of patients from the wards to the ITU did not seem to be in place or alternatively did not seem to have worked as it ought to have done when the ward sister wanted to send the patient to the ITU (Stockport NHS Trust).

10. Hospital notes and especially those in the E.D. (on the ADVANTIS SYSTEM) seem to have been less than comprehensive and efficient. The emergency doctor fed the patient's 'number' into the computer but it did not reveal the notes of the previous admission.(Stockport NHS Trust)

11. I was told that a new electronic system of note keeping is being introduced at Stockport and throughout the NHS. I would consider it helpful if that system had an in-built 'flag' which highlighted to a doctor that he or she was prescribing drugs before the requested blood/urine test results had been received.(Stockport NHS Trust and The Secretary of State)

12. There seemed to have been a very subjective interpretation of the EWS at the hospital by using the 'manual' assessment method. I was told that an electronic version is being rolled out. I would hope that this can be sooner rather than later as it will give a far better and more objective assessment of the Early Warning Scores. (Stockport NHS Trust and The Secretary of State)

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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **10th July 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 namely [redacted] **(Partner of the deceased).** 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	**Date 15/05/14** **John Pollard, HM Senior Coroner**