REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [redacted] Clinical Governance and Risk Manager, The Alexandra Hospital, Mill Lane , Cheadle.**
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 7th October 2013 I commenced an investigation into the death of **Frederick William Hall** dob 2nd June 1942. The investigation concluded on the 20th March 2014 and the conclusion was that the deceased died as a result of **Misadventure contributed to by neglect.** The medical cause of death was 1a Aspiration Pneumonia 1b Colonic Carcinoma (operated).
4	**CIRCUMSTANCES OF THE DEATH** On the 30th September 2013, four days post-operatively from a right hemi-colectomy, Mr Hall was taken to the C.T.Scanner for a CT scan of the abdomen and chest. He was supposed to have had a naso-gastric tube inserted prior to the scan being performed, in order to decompress his distended abdomen. Despite the instruction of the consultant surgeon to this effect, the tube was not so inserted and as he was being prepared for scanning, he vomited profusely and aspirated a quantity of gastric contents, leading to his developing aspiration pneumonia.
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 seemed to be a lack of skill and/or training amongst the general nursing and medical staff in the passing of NG Tubes. However, it was noted that the ITU staff regularly insert such tubes and one would question whether there should be an agreed procedure whereby they should be asked to undertake this task throughout the hospital. 2. There was a degree of ignorance amongst the senior staff (medical and nursing) as to the availability of NG Tubes, and specifically as to their storage location within the hospital. 3. The monitoring of, and response to, the patient's condition seemed somewhat erratic. Both the surgeon and the senior nurse agreed that "an earlier review" should have been sought and that observations should have been taken more promptly following the patient having chest pains. 4. There was a lack of response (or timely response) to the instructions given by

	the Consultant. On the night of the 30th September the Consultant ordered an NG tube be passed before the scan was carried out. This did not happen. On the 29th September the Consultant had also ordered an NG tube be passed if the patient "starts vomiting or not relieved"; this was not acted on, nor did the nursing staff seek to gain the advice/help of the Consultant or the RMO. 5. There were clear and significant deficiencies in communication between and among various staff members; incomplete information was passed from one RMO to the other on shift hand-over; the Consultant was not given full information when being spoken to by telephone; the radiology department were not fully appraised as to the patient's fragile condition. Most notably the RMO did not tell the Consultant that he (the RMO) intended to go to treat another patient on another ward before addressing the passing of the NG tube as instructed. 6. General note-keeping was not of the requisite standard as exemplified by:- (a) The poor quality of the fluid balance chart and the observation/NEWS chart. (b) The fact that there were no nursing entries made in the patient's records between midday and 8.40 pm, during which time a number of significant events had occurred. (c) Retrospective nursing notes were made which were inaccurate and incomplete. (d) The required ORDER of the tasks as ordered by the Consultant was different from that actually written in the notes. 7. Whilst 'on paper' the staffing levels were adequate, in fact due to the specific demands on the wards during that period, there was a need for more nursing /medical staff to be available. What measures are in place to address this type of situation?
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 3 June 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] **(wife of the deceased), N.E.S. Holdings Ltd**. I have also sent it **to** [redacted] 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	**8 April 2014** **John Pollard, HM Senior Coroner**