REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Secretary of State for Health and to the Chief Executive, Tameside Hospital NHS Foundation Trust**
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** On14th May 2014 I commenced an investigation into the death of **Mary Fenton** dob 13th September 1931. The investigation concluded on the 8th October 2014 and the conclusion was one of **Natural Causes**. The medical cause of death **was (1a) Coronary Artery Atheroma (1b) Acute Cerebral Infarction.**
4	**CIRCUMSTANCES OF THE DEATH** **On the 26th April 2014 she was admitted into Tameside Hospital as being in need of an urgent heart pacemaker. Various delays then occurred and opportunities were missed and she died on the 30th April 2014.**
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. **Although Tameside Hospital holds itself out as performing pacemaker insertions, both temporary and permanent, no Cardiology Consultant is on call after 5.00pm or at week-ends. There is therefore no-one available to the junior staff having the requisite levels of skill and expertise to advise. (For Tameside Hospital)** 2. **After 5.00pm there is no facility for an echocardiogram to be performed at the hospital. (For Tameside Hospital)** 3. **This patient was being kept alive by the use of Isoprenaline. It transpires that there were severe shortages of this drug in the hospital but also nationally. I was told that this drug is produced as an unlicensed drug by NHS Pharmaceutical Productions. If so why do they not ensure sufficient supply? (For Tameside Hospital and for The Secretary of State)** 4. **There was a failure of the medical staff to assess and/or document the mental "capacity" of the patient (For Tameside Hospital)**

	5. **There was a failure of the medical staff to obtain "consent" to treatment or to document why such consent was unavailable and why they were "self-consenting". (For Tameside Hospital)** 6. **Despite this being a major District General Hospital providing cardiology cover for a large proportion of the population of Greater Manchester, there is no-one with the skill or qualification to fit "temporary/permanent" pacing wires.(For Tameside Hospital)** 7. **There were inexcusable and potentially catastrophic delays in inserting the pacing wires (For Tameside Hospital)** 8. **It was demonstrated by the evidence that if there should be a situation where the placing of the pacing wires causes unforeseen problems (e.g. by causing bleeding within the pericardium leading to cardiac tamponade) there is a lack of adequate facilities to address that situation. (For Tameside Hospital)** 9. **The National pharmaceutical supply chain was described in evidence by a Chief Pharmacist as being "very fragile" (For Secretary of State)** 10. **There was very poor communication between staff and other staff, and between staff and the family of the deceased and the patient herself (e.g. in relation to DNAR notice, "consent" forms etc.) (Tameside Hospital)**
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe either or both of 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 **8th DECEMBER 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] **(Son 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** **13/10/14** **John Pollard, HM Senior Coroner**