REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr Tom Riall , Chief Executive Officer, Priory Group, Floor 5, 80 Hammersmith Road, London W14 8UD.**
1	**CORONER** I am Andrew Bridgman, Assistant Coroner, for the coroner area of Manchester South.
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 24th March 2014 an investigation was commenced into the death of Sara Jane Green who died whilst an in-patient at the Cheadle Royal Hospital, Cheadle on 18th March 20104. The investigation concluded with an Inquest held between 7th and 28th April 2015. The conclusion of the inquest was a Narrative Conclusion: *On the 17th July 2013 Sara Green was admitted to Cheadle Royal Hospital for in-patient assessment, treatment and management following an overdose of Anadin tablets on 12th July 2013. At the date of Sara's death on 18th March 2014 she had been an in-patient at Cheadle Royal for 9 months, despite having been considered ready for discharge to a community placement at the beginning of October 2013, with no soon prospect of discharge either to hospital or to a community placement closer to home. Sara's prolonged admission was consequent to* *1. the inadequate provision of Tier 4 placements within the Humber & Yorkshire area* *2. the lack of Tier 3 community placements within the Humber & Yorkshire area* *3. a failure by those engaged in Sara's care to properly and expeditiously arrange and or manage Sara's discharge from Cheadle Royal from October 2013 onwards.* *Sara's continuing admission with no soon prospect of discharge was a contributory factor to her act of self-harm on the evening of 18th March 2014 which ended her life.* Medical cause of death 1a) Asphyxia 1b) Ligature Compression of the neck.
4	**CIRCUMSTANCES OF THE DEATH** On 17 March 2014 Sara returned to the Orchard Unit, Cheadle Royal Hospital following a period of home leave which commenced on 6 March 2014. Sara was placed on Level 2 observations on five minute intervals. At a ward round on 18 March 2014, at 16:00 hours, the frequency of the Level 2 observations was reduced to 15 minutes, at Sara's request and in accordance with the observation prescription dated 11 March 2014. Level 2:15 observations commenced at 19:00 hours.

	At about 20:55 - 21:00 hours Sara was found on the floor of her bedroom with the wire spiral binding taken from an A4 pad wrapped around her neck. CPR was commenced and the emergency services summoned. Resuscitation was unsuccessful and Sara was pronounced dead at 22:31 hours.
5	**CORONER'S CONCERNS** During the course of the evidence it was discovered that the medical staff (not the nursing staff or other healthcare professionals) were not making contemporaneous records of consultations or attendances with Sara. On occasions there were days passing between a consultation and the medical record being completed. Some examples are below: The record of a consultation on 30 January 2014, timed to have taken place at 15:30 hours was not entered until 09:21 hours on 7 February 2014. The record of a consultation that took place on 4 February 2014 was not entered until 7 February 2014, and was not checked for its accuracy until 10 February 2014. The record of a consultation that took place on 25th February 2014 was not entered until 4 March 2014, and was not checked for its accuracy until 10 March 2014. I was advised that the method of record-keeping employed is that the consultation is dictated and it is then entered into the records by a secretary. In terms of the record being checked for accuracy, the entry is then simply read by the relevant practitioner without any reference to any hand written note, nor hearing the dictation. It was accepted by one of the doctors subscribing to such a practice that this was an unacceptable practice. That such a late entry into the records of a consultation did not comply with the General Medical Council guidelines for 'Good Medical Practice 2013'. ***19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.*** As I understand one of the purposes of clear, accurate, legible and up-to-date record-keeping is the dissemination of information to others caring for a patient. In circumstances where days may pass before the record of a consultation/assessment is available to others caring for a patient the passing on, or easy availability, of important information will be denied. That, in my view, places patients at risk. The evidence received on this issue at the Inquest suggests that the system of record-making has not changed but that the entry must now be completed within 24 hours of the consultation. In my view that remains an unacceptable period of time and does not comply with the General Medical Council guideline of completing records "as soon as possible afterwards". It was suggested to me that those healthcare professionals accompanying the medical practitioner(s) on ward rounds and at consultations would pass on any important information at a handover. I am not satisfied that dissemination of information in this manner is entirely appropriate, and that it does not adequately compensate for the lack of contemporaneity. 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 **MATTER OF CONCERN** is as follows. – That a delay, of up to 24 hours, in 'writing up' the record of a medical consultation may result in important information not being available to, or easily accessible to, other healthcare professionals involved in the care of a patient, or give rise to the possibility of a misinterpretation of that information, or of the information being inaccurate, if it is passed on orally while waiting for the entry to be 'written up'. This gives rise to a risk of harm to the patient.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to develop a system, and to ensure its operation, such that the making of medical records complies with the GMC guidelines, "You should make records at the same time as the events you are recording or as soon as possible afterwards", which could not possibly be more than 2-3 hours following a consultation, and certainly before the medical practitioner concerned leaves the hospital.
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 2015. 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. I have also sent it to: a) [redacted] Sara's mother b) [redacted] Sara's father c) Rotherham and Doncaster and South Humber NHS Foundation Trust d) North Lincolnshire CAMHS e) NHS England (South Yorkshire and Bassettlaw) f) The Health & Safety Executive 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]** **[SIGNED BY CORONER]** **15.05.15** **Andrew Bridgman**