REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT 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** On 2nd October 2013 I commenced an investigation into the death of **Agnes Mary Hannan** dob 6th December 1937. The investigation concluded on the 23rd October 2014 and the conclusion was one of **Natural Causes**. The medical cause of death was **1a Bowel Infarction 1b Superior Mesenteric Vein Thrombosis 1c Hepatic cirrhosis due to auto immune hepatitis.**
4	**CIRCUMSTANCES OF THE DEATH** **Mrs Agnes Hannan was a 75 year old lady who had been diagnosed with Auto Immune Hepatitis, with cirrhosis, in June 2013. On the 16th, 17th and 18th September 2013 she presented to the ED of Tameside General Hospital. On each occasion she reported severe abdominal pains. On the third attendance she was finally admitted to the hospital. Over the next few days, whilst it transpires that her death was, on the balance of probabilities an inevitability, opportunities were missed to make an earlier diagnosis of her condition, to alleviate her symptoms and to inform her family members as to her condition. She was, allegedly, placed on the Liverpool Care Pathway, although no clear indication of this appears in her clinical notes nor was any clear indication given to her family. She was declared not for active resuscitation without any, or any adequate, discussion with her family members. During her visits to the ED and perhaps even more pertinently whilst an in-patient at the hospital, there seems to have been an almost complete failure to obtain details of her already existing Consultant care and to conduct multi-disciplinary decision making processes. On the 20th September she was finally diagnosed as suffering from Superior Mesenteric Vein Thrombosis which caused an infarction of her bowel, leading to her death on the 21st September 2013.**
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 an actual, or perceived, lack of availability of the hospital notes and records of previous diagnoses and treatments by hospital doctors, for**

	the staff working in the Emergency Department. 2. On one occasion whilst she was an in-patient, Mrs Hannan who was desperately ill and needing intra-venous hydration, was found to be lying in a soaking wet bed because the tube leading to her cannula had become dislodged and disconnected. The nursing staff had failed to notice this problem. The doctors in evidence, acknowledged that her lack of hydration would inevitably have worsened her already thrombosed veins. 3. There was extremely poor communication between hospital staff and the patient (and her family), and between and amongst themselves. There was evidence of a lack of handover between staff, and this was exacerbated by the fact that the medical and nursing notes were frequently inadequate. 4. Whilst it was, or should have been apparent that she was already under the long term care of [redacted], no-one made any attempt to speak with him or his department for advice. 5. Throughout the hospital notes for this patient, there is widespread use of initials and abbreviations. On at least one occasion in court, none of the medical/nursing staff present could explain to me what the abbreviation in the notes meant. 6. This patient needed very careful monitoring at all times and yet there was a period of 24 hours when no nursing observations were carried out or recorded. 7. The communication of Medical/nursing diagnoses and decisions to the family, was extremely poor and frequently did not happen. An example of this was the failure by the staff to explain the critical nature of Mrs Hannan's condition, so that the grandson of the deceased failed to be able to come and see his grandmother in hospital before she died. 8. I was told that there is no CT scanner facility available for the use of the ED out of normal hours. This meant that a scan was delayed/missed and led to a delay in diagnosis of her underlying condition. 9. I was told in evidence that it takes up to three months for the paper records of the ED to be scanned electronically. This means that recent notes may not be available on the computer screens for the staff in the ED. 10. When a patient is admitted there is little or no logic as to determining which Consultant shall be in charge. In this case she was allocated under the care of [redacted] who was not even in the hospital for the first two days of her admission and in fact who NEVER actually saw the patient. 11. The End-of Life Care Pathway must be initiated only after full and meaningful discussion with the patient and/or her family. In the present case there was no evidence to show that any such discussion had taken place.
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 **22nd 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 and principal family**

	representative). 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	**27/10/14** **John Pollard, HM Senior Coroner**