REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: BMI Healthcare and to GTD Healthcare.**
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 March 2015 I commenced an investigation into the death of **Amanda Jane Ellams** dob 21st March 1963. The investigation concluded on the 4th August 2105 and the conclusion was one of **a narrative conclusion**. The medical cause of death was **1a Ischaemic Heart Disease 1b Coronary Artery Atheroma 11. Subacute bowel obstruction due to band adhesions, Abdominal Hernia Repair (February 2015)**
4	**CIRCUMSTANCES OF THE DEATH** **In 2008 this lady had a gastric band fitted. In 2011 she suffered bowel problems which were not directly related to the gastric band procedure, but which required open surgery. Following that surgery she suffered with an increasingly large incisional hernia and with band adhesions. This hernia was repaired in February 2015, and she died approximately four days post operatively.**
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. **During the course of the inquest it was apparent that the standard of note keeping at the Alexandra Hospital (both medical and nursing) was well below that which would be generally regarded as satisfactory. There was even one attendance on the patient by the consultant surgeon in February (according to the surgeon's evidence to me) for which there was no written record whatsoever. The surgeon conceded that he did not have a full medical history available to him pre-operatively and he was not aware of all the prescribed drugs which she was taking.(BMI Healthcare)** 2. **The Alexandra Hospital Staff Nurse conceded that Mrs Ellams was discharged from hospital even though it is now clear that her oxygen saturations were still too low for such discharge to take place. There was what appeared to be a very lax attitude to recording and monitoring the Blood/Oxygen levels and the patient was allowed to disconnect her oxygen supply and walk out of the ward to go for a cigarette.(BMI**

	Healthcare) 3. **The out-of-hours telephone system for the District Nursing team in Tameside area was operated by GTD Healthcare (which also provides the out-of-hours GP service in that area). It was apparent that during the night of her death, Mrs Ellams had made three separate calls to the telephone number she had been given to contact the District Nurses and none of those calls was answered. The duration of the unanswered calls was 2 minutes, 1 minute 50 seconds and 1 minute 14 seconds respectively. In giving his evidence, the Chief Executive of GTD conceded that "it is a flawed system". (GTD Healthcare)**
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 2nd October 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** and to the following Interested Persons namely [redacted] (son of the deceased). I have also sent it to **Stockport NHS Foundation Trust (which runs the Tameside District Nursing)** 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	**7.8.15** [redacted] **John Pollard, HM Senior Coroner**