OFFICE OF HER MAJESTY'S CORONER
DERBY& DERBYSHIRE CORONER'S AREA

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Karen James Chief Executive, Tameside Hospital**
1	**CORONER** I am Robert W Hunter, senior coroner, for the coroner area of Derby and Derbyshire.
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 23rd May 2013 I commenced an investigation into the death of Sheila Johnson aged 74 years. The investigation concluded at the end of the inquest on 11th March 2015. The conclusion of the inquest was that the medical cause of death was: 1a. Haemorrhage from left femoral artery graft site (operated May 2013). The circumstances were that on the 15th May 2013 Sheila Johnson died at 11 John Street, Glossop from catastrophic haemorrhage from a femoral graft wound less than 24 hours after being discharged from Tameside Hospital with an open left groin wound being treated with Total Negative Pressure Therapy. My Conclusion was: Sheila Johnson died as a result of wound dehiscence from a left femoral endarterectomy and bovine graft, in part because signs of bleeding from the wound were recognised before her discharge from the ward, however a number of failures prevented appropriate measures being taken to address the issue and prevent further bleeding. On balance these failures were gross failures and Sheila Johnson's death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** The nurse in charge of Mrs Johnson's care was informed by two doctors that Mrs Johnson was not to be discharged until Mrs Johnson had been reviewed by the

	consultant later that afternoon. Despite this she carried on and discharged Mrs Johnson before that consultant review. The consultant when he came to the ward to review Mrs Johnson he was made aware that she had already been discharged. Despite appreciating that she was at risk of catastrophic haemorrhage he made no effort to recall Mrs Johnson back to the ward that afternoon as a matter of urgency.
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) The court was provided with a copy of the Trust's Internal Report of the circumstances of Mrs Johnson's death and heard evidence regarding the findings from the author of the report. (2) The court was of the opinion that any such investigation and report must be sufficiently robust if it is to have any meaning and lessons learnt to prevent future deaths. (3) The court was of the opinion that on this occasion there was insufficiency of inquiry and the investigation was perfunctory and slipshod. (4) Statements of 6 members of staff were taken. Two of those members were interviewed, the court was of the opinion that other key witnesses including the nurse who discharged Mrs Johnson should have been interviewed. (5) An audit of the nursing and medical documentation was undertaken, however this confined itself to establishing that the entries were accurately dated and timed with a legible signature. No consideration was given to the clinical content of those entries and as to whether or not they were appropriate. (6) The report contained serious factual inaccuracies and based on those errors of fact erroneous findings and recommendations were made. (7) The court believes that should future reports be conducted in this manner then patient's clinical conditions may be compromised and such errors could lead to deaths in the future. (8) The Trust appeared to have no system in place for the urgent recall of patients who had been discharged with potentially life threatening conditions.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation has 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 14th 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 and to the following Interested Persons**; the Family of Mrs Johnson.** I have also sent it to: **The Secretary of State for Health.** **The Chief Executive of the Care Quality Commission.**

	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	**19th May 2015** **Robert W Hunter**