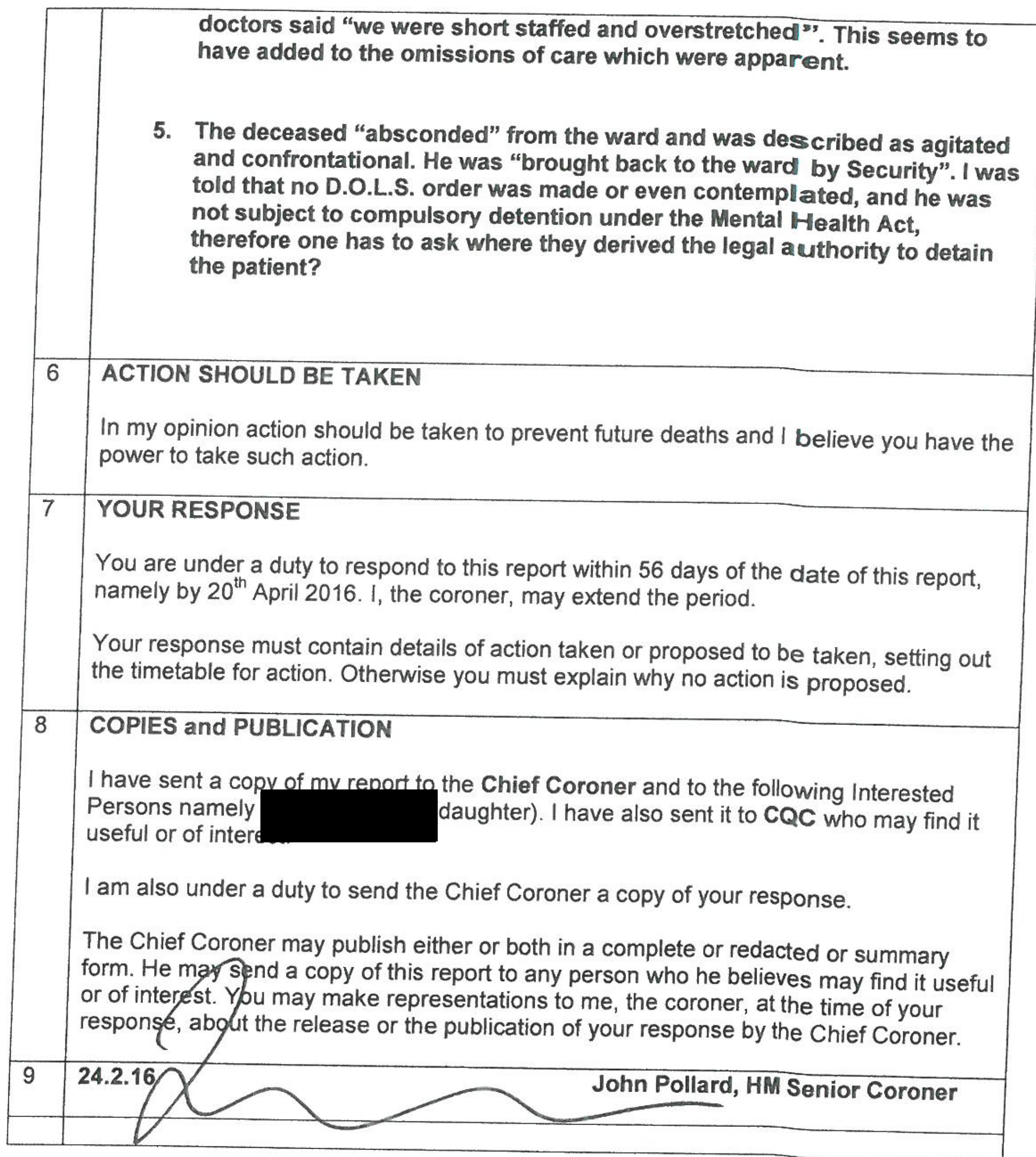
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	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 19th October 2015 I commenced an investigation into the death of Wilfrid Pearson dob 21st March 1927. The investigation concluded on the 22nd February 2016 and the conclusion was one of **Natural Causes**. The medical cause of death was 1a Bronchopneumonia 1b Epilepsy.
4	**CIRCUMSTANCES OF THE DEATH** **On the 22nd April 2015 he was admitted to Tameside Hospital suffering from epilepsy: his condition worsened and became status epilepticus, medical opportunities were missed and he died at the local Hospice a month later.**
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 protocol for the observation, diagnosis and treatment of Status Epilepticus was written by the Consultant Neurologist who gave evidence to me. There was some doubt as to whether the document had been properly updated and whether and how it was promulgated to all relevant medical staff including locum doctors.** 2. **The medical and nursing notes for Mr Pearson left much to be desired in terms of their clarity, accuracy and completeness.** 3. **There was no understanding of the need for, and method of, escalation of the care to the HDU or ITU and indeed according to the expert witness instructed by the Trust the impression is that the ITU doctors did not consider that brain protection was a high priority in Mr Pearson's case".** 4. **There appears to have been a huge stress on the junior medical staff and I was told that "the ITU Registrar refused to attend the ward, but it is not normal for the ITU registrar to refuse to attend" and one of the junior**



doctors said “we were short staffed and overstretched”. This seems to have added to the omissions of care which were apparent.

5. The deceased “absconded” from the ward and was described as agitated and confrontational. He was “brought back to the ward by Security”. I was told that no D.O.L.S. order was made or even contemplated, and he was not subject to compulsory detention under the Mental Health Act, therefore one has to ask where they derived the legal authority to detain the patient?

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 20th April 2016. 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] daughter). I have also sent it to **CQC** 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 24.2.16 **John Pollard, HM Senior Coroner**