REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive, Stockport 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 3rd February 2016 I commenced an investigation into the death of Michael Guy Hutchence dob 28th March 1958. The investigation concluded on the 15th June 2016 and the conclusion was one of **Accidental Death**. The medical cause of death was 1a Bronchopneumonia 1b Deep Vein Thrombosis and Pulmonary Embolus 1c Fractured tibia and fibula.
4	**CIRCUMSTANCES OF THE DEATH** **On the 16th January 2016 he slipped on an icy pavement and broke his lower leg. He was taken to hospital where he was operated on, although there was a delay due to the fact that the operation kit was found to be non-sterile (twice). He died on the 28th January 2016 despite the fact that he was anti-coagulated throughout.**
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. For no other reason than the convenience of the hospital bed-managers, he was moved at least four times from ward to ward in the hospital.** **2. The quality and accuracy of the nursing and medical notes left much to be desired and it was noted that he was cared for by non-specialist nurses on a number of occasions and even when he was in the I.T.U. he was looked after by a trainee nurse.** **3. He was administered his anti-coagulant simply on the basis of his body weight. He weighed 99.8Kg and the difference between a daily dose of 40mg of Clexane and a twice daily dose of 40mg of Clexane is arbitrarily set at a body weight of 100Kg. Should there not be a rather more refined way of assessing the dose required?** **4. In addition to the above problem, the body weight was recorded on some occasions in metric and others in imperial weights. This can and does lead**

	to **confusion.** **On one page of the notes, the predicted weight was shown as 15stone 10lbs which was in fact the actual weight and NOT the predicted weight. For the purpose of the accurate delivery of many drugs including anti-coagulants, accurate weight recording is essential.** **5. There was a shortage of trained nurses in the hospital, and this may have led to at least one of the "ward moves". Ward D2 was closed due to lack of staff.** **6. I was told that the ideal way of elevating a patient's leg is by using a Braun's Frame. There was (and apparently still is) a shortage of these within the hospital, such that his leg was at all times elevated by using pillows. This was a potential for causing or contributing to the formation of DVT's.** **7. The patient was taken to theatre for the operation and this could not be started as the "kit" for the operation was found to have a non-sterile status as the outer wrapping had been breached. The operation was delayed whilst another kit was obtained but this was also found to be defective. The operation was then aborted and put off for a further two days, during which time the patient was immobile and the risk of DVT and PE was inevitably increased.**
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 **by15th August 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] (Wife of the deceased). 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	**20.6.16** **John Pollard, HM Senior Coroner**