REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive, Pennine Acute Hospitals NHS Trust Headquarters, Crumpsall, North Manchester 2. Department of Health, London
1	**CORONER** I am Ms L J Hashmi, Area Coroner for the Coroner area of Greater Manchester North.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 18th July 2016 I commenced an investigation into the death of Mrs Kathleen Cooper.
4	**CIRCUMSTANCES OF DEATH** Mrs Cooper was 73 years of age at the time of her death. She admitted to the Royal Oldham Hospital on the 27th June 2016 for and elective sigmoid colectomy. The surgery was necessary as she was suffering from severe diverticulitis and bowel stricture. The operation was carried out on the 28th June and was technically competent. The immediate post-operative period was relatively uneventful. However, by the 5th July Mrs Cooper started to show subtle signs of deterioration. Over the course of the weekend of the 8th – 11th July, her condition rapidly worsened. She was taken back to theatre on the evening of the 11th July but suffered an intra-operative cardiac arrest. Despite resuscitation and advanced life support, she succumbed. The Hospital Trust's subsequent Root Cause Analysis ('RCA') identified a number of errors, omissions and missed opportunities to treat. An inquest hearing was held on the 1st March 2017. Article 2 was engaged during the course of the inquest (operational duty). Following independent post mortem examination, the medical cause of death was established as: 1a) Acute intraoperative cardiac arrest due to myocardial ischaemia 1b) Sepsis due to faecal peritonitis 1c) Breakdown of colonic anastomosis following colectomy for diverticular stricture and diverticulitis 2) Coronary artery disease and hypertensive hear disease I concluded narratively with a rider of medical and nursing neglect:

' The deceased was admitted to the Royal Oldham Hospital on the 27th June 2016 for an elective sigmoid colectomy, secondary to severe, long standing diverticular disease and bowel stricture. Despite her pre-existing co-morbidities she was deemed medically fit for anaesthetic and surgery. The operation itself was technically competent and the post –operative period up until the 4th July 2016 relatively uneventful. However, by the 5th July the deceased started to show very subtle signs of deterioration. By the weekend of the 8th July marked deterioration set in. The standard of medical and nursing care afforded to the deceased during the course of the weekend of the 8th – 11th July was significantly suboptimal. There were a number of missed opportunities to treat as a result of the multiple errors and omissions that were made. Staff did not take steps to rescue the deceased, in a timely manner, when she became perilously unwell.

By the morning of the 11th July, the deceased was in a critical condition. Whilst a CT scan was eventually directed at 09:00 the same day, the request was not completed and/or in the alternative sent by medical staff until 12:00 – 13:00 hours and the scan was not performed until 18:20 hours, by which time the deceased was in *extremis*. When the scan was carried out, it showed that the bowel anastomosis had failed and there was evidence of a pelvic collection. Following attempts to stabilize the deceased's condition, she underwent an emergency laparotomy. Her condition deteriorated in theatre, culminating in cardio-respiratory arrest. Despite resuscitation and advanced life support, the deceased succumbed. She died at 23: 06 hours on the 11th July 2016, at the Royal Oldham Hospital.

Medical and nursing neglect more than minimally contributed to the deceased's demise.'

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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:-

Department of Health:

1. During the course of the inquest, a medical practitioner raised concerns regarding the difficulties faced by clinicians in providing safe and effective care where an acute NHS Trust has a number of hospitals/departments on different sites i.e. the difficulties faced as a result of split-site commitments as a result of NHS reconfiguration. I echo this concern.

2. The standard of care provided to hospital patients out of hours/weekend and the risk/s posed to patient safety as a result.

Pennine Acute Hospitals NHS Trust:

3. The RCA and the inquest process identified a significant number of errors, omissions and missed opportunities to treat the deceased – all of which, on the balance of probabilities, could and would have improved the deceased's chances of survival, despite her pre-existing co-morbidities. Most of the failings identified in this case have been recognised in previous RCAs conducted by the Trust over the last 6-12 months. Despite evidence as to 'lesson learned'/action plans set etc. flowing therefrom, there appears to be little (if any) timely progress being made in terms of improving/driving up care standards and preventing future deaths. My concerns relate to the following in particular:

   - Poor communication by/between clinicians and nurses
   - Poor record keeping – medical and nursing
   - Poor leadership/supervision of nurses - Ward/Matron level

	- Inadequate supervision by on-call consultants of junior colleagues - Incorrectly calculated early warning scores - Baseline observations not recorded/inaccurately record/missing vital parameters (impacting upon the calculation of early warning scores) - outwith Trust guidance/deviation from the same not clinically justified - Inaccurate fluid balance charts (persistent basic arithmetical errors/lack of recording) - The absence of clinical judgement as a result of the over-reliance placed upon tools such as the early warning scores - Failure to repeat tests such as bloods and to act upon the results accordingly - Failure to escalate (by doctors and nurses) when signs of deterioration/change in the patient's clinical condition become apparent - Delays in arranging urgent/additional tests and treatment (in this case radiological CT scanning, bloods and IV antibiotics) 4. Split site commitment/reconfiguration and the impact this potentially has upon patient safety and clinical care (please see 1 above).
-	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 the 4th May 2017. 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:- Team - The deceased's family - The Trust's solicitors - CQC Inquest Team - Nursing & Midwifery Council - General Medical Council - Bury, Rochdale & Oldham Clinical Commissioning Groups ('CCGs') 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 from. 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	Date: 8th March 2017 Signed: