REGULATION 28: REPORT TO PREVENT FUTURE DEATHS .

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Medical Director of UHSM – [redacted] Copied for interest to: • Chief Coroner • Family of Deceased • [redacted] – GP, Cornish Way Group Practise
1	**CORONER** I am Nigel Meadows, H.M. Senior Coroner for the area of Manchester City.
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	**INQUEST** I resumed and concluded the inquest into the death of **Mr John Griffiths on 5 September 2017** and recorded that he died from: 1a Pneumonia an acute left ventricular failure 1b Ischaemic heart disease I recorded a conclusion ultimately of death from Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was born 19 June 1936 and was 79 years of age. He had a general medical history of suffering from an abdominal aneurism which was treated surgically over 20 years ago. He also suffered a heart attack over 10 years ago and was treated by PCI-Stenting. He also suffered from hypertension, chronic kidney disease, previous deep vein thrombosis and vitamin D deficiency. He had an occupational history of exposure to asbestos and had an in live diagnosis plural plaques and asbestosis. He was being prescribed a combination of mediation for his condition and initially presented at his GP on 4 December 2015 complaining of weight loss and gastrointestinal symptoms. He was referred for the urgent suspected cancer pathway and was seen in the gastroenterology clinic on 16 December 2016, which resulted in a diagnosis of a hiatus hernia and diverticular disease.

He consulted his GP again on 2 February 2016 and he was referred to dieticians for nutritional support and advice.

He consulted his GP again on 1 March 2016 with a chest condition and was a general discussion of his recent CT scan and a request for a further CT scan to be performed.

The deceased had a very supportive family and on 3 March 2016 he presented at the Emergency Department of UHSM and then was referred to the Respiratory Team after his chest x-ray and his reported history of weight loss and increasing shortness of breath over the previous three months of so. It appears that a junior doctor may have wrongly interpreted the presence of plural plaques as being an indication of malignancy and unfortunately the deceased and his family were left with that impression.

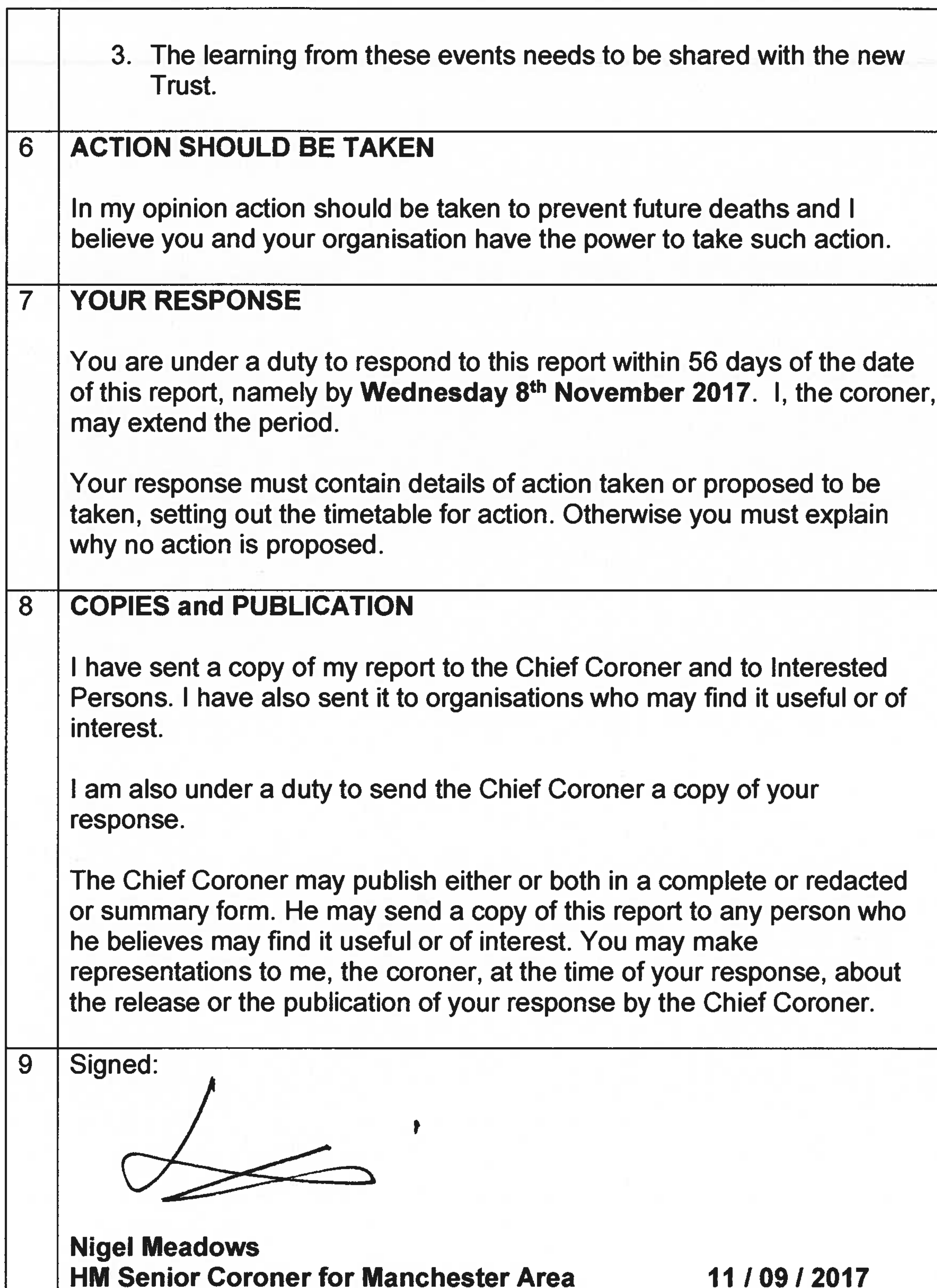
He was admitted to Doyle Ward and it was noted that he had a raised troponin and then a further raised level when it was retested. Ultimately he was not further reviewed by the cardiology team and it was suggested that he self-discharged but was advised to consult his own GP. Unfortunately no discharge summary was subsequently completed and forwarded to his GP.

After being discharged he went to see his GP on 4 March 2016 and saw a locum GP. They managed to contact UHSM and speak to an on-call cardiology registrar and obtain some records. It was noticed that there had been some ECG changes and there was a recommendation for a referral to the cardiology team. Unfortunately the locum GP, although recording in the medical records that they had made the referral, failed to properly follow the formal GP Cardiology Review Referral process and ultimately that resulted in no formal referral being made.

This was not discovered until after the deceased died and the GP practice carried out their own Significant Event Analysis. He had further GP contacts on 18 and 24 March 2017 but then attended UHSM Emergency Department on 28 March 2017 with a recorded history of 1/52 increasing shortness of breath. A chest x-ray was obtained but he was diagnosed with anxiety and a lower respiratory tract infection and discharged home with antibiotics and steroids. It does not appear that the Emergency Department were aware of his previous cardiac history or his admission on 3 March 2017, and the ECG results. The old notes were not available and it does not appear that such electronic records that did exist of the attendance on 3 March were reviewed and considered.

UHSM subsequently conducted its own Incident Investigation and recognised this as s missed opportunity.

	The GP Practice did have an appropriate system of formal referrals and it is unclear why the locum doctor failed to follow that process. Since the event they have reinforced the training and awareness of the referral process for all GPs in the surgery as well as trying to ensure that the same GP sees patients regularly in order to achieve consistency. It is understood that UHSM is introducing in a phased fashion electronic medical records and that all medical records in the emergency department should become electronically. In the present case they were limited electronic reports but paper records could not quickly or easily be recovered. It is understood that in the coming months UHSM will be merging with another major NHS Trust to create one of the largest Trusts in the country and it its hoped that there will be consistent practise and procedures across the entirety of the Trusts sites and in particular in the respective emergency departments. The deceased's condition continued to deteriorate and on 1 April 2016 the family made contact with the GP practice requesting a visit. His reported symptoms did not indicate an acute condition appropriate for such a visit and in any event the particular GP had other responsibilities. He planned, however, to visit the deceased on 4 April 2017. However on 3 April the deceased had a cardiac arrest at home and although given bystander CPR and the ambulance service attending he had a significant period of cardiac cessation. He was taken to the emergency department of UHSM where further resuscitation took place but his condition deteriorated and he died on 8 April 2016.
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. UHSM did not appear to have a system or process that when patients attend the emergency department it is checked whether or not they have had any recent relevant presentations or admissions. 2. If so, then appropriate records are accessed and considered including the results of previous relevant investigations and assessments. If a completely electronic patient record is introduced then this gives the opportunity for that to be achieved easily. Unless and until that occurs other checking processes need to be considered.



	3. The learning from these events needs to be shared with the new Trust.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 **Wednesday 8th November 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 Interested Persons. I have also sent it to organisations 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	Signed: **Nigel Meadows** **HM Senior Coroner for Manchester Area** **11 / 09 / 2017**