REGULATION 28: REPORT TO PREVENT FUTURE DEATHS .

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted] - Medical Director of the University of South Manchester Hospitals NHS Foundation Trust Copied for interest to: • The family of the deceased • Manchester CCG • CQC
1	**CORONER** I am Niger 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** The deceased died on the 23 March 2015 and her death is reported to my but I was not told that any incident had been recorded and was being investigated relating to her care. No post mortem examination was undertaken and her body was released and no investigation was commenced because at that stage there was no reason to suspect that the death was unnatural. Subsequently, UHSM completed a RCA investigation report which was disclosed to the family who then took legal advice and contacted me. I then commenced an investigation and the inquest was resumed on the 4 May 2017 and concluded the following day. I recorded the pathological death as:- 1a. Acute Respiratory Distress Syndrome 1b. Sepsis 1c. Pneumonia 11. Schizophrenia
4	**CIRCUMSTANCES OF THE DEATH** 1. In rehearsing the history below I have used staff surname initials simply by way of ease of reference. They have not and would not be granted anonymity and were publicly identified during the hearing. The Solicitor representing UHSM and all staff involved agreed and accepted that Article 2 of the ECHR was engaged because there was an arguable breach of the general or systemic duty owed to the deceased by the State or agents of the State. Consequently, this was an inquest which complied with S.5 (2) of the Coroners and Justice Act 2009. Towards the end of the hearing when I was able to give an indication that I was

considering reporting [redacted] and [redacted] to the NMC, Sister F obtained separate legal advice and was represent by counsel. I recognised her as an interested person.

2. The deceased was 79 years of age and suffered from hypertension and a chronic mental health illness, namely paranoid schizophrenia, which by its nature was a relapsing and remitting condition. She had a history of partial compliance with her medication and she lived in her own accommodation with support from her family. On the 15 March 2015 she exhibited behaviour, which gave her family concern that she may not be taking her anti-psychotic medication and she also appeared to becoming generally unwell and was increasingly unresponsive with reduced mobility a significant reduction in the amount of urine that she was passing. The out-of-hours GP services was contacted and she was seen and assessed. She was then admitted to the accident and emergency department (A & E) at Wythenshawe Hospital (UHSM) where she was further assessed by [redacted]. She was noted to be hypothermic and required warming in addition to having a fluctuating GCS. The cause of her presentation was not clear and the possibility of a CVA or complication arising from her anti psychotic medication was considered. She underwent a CT scan which did not reveal any relevant neuro pathology.

3. The management plan formulated by [redacted] was for her to admitted and treated with fluids plus to re-start her mental health medications and for her to have a chest X-Ray plus telemetry observations and then she was going to be re-assessed. She did not have the X-ray before she left the A & E department and there was no hand over to the receiving ward medical staff. Nor was her mental capacity assessed.

4. She was transferred to the Acute Medical Unit (AMU) arriving there at about 19:30 hours and was meant to have hourly neurological observations as well as general observations undertaken as appropriately indicated. She had a set of observations undertaken at about 19:50 hours by [redacted]. Unfortunately, she did not include the GCS in the calculation which was inaccurate. In a subsequent written statement she said that she indicated that she had contact with the deceased at 20.20 hours although she made a clinical nursing record timed at 20.10 hours. This indicated that observations were taken- MEWS of 3 for a temperature of 32.1 c. GCS of 10/15. Patient was awaiting an NG tube. She claimed to have given a verbal handover to the Nurse (supposedly [redacted]) who was looking after her, including her most recent observations and MEWS score. However, in any event this should have triggered escalation and referral to the medical team. It should also have triggered another set of general observations to be undertaken within 1 hour. No further observations were undertaken until about 01:45 hours on the 16 March 2015.

5. She was seen and reviewed by a Consultant [redacted] at about 22.30 hours on the 15 March 2015 who examined and reviewed her. He formed a differential diagnosis and decided that antibiotics should be given as well as an anti convulsant medication but that her anti psychotic drugs should not be administered. In addition that she should be subject telemetry observations and a chest X-Ray.

6. Despite the clinical management plan to initiate telemetry observations these were not undertaken and her general and neurological observations were not undertaken as required and indicated or accurately calculated whilst on the AMU.

7. Her GCS was meant to be assessed as part of the required neurological observation and her early warning scores (MEWS) were incorrectly calculated and her care was not escalated once again as it should have been in accordance with UHSM Trust policy. In addition, she should have had more

frequent observations undertaken. When her observations were undertaken at 01:45 hours by [redacted] the on call junior doctor was i-Bleeped (message read – " EWS 5 Hypothermia and low 02 saturation levels") but they were unable to attend immediately. [redacted] spoke to [redacted], who was the Nurse in charge of the AMU,

8. In the meantime, no further observations were undertaken until shortly before the junior doctor [redacted] arrived at 06.00 hours. She was examined and assessed and there were further investigations ordered. At 07:00 hours, a [redacted] who was about to start his morning ward round on AMU was coincidentally close by to the deceased's bed space and had noticed her erratic breathing noises and immediately recognised that she was in a peri-arrest condition. He abandoned the ward round and called the crash team and led her medical management for about the next 2 hours. She then had a chest X-ray.

9. A " Complaint Details for Agency" form was completed and appears to be dated 17 March 2015 includes the following complaint description : "On commencing the early shift following a handover the AMU consultant entered the Bay to find a patient in a per-arrest state. On further investigation the nurse caring for the patient had not complied with the MEWS observation policy overnight and had not informed the next shift of the urgent nature of her required medical review. The nurse failed to recognise the deteriorating patient which resulted in the patient been transferred to theatre recovery for intubation. On further questioning of the sister in charge of the nightshift, the patient's condition was not escalated to her and therefore she was unaware of the situation. The patient had already been seen by the AMU consultant prior to the commencement of the nightshift and concerns were raised that the patient was poorly and if a condition worse to deteriorate medical review should be sought. The patient was immediately reviewed and escalation was sought. The patient was transferred to theatre recovery for intubation and further management. It is imperative that all nurses working on the AMU followed the M EWS escalation protocol and can be detrimental to the health and well-being of patients if this is not followed as shown in this case. I will inform the AMU ward manager of the current situation and matron whom will decide if this worker is to be booked again. Until then this flexible worker must not be booked to work on the AMU."

10. It appears that [redacted] (who was responsible for the deceased during the overnight shift) responded in person on the 17 March 2015 but this did not sufficiently or adequately explain what had happened or why observations were not completed or accurately calculated and escalated. Unfortunately , when he gave evidence he could not explain why he had not acted as he should have.

11. A HIRS report number 56358 was made on the 19 March 2015 included the following : " On review of nursing and medical notes standard of observation and MEWS escalation not as per Trust policy. Doctor review of patient at 06.00 on the 16 march should have been escalated to a senior doctor for urgent review and appropriate management plan".

12. She was then admitted to the Intensive Care Unit (ICU) where she was further treated. She was diagnosed as suffering from pneumonia, which had led to sepsis. Despite, appropriate treatment, her condition deteriorated and she required intubation and sedation. She then developed Acute Respiratory Distress Syndrome and despite treatment her condition further deteriorated and she died on the 23 March 2015.

13. There were significant failures to ensure that all appropriate investigations and a chest X-ray was undertaken before she left the A & E department and no appropriate hand over was completed. Overnight between the 15 and 16 March 2015 in the AMU there were serious and significant failures in her nursing care and management which went unrecognised.

14. When the deceased's death was reported to my office I was not advised about the HIRS report or any concern identified at that stage about any concerns about the deceased's clinical or nursing management.

15. [redacted] made a statement about the events but this was not until (if this is correct) until 19 December 2016 and after having been made aware of the death of the deceased and seeing the RCA report. In that document [redacted] does not seem to acknowledge or appreciate that he should have acted very differently but claims to have spoken to Sister F at the time. Nor is any explanation given for the failure to undertake the required observations or calculate them correctly.

16. [redacted] provided a short statement (the copy provided to the court is undated and not signed) in which she says she recalled speaking to [redacted] SpR [redacted], at about 23.15 hours on the 15 March 2015 and accepts that she was told that the deceased was unwell with the potential to become even more unwell. She instructed [redacted] to administer the prescribed medication and then some hours later [redacted] told her that he had "i-bleeped" the on call SHO as she had dropped her oxygen saturation levels. She indicated that she asked [redacted] if there was anything else she could do to ass sit but he declined. She claimed that at no point did anyone tell her about the deceased's MEWS scores. She only learned that the deceased required urgent medical review at 07.00 hours on the 16 March 2015 when she read the safety huddle document.

17. It seemed to me that as Sister in charge of AMU who had worked there for a lengthy period [redacted] failed to demonstrate the leadership required for the role. Although in evidence she accepted the findings of the RCA report she could not explain why she had not known more about the deceased or taken action herself.

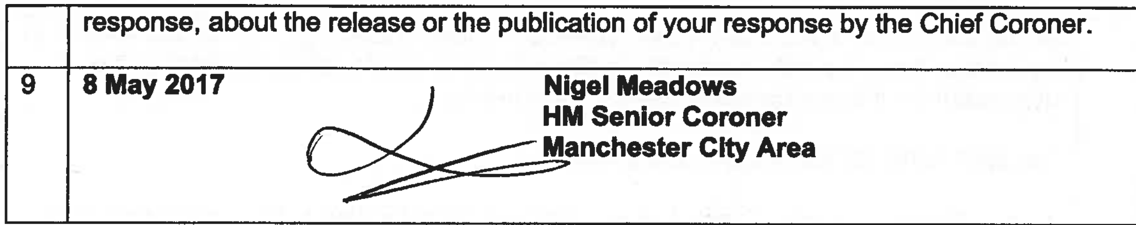
18. [redacted] then made a further statement after she had seen the RCA report in which she said that there was no individual handover for each patient and when she started she was actually unaware that the deceased had been admitted to the AMU. She also said she was unaware of the potential need to refer her to the ICU should she deteriorate or that [redacted] could be contacted at home overnight if necessary. She said that she was not informed that any telemetry was to be undertaken nor the very small amount of urine she had passed. She said that she was also not informed about the deceased being hypothermic or that there was no heated blanket in place. She did not see [redacted] who discovered the deceased in a peri arrest state.

19. After much deliberation and anxious thought I came to the conclusion that it was appropriate to formally report my concerns about the conduct of [redacted] and Sister F to the NMC. It seemed to me that patient safety issue arose and had not been dealt with.

I returned a Narrative Conclusion as follows: The deceased died as a consequence of the complications of pneumonia and sepsis in combination with the chronic and acute effects of schizophrenia and treatment for that condition and that there were significant and serious failures in her nursing care and management, which contributed to her death. It was possible that appropriate nursing observations, management and consequent escalation would have produced earlier senior clinical involvement and medical management, which may have prevented the death.

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. Mental Capacity. There was no apparent consideration to the issue of whether or not the deceased had mental capacity from admission to A & E and transfer to AMU. 2. Ensuring all investigations/assessments are completed before a patient leaves A & E and ensuring an appropriate handover. It is appreciated that it will not be possible for all investigations and tests to be performed before a patient leaves the A & E department but if that is the case then the receiving ward should be informed and there should be a clear documented audit trail so that it is clear what is outstanding. 3. Transfer and hand over of a patient to AMU from A & E. There was no clear hand over process and review when the deceased arrived on the AMU. It would seem sensible that a Senior Nurse/Sister be informed and can then ensure appropriate care is given. 4. Ensuring investigations are progressed as appropriate. There was no progression of necessary basic assessments/tests which remained outstanding. For example, a chest X-ray. 5. Ensuring that all neurological and/or general observations are appropriately undertaken, accurately recorded and calculated but also escalated as necessary. It is a fundamental part of basic medical and nursing care that a patient who requires neurological or general observations has them completed in a timely manner, accurately recorded and calculated and then appropriately escalated. This was simply not done and simple systems or protocols could be introduced to ensure that this is completed. It would seem that the primary responsibility for this should be shared between the Nurse in charge of the individual patient and the nurse in charge of the AMU. 6. Staffing levels, competence and seniority. The levels and competence of staff (whether agency or Trust employees) needed to deliver safe and appropriate care and with sufficient senior Nursing staff in leadership roles requires assessment and implementation.
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 Friday 10 July 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	**8 May 2017** **Nigel Meadows** **HM Senior Coroner** **Manchester City Area**