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
1	**CORONER** I am Ms L Hashmi, Area Coroner for the Coroner area of 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 19th June 2017 I commenced an investigation into the death of **John Lea,** concluding by way of inquest on the 27th November 2017.
4	**CIRCUMSTANCES OF DEATH** On the 7th June 2017 Mr Lea was admitted to hospital, upon the referral of his GP, for further management of his heart failure. He had a number of pre-existing co-morbidities, including stroke, peripheral vascular disease, chronic obstructive pulmonary disease and chronic kidney failure. Treatment for heart failure was instigated and he appeared to respond well. At around 23:30 on the 11th June 2017, the 'bay tagging' nurse left the bay in order to assist in another part of the ward. She could not see her bay from where she was, had not asked another to monitor the bay in her absence and upon her return, did not notice that Mr Lea was no longer in his bed. Leaving the bay without asking another nurse to observe was a breach of policy. Mr Lea was found on the floor in a collapsed state, on the opposite side of the bay, at around 23:40. The emergency buzzer was activated and a crash call put out. Basic life support was commenced. Despite best attempts at resuscitation, the fact of Mr Lea's death was confirmed at 00:04 on the 12th June 2017 at the Royal Oldham Hospital. It was not possible to say on the evidence heard whether earlier discovery/intervention would have materially altered the outcome. An internal investigation by the Trust identified a significant number of errors and omissions (some of which amounted to gross failings to provide basic care) however none were causally linked to Mr Lea's death. Given the evidence overall, it is more likely than not that Mr Lea suffered a collapse as a result of a sudden cardiac-related event. Conclusion – natural causes
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. In this case, critical risk assessments had not been updated and/or completed (falls, cot sides etc.) There were missed opportunities to re-assess. 2. Poor communication between the nursing team, with particular reference to 'bay tagging'.

	3. Gaps within the documentation/record keeping/missing entries by both doctors and nurses (including fluid balance charts for a patient in heart failure and subject to fluid restriction, risk assessments, care planning, rounding tool and medical attendance upon the deceased). 4. No escalation when the on call doctor failed to attend following a marked change in the deceased's oxygen saturations. 5. Incorrectly calculated NEWS scores. The NEWS was designed to address mistakes brought about by the previous early waring score tool (EWS), yet mistakes with regard to score calculations continue. 6. Failure to adhere to Trust policy/protocol – prevention of falls, patient observation. 7. Insufficient progress with regard to the NAAS rating for the ward in question (initial assessment a year ago 'red', more recent assessment 'high amber').
6	**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 23rd day of January 2018. 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:- • The deceased's family • CQC (Per MoU) 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: 28th November 2018 Signed: