REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive, Salford Royal Hospital
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 20th July 2017 I commenced an investigation into the death of Mrs Lindsey Parker. This concluded, by way of inquest, on the 18th December 2017. I reached a narrative conclusion, namely that the deceased died as a result of the rare but recognised complications of medical therapy (Naproxen).
4	**CIRCUMSTANCES OF DEATH:** **I found:** In mid-2016 Mrs Parker presented to her GP with a cyst-like swelling to her scalp. This was initially treated with antibiotics and she was listed for minor surgery at the Practice. On the 10th August the lump was removed and sent for histopathology. She returned to the surgery on the 24th August 2016 for suture removal by the Health Care Assistant. During the course of this appointment she saw her digital health record; it alluded to a diagnosis of cancer. She had not been formally advised by her doctor of the outcome of the histopathology result, received on the 23rd August, which confirmed a diagnosis of probable metastatic Adenocarcinoma (the scalp lesion believed to be a secondary tumour). Mrs Parker was referred to the hospital and underwent a number of tests and medical appointments with Physicians, Radiologists and Oncologists. A primary lung cancer was diagnosed with metastatic spread into scalp and eventually, the pancreas and liver. Whilst the cancer could not be cured, symptom management/treatment was instigated and steps were taken to establish whether Mrs Parker was appropriate for inclusion in clinical cancer trials. As part of her pain management regime, Mrs Parker was prescribed Naproxen. More likely than not, whilst originally having been prescribed by her GP, she did not receive a first dose of this medication until around the 28th April 2017 whilst a hospital inpatient. On the 21st June 2017 a skin rash started to appear on Mrs Parker's neck and shoulders - initially believed to be due to sun exposure. However the rash continued to spread and blisters started to appear. She attended Accident and Emergency on the 23rd June and was immediately referred to the Dermatologist on call, who made differential diagnoses of Toxic Epidermal Necrolysis (TEN)/Stevens Johnson Syndrome (SJS). Mrs

	Parker was transferred to ICU but subsequently moved on to a Dermatology ward where topical therapies, symptom management, fluid replacement/fluid balance and antibiotic therapy (upon the advice of the Microbiologist) were instigated. There was liaison between the Dermatology and Oncology teams. TEN was subsequently confirmed by skin biopsy. An elevated CRP count was attributed to inflammatory response. Up until the 7th July Mrs Parker's condition remained guarded but stable. On the 8th July there was a marked deterioration in her overall condition. She became confused, agitated and her oxygen saturations fell. The doctor was notified at around 13:30. A medical review was to be conducted. This did not take place until 6-7 hours later. In the intervening period, staff did not adequately recognise or act upon ongoing deterioration, nor was there sufficient escalation when medical staff did not appear. When a chest x-ray and further tests were conducted diagnoses of pneumonia and acute kidney injury were made. Mediation was revised. Consideration was given to transferring Mrs Parker to the HDU, however this was not deemed to be in her best interests. She continued to succumb and died at the Salford Royal Hospital on the 9th July 2017, with the fact of her death confirmed at 06:15. A review of care conducted by the Hospital Trust identified that fluid balance charts were not completed and observations were not taken/recorded, outwith expectation. It was not possible, on the evidence heard, to causally link the omissions identified to Mrs Parker's 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:- Whilst I heard evidence from Matron regarding her (albeit limited) review of the circumstances surrounding Mrs Parker's admission and from the Consultant involved in her care, I was not reassured by the steps taken to date, nor do I believe that they have been taken in a timely manner. No substantive action plan has been proffered. I remain concerned about the following: 1. A lack of continuity in medical care. According to the family's evidence, Mrs Parker was seen by 16 different doctors during the course of her last admission. Of these, seven were junior doctors (FY grade). 2. Matron's review identified gaps in basic nursing care – vital signs/observations not recorded, potentially affecting the NEWS and inadequate fluid balance chart completion. Both are critical to patient care and safety, particularly given Mrs Parker's serious clinical diagnosis (TEN), against a backdrop of an already life limiting/threatening diagnosis. 3. Failure to adequately recognise the deteriorating patient and to act and/or escalate matters accordingly. 4. During the course of the evidence, Trust staff were unsure as to what qualifications the 'Hospital at Night' site co-ordinators held. They believed that most, if not all, were likely to be Nurses. My concern here is how/why nurses are deemed suitably qualified to manage out of hours medical prioritisation of care.
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 13th February 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 - Pennine Acute Hospitals NHS Trust - Department of Health, London - Salford CCG - CQC 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: 19th December 2017 Signed: