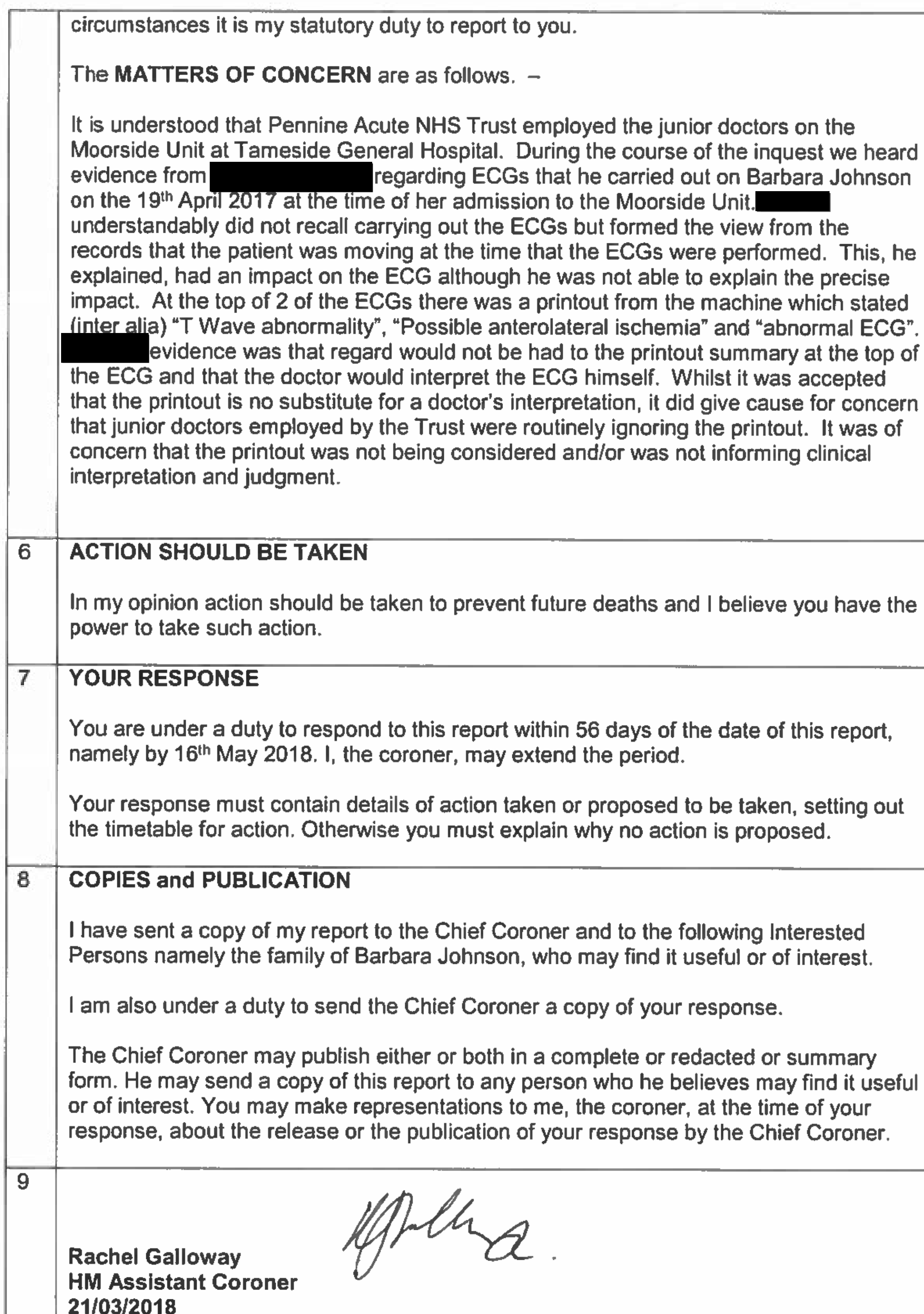
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(a) Medical Director, Pennine Acute NHS Trust**
1	**CORONER** I am Rachel Galloway, assistant coroner, for the coroner area of South Manchester
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	**INVESTIGATION and INQUEST** An inquest was opened into the death of Barbara Johnson on the 12th May 2017. The inquest commenced on the 12th March 2018 and concluded on the 16th March 2018. Mrs Johnson was sectioned under section 3 of the Mental Health Act at the time of her death. Article 2 was engaged. I sat with a jury. The jury left the short form conclusion of natural causes and, in addition, a narrative conclusion: *"There were deficiencies in the handover of Barbara Johnson's care on the 30th April, which possibly did contribute to her death. There was a failure to carry out a further physical observation on Barbara Johnson on her admission to the Moorside Unit on the 19th April 2017, which did not contribute to her death. In addition, there were deficiencies in equipment used in the emergency response on the 30th April 2017 (in particular an unplugged suction machine and an oxygen cylinder which ran out of oxygen), which did not contribute to Barbara Johnson's death".* The jury recorded the medical cause of death as: 1a Myocardial infarction 1b Coronary Artery atheroma II Chronic Obstructive Pulmonary Disease
4	**CIRCUMSTANCES OF THE DEATH** Under Part 3 of the Record of Inquest, the jury recorded: *"Barbara Johnson was detained under Section 3 of the Mental Health Act on the 19th April 2017, and admitted to the Moorside Unit of Trafford General Hospital. A number of routine physical tests were conducted on admission. On the 30th April 2017 Barbara Johnson suffered a heart attack on the Moorside Unit at Trafford General Hospital. She was pronounced deceased following resuscitation efforts at 2.30 pm on the 30th April 2017. Physical observations were carried out every day on the unit with the exception of the 30th April 2017. Consideration should have been given to a doctor's review of Barbara Johnson on the 29th or 30th April 2017. There should have been a further physical observation carried out after 9 am on the 29th April 2017".*
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. – It is understood that Pennine Acute NHS Trust employed the junior doctors on the Moorside Unit at Tameside General Hospital. During the course of the inquest we heard evidence from [REDACTED] regarding ECGs that he carried out on Barbara Johnson on the 19th April 2017 at the time of her admission to the Moorside Unit. [REDACTED] understandably did not recall carrying out the ECGs but formed the view from the records that the patient was moving at the time that the ECGs were performed. This, he explained, had an impact on the ECG although he was not able to explain the precise impact. At the top of 2 of the ECGs there was a printout from the machine which stated (inter alia) "T Wave abnormality", "Possible anterolateral ischemia" and "abnormal ECG". [REDACTED] evidence was that regard would not be had to the printout summary at the top of the ECG and that the doctor would interpret the ECG himself. Whilst it was accepted that the printout is no substitute for a doctor's interpretation, it did give cause for concern that junior doctors employed by the Trust were routinely ignoring the printout. It was of concern that the printout was not being considered and/or was not informing clinical interpretation and judgment.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 16th May 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 family of Barbara Johnson, 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	**Rachel Galloway** **HM Assistant Coroner** **21/03/2018**