REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Sir David Dalton, Chief Executive, the Pennine Acute Hospitals NHS Trust, Trust Headquarters, North Manchester General Hospital, Delaunays Road, Crumpsall M8 5RB

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 10th October 2017, an inquest was opened into the death of Janet Hall, who died aged 67 years at Tameside General Hospital, Ashton under Lyne on 18th September 2017. The investigation concluded at the end of the inquest which I heard on 21st February and 12th March 2018.

The conclusion of the inquest was that Mrs Hall died as a consequence of acute heart failure. Although Mrs Hall had underlying ischaemic heart disease, her heart failure was precipitated by very advanced B Cell lymphoma which had not been diagnosed at the time of her death. The conclusion of the inquest was natural causes.

CIRCUMSTANCES OF THE DEATH

Mrs Hall first presented to her GP with symptoms of left leg and back pain on 22nd May 2017. The pain was not relieved by anti-inflammatories, and continued to progress with increasing analgesia requirements over the course of the summer.

On 19th July 2017, Mrs Hall attended the Emergency Department of The Royal Oldham hospital, complaining of palpitations and a raised heart rate. She was discharged following examination and investigations with a request that her GP arrange cardiology follow up.

On 9th August 2017, Mrs Hall attended her GP with leg swelling. Her GP referred her to the Vascular Studies centre at Tameside General Hospital where, the following day a scan confirmed the presence of an extensive Deep Venous Thrombosis. Mrs Hall was admitted to hospital for further investigations, pain relief and anti-coagulant therapy.

There then followed a series of admissions and attendances to Tameside General Hospital, culminating in Mrs Hall's sad death on 8th September 2017. The medical cause of Mrs Hall's death was:

1)a) Acute left ventricular failure;

b) B Cell lymphoma on background of ischaemic heart disease.

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. –

Following Mrs Hall's attendance at the Royal Oldham Emergency Department, a letter was written to her GP which included the text *'Bloods and ECG all normal'*. The evidence before the court was that contrary to this statement, Mrs Hall's full blood count was, in fact, abnormal, with a slightly low haemoglobin at 96 grams / litre.

[redacted] Consultant in Emergency Medicine, explained in his evidence that in contrast to other systems which operate across the Trust whereby complete sets of results are automatically incorporated into discharge letters, the Emergency Department system is currently predicated on junior doctors accurately transcribing significant individual results.

In addition to increasing the chances for errors of the sort that occurred in this case, it is a matter of concern that the absence of a complete set of blood results in discharge letters reduces the potential for GPs to compare results with others on their own systems, reducing the opportunity for trend analysis.

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.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 9th 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

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to [redacted], Mrs Hall's widower.

I have also sent it to the Healthcare Safety Investigation Branch, the Care Quality Commission, and [redacted] 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.

Dated: 14th March 2018

Signature:

Chris Morris HM Area Coroner, Manchester South.