REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted] Partner, Denton Medical Practice, 100 Ashton Road, Denton, Manchester M34 3JE

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 7th February 2018, I opened an inquest into the death of Joan Hanratty who was aged 75 years when she died at Tameside General Hospital, Ashton-under-Lyne on 28th January 2018. The investigation concluded at the end of the inquest which I heard on 30th April 2018.

The conclusion of the inquest was that Mrs Hanratty died as a consequence of septic shock due to pneumonia and Chronic Obstructive Pulmonary Disease against a background of multiple complex medical problems. At the end of the inquest, I recorded a conclusion of Natural Causes.

CIRCUMSTANCES OF THE DEATH

Mrs Hanratty had a complex medical history, which included heart failure, ischaemic heart disease, atrial fibrillation, hypertension and moderate to severe Chronic Obstructive Pulmonary Disease.

On 23rd January 2018, Mrs Hanratty contacted Denton Medical Practice and requested a prescription for antibiotics and steroids having developed a chest infection. As Mrs Hanratty was subject to regular review for her Chronic Obstructive Pulmonary Disease, a prescription for Amoxicillin and Prednisolone was issued automatically in accordance with relevant best-practice guidelines.

On 28th January 2018, Mrs Hanratty was brought into hospital by ambulance, having collapsed and suffered a cardiac arrest. Despite attempts to resuscitate her, she sadly died in hospital later that day.

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 was confirmed in the course of evidence given at the inquest that under certain circumstances, patients who have been diagnosed with, and are subject to regular review as a result of, Chronic Obstructive Pulmonary Disease are issued with prescriptions for antibiotics and steroids upon request and without requirement for a telephone or in-person consultation with a doctor.

Whilst it is recognised that this practice accords with relevant clinical guidelines, it is a matter of concern that the system currently operated by the practice does not currently include explicit advice to patients that, in the event a significant improvement in condition is not experienced within a specified period of time of beginning antibiotic and steroid therapy, medical advice should be sought.

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 4th July 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 Mrs Hanratty's daughter (on behalf of her wider family), [redacted]

I have also sent it to Tameside and Glossop Clinical Commissioning Group and the Care Quality Commission 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: 9th May 2018

Signature:

Chris Morris HM Area Coroner, Manchester South.