REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: 1. Mr Steve McManus – CEO, Chief Executive's Office, Level 4, Royal Berkshire Hospital, London Road, Reading, RG1 5AN. 2. [redacted] - Practice Manager – The Waterfield Practice, Ralphs Ride, Harmanswater, Bracknell, RG12 9LH.
1.	**CORONER** I am Mrs Heidi J Connor, Senior Coroner for the coroner area of Berkshire.
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** I conducted an Inquest into the death of Michelle Roach that was heard at Reading Town Hall between 6th and 9th November 2018. I recorded a narrative conclusion as follows: *Natural causes contributed to by neglect in her clinical management from 0911 hrs on 29th January 2014 until 1807 hrs on 30th January 2014.*
4.	**CIRCUMSTANCES OF THE DEATH** The family asked us to refer to the deceased as Michelle at the inquest. I have reflected that request in this report. I have attached my detailed summing up and conclusions provided at the conclusion of this inquest which sets out the history in detail.

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

Brief Summary

Michelle Roach was a 32 year old woman who had given birth to her first child on the 17th December 2013. She had a past medical history which included treatment for asthma and hypertension.

She attended her GP on the 15th January 2014 after suffering a fainting episode 3 days earlier. Her hypertension medication was adjusted and she was seen again two weeks later – on 29th January 2014.

At this appointment, she reported a further collapse. Her heart rate was very high. The question of whether Michelle was short of breath at this appointment was a matter of factual dispute between the witnesses. I made a finding of fact that Michelle was likely to have been short of breath or at the very least to have reported being short of breath earlier that day.

During a telephone appointment on 30th January 2014, Michelle's husband reported that she was too weak to attend an appointment. The GP's advice was for Michelle to attend 4 days later. A further telephone call was made to the GP later that day, which resulted in a home visit and subsequent admission to hospital – on the evening on the 30th January 2014.

Despite being admitted as a "?PE" patient, there was inadequate senior review at the hospital resulting in a delay in the administration of anticoagulants. Michelle died in the early hours of 31st January 2014.

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 could occur unless this action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows:

In relation to GP Management

(1) I believe [redacted] should consider reviewing and updating her knowledge in relation to the signs and symptoms of venous thromboembolism.

(2) I believe [redacted] should review her record-keeping practices.

(3) The GP practice should review their system for investigating unexpected deaths in order to learn from them and improve clinical management. It should also audit and review [redacted] clinical knowledge in this area

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS	
	and her record keeping. Hospital Management (1) I consider that the trust should review its level of cover by medical registrars at night. Financial constraints and limits on the numbers of medical registrars available to the trust are frequently matters determined outside of the trust's immediate control, and, as such, these matters may need to be raised outside the trust.
6.	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe your organisation has 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 23rd January 2018. 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 Michelle's family. 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.	**28th November 2018** **Mrs Heidi J Connor** **Senior Coroner for Berkshire**