REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Senior Partner, Highlands and Trafalgar Square Surgery, Highlands Surgery, 156 Stockport Road, Ashton-under-Lyne OL7 ONW.

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 6th September 2018, Christopher Murray, Assistant Coroner for Manchester South, opened an inquest into the death of George Foster Thompson who died on 23rd August 2018 at Tameside General Hospital, Ashton-under-Lyne, at the age of 86. The investigation concluded with an inquest which I heard on 8th January 2019. My conclusion was that Mr Thompson died as a consequence of natural causes.

CIRCUMASTANCES OF THE DEATH

In later life Mr Thompson developed an array of chronic health problems. In addition to being suspected to have dementia, he had diabetes mellitus, heart failure, ischaemic heart disease and high blood pressure.

In 2017, he moved into Firbank Lodge Residential Care Home. Over the course of his time there, he developed, and was treated for, a number of chest and urinary tract infections.

On 21st August 2018, staff at Firbank Lodge contacted Highlands and Trafalgar Square Surgery requesting a home visit as Mr Thompson had become unwell. The duty doctor who spoke to staff dealt with the call as what he termed in his evidence as a telephone "triage" call, and prescribed antibiotics following a discussion with a carer with a view to adding Mr Thompson to the home visit list the following day if his condition did not improve with medication.

The following day, Mr Thompson's condition deteriorated (notwithstanding three doses of oral antibiotics which had been delivered to Firbank lodge) and was admitted to Tameside General Hospital by ambulance where he died on 23rd August.

A doctor treating Mr Thompson confirmed the medical cause of his death was:

1) a) Bronchopneumonia;
2) Vascular dementia, ischaemic heart disease, aortic stenosis, chronic kidney disease and Type 2 diabetes mellitus.

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. –

The evidence before the court was that, on the afternoon of 21st August 2018, there was only one doctor on duty for the practice as a whole. The evidence of the relevant clinician is that in addition to undertaking a (habitually) busy afternoon surgery, he was the only doctor available to deal with emergencies or clinical queries. In those circumstances and whilst the relevant clinician described his telephone call with the care home in terms of being a "triage" consultation, there was no resource in the practice for a home visit to be undertaken that afternoon even if considered indicated by the doctor.

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 13th March 2019. 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 Susan Hughes on behalf of Mr Thompson's family.

I have sent a copy of my report to the Care Quality Commission, and Tameside Clinical Commissioning Group, 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: 16th January 2019.

Signature: Chris Morris HM Area Coroner, Manchester South.