# REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

This report is made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

Recipients

This report is being sent to:

- **Prof Matthew Makin, MD of NMGH, Penine Acute Hospitals NHS Trust**

Copied to:

- **Greater Manchester Mental Health NHS Trust c/o Hempsons Solicitors**

Coroner

I am **John Hobson, Assistant Coroner for the Manchester City Area**.

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.

Investigation and Inquest

On 19th January 2016 an investigation was commenced into the death of Graham Tailby, aged 58. The investigation concluded at the end of a jury inquest on 8th March 2019 and which was heard before me.

The cause of death was found to be:

1a Broncopneumonia
1b Combined sertraline and fentanyl toxicity

The conclusion of the inquest was as follows:

Mr Tailby died as a result of a combined toxicity of prescribed drugs but it was unclear as to how that toxicity occurred or developed.

Circumstances of death

Mr Graham Tailby was a patient detained under the Mental Health Act 1983 on Juniper Ward, Park House, North Manchester General Hospital, Delaunays Road, Crumpsall, Manchester.

On the evening of 22nd December 2015 Mr Tailby was discovered unresponsive in his room during a 1:15 minute observation of a type and frequency that had been carried out consistently throughout the day and during which no concerns were raised by staff tasked with completing observations.

Upon discovering Mr Tailby to be unresponsive, an alarm was raised followed by a crash call by way of dialling emergency line 2222.

The crash team attended Mr Tailby's room on the ward where CPR had been commenced by staff attending in response to the alarm.

Assessment and appropriate medical interventions were carried out by the crash team utilising equipment from the crash trolley which had been brought to the room, but despite all efforts the decision was taken to cease further action and Mr Tailby's death was confirmed at 20:00 hours.

Coroner's concerns

During the course of the inquest the evidence revealed a matter 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 is as follows.

> The leader of the crash team gave comprehensive and clear evidence as to the appraisal of Mr Tailby's situation upon his emergency arrival on the ward in response to the crash call and the decisions that were then taken.
>
> His evidence was that he whilst struggling to gain intravenous access to administer relevant drugs to Mr Tailby he had considered the possible use and assistance of a piece of equipment known as an intraosseous drill. The equipment however wasn't present on the crash trolley which had been brought to Mr Tailby's room.

In the event he was in fact able to secure intravenous access and proceed accordingly. He also acknowledged that whilst the use of an intraosseous drill was an option with which he was familiar, that might not be the case for others and in any event is not a core requirement of expertise of those involved in emergency responses such as that which took place.

The point that I raise is that the provision of the intraosseous drill on crash trolleys may provide another route of intervention for those familiar and trained in its use in other circumstances in the future, and having that option may prevent deaths in the context of emergency crash responses to wards for which the Trust has responsibility.

Action should be taken

In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 **Wednesday 15th May 2019**. I, John Hobson, 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 the following Interested Persons:

Greater Manchester Mental Health NHS Foundation Trust

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.

**John Hobson**
H.M. Assistant Coroner – Manchester City Area **Date:** 19th March 2019