REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive of Tameside and Glossop Integrated Care NHS Foundation Trust
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 On 21st May 2019 I commenced an investigation into the death of Shirley Anne Nightingale .The investigation concluded on the 21st November 2019 and the conclusion was one of **Narrative: Died from the complications of a gastro-intestinal haemorrhage contributed to by neglect.** The medical cause of death was 1a) Gastro-intestinal haemorrhage
4	CIRCUMSTANCES OF THE DEATH Shirley Anne Nightingale had Crohn's Disease which had resulted in an inflammation that was treated with a reducing dose of steroids - a recognised treatment. On 19th May 2019 she had both hematemesis and haematochezia and went to Tameside General Hospital. In Accident and Emergency an upper gastro-intestinal bleed was diagnosed and an urgent endoscopy requested. Guidance indicated this should take place within 24 hours. In the early hours of 20th May 2019 she had a further episode of bleeding. On 20th May 2019 it was identified she was not on the list for an endoscopy. It is unclear why not. She was a high risk patient. It was agreed by the clinicians that it could take place on 21st May 2019 outside the guidance period. At 7pm on 20th May 2019 she suffered a catastrophic bleed and died at Tameside General Hospital. Post mortem found the source of the bleed was the lower oesophagus and stomach. She had excisions and ulcers at the gastro/oesophageal junction

	which had caused the bleed on 20th May 2019. An endoscopy within the 24 hour timescale would have identified them and led to urgent investigation and on the balance of probabilities avoided the bleed on the evening of 20th May 2019.
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 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. – 1. The inquest heard that there was no clear system for escalation /prioritisation by treating clinicians in relation to management of the OGD lists and patient need where the OGD team said there was no capacity; 2. The inquest heard that it had been identified in Accident and Emergency that the OGD was required. The notes were marked accordingly but there was no clear system to ensure that this was followed up prior to the ward round on AMU the next day; 3. When a decision was made to depart from the recognised best practice timescales the rationale was not recorded and there was no system to ensure that a suitably experienced clinician agreed with the decision.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you have 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 10th February 2020. 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.
8	COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely [redacted] on behalf of the family, 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.
9	**Alison Mutch OBE** **HM Senior Coroner** **16.12.2019**