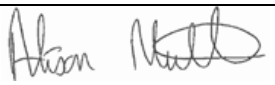
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health and Social Care
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 14th December 2020 I commenced an investigation into the death of Margaret Kinsey. The investigation concluded on the 23rd August 2021 and the conclusion was one of narrative: Died from acute left ventricular failure having being discharged from hospital when the significance of her heart symptoms was not recognised by the treating clinician as being linked to her heart disease and her early warning score was 5.The medical cause of death was 1a Acute left ventricular failure 1b Mitral valve disease and ischaemic heart disease 1c II Chronic kidney disease, chronic obstructive pulmonary disease
4	CIRCUMSTANCES OF THE DEATH Margaret Rose Kinsey had significant heart disease and had previously had heart surgery. She was taken to Stepping Hill Hospital Emergency Department on 11th December 2020 at 01:25. Her NEWS2 score was 1. She had shortness of breath and significant bilateral leg swelling. Her NEWS2 score at 04:05 was 5. She was examined by a junior doctor inexperienced in emergency medicine. They attributed her presentation to COPD. They had not considered the available GP information and the legible copy of the PRF from NWAS. There was a discussion with a middle grade doctor and her discharge was agreed. The details discussed with the Registrar were not documented. An admission to hospital would have been appropriate and allowed further tests, observations and treatment to have been provided to her. On 12th December 2020 she collapsed at home, attempts to resuscitate her were unsuccessful and she died at Stepping Hill Hospital. Post mortem examination found she had died from acute left ventricular failure caused by her underlying heart disease.

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 due to the time of her arrival in the Emergency Department on 11th December 2020 consultants were not on site. The most senior doctors available were middle grade and the number available at that time of night was significantly reduced. As a consequence the evidence was that supervision and support of junior doctors was very difficult given the demands on the middle grade doctors on site. This was exacerbated by the fact that on the evening Mrs Kinsey was admitted the FY doctors had just rotated. The FY2 who saw her had very limited post qualification experience of Emergency Medicine. The inquest heard that particularly at night time support and supervision of FY ED doctors presents significant challenges across the NHS in relation to patient care. 2. The inquest heard that there was a shortage of ED consultants across the NHS which led to these challenges in relation to staffing ED and that it was not uncommon for staffing of ED to be based on there being no on site consultant cover in ED from late evening until the morning. 3. The inquest heard that there was no standard approach as to how the details of information shared/discussions between clinicians should be detailed or signed off in the notes when one clinician was acting in a supervisory capacity. Given the regular movement of junior doctors across the NHS this meant documentation quality was inconsistent.
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 20/12/2021. 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 yourselves and 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 HM Senior Coroner HM Coroner's Office Manchester South