## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: The Chief Executive, Tameside Hospital NHS Foundation Trust.** |
| 1 | **CORONER**<br><br>I am John Pollard, senior coroner, for the coroner area of South Manchester |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>**On 26th June 2013 I commenced an investigation into the death of Afifa Qaisar dob 4th April 1975. The investigation concluded on the 6th March 2014 and the conclusion was that the deceased died from Natural Causes, the medical cause of death being 1a Viral Encephalopathy** |
| 4 | **CIRCUMSTANCES OF THE DEATH On the 23rd June 2013 she was admitted to Tameside General Hospital with collapse and confusion. The initial diagnosis was meningitis, with sepsis. She was admitted to the hospital but died at 20.30 hours the same day.** |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br>**1. During the course of the evidence it became apparent that the time of delivery/administration of various drugs was of the utmost importance. The nursing staff had completed the records to say that the drugs had been 'given'. The Ward manager accepted that this simply meant that the drip had been 'put up' and did not confirm that the drug had actually been delivered into the vein of the patient. The husband of the patient contended that the 'bag' remained full and that he did not see any evidence that its contents were in fact administered to the patient.**<br><br>**2. During resuscitation the staff wished to use a "Gum –elastic Bougie Airway" but when they looked they found it was not available on the 'crash trolley'.**<br><br>**3. It transpired that this patient was NEVER notified to the RMO on duty as should be the case.** |

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| | 4. **I heard evidence that she required platelets to be transfused but there was a considerable delay in these being made available because "they are not kept on site" and in any event there is no 'agitator' on site for their preparation.**<br><br>5. **When the husband of the deceased drew to the attention of the staff that the saline infusion appeared not to be 'running' he was told by the nurse to "hold her arm straight" to enable it to do so. He and I, and the Ward manager, felt that this was entirely inappropriate.**<br><br>6. **Despite the fact that this patient was receiving (apparently) i.v. fluids, at no time was a fluid balance chart commenced nor was the patient catheterised. The Ward manager agreed that both of these failings were unacceptable.**<br><br>7. **It was acknowledged early in the patient's passage through the hospital that she would need platelets and Hb support, yet it took over four and a half hours for anything to be done about this.** |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe that you have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by **5th May 2014** . I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to **the Chief Coroner** and to the following **Interested Person namely** [redacted] **(husband of the deceased)**. I have also sent it to [redacted] and to **the Coroners Society of England and Wales** who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **10th March 2014** **John Pollard, HM Senior Coroner** |
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