REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Arrowe Park Hospital**
1	**CORONER** I am Alan Wilson, Assistant Coroner, for the area of Merseyside [Wirral].
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 11th January 2013 an investigation commenced into the death of Jennifer Morrison, aged 62 years. The investigation concluded at the end of an inquest on 22nd May 2014. The conclusion as regards the medical cause of death was 1a Acute Respiratory Distress Syndrome 1b Bronchopneumonia and trauma to chest from a fall 11 Ischaemic heart disease The conclusion of the Coroner as to the death was a narrative conclusion as follows: Following a two week period during which she was suffering from significant breathing difficulties, Jennifer Morrison fell down some stairs at her home address at approximately 04.00 hours on 30th December 2012. She was admitted to hospital later that evening. It was not appreciated that she may have been suffering from acute respiratory distress syndrome. Despite treatment she deteriorated. At 08.45 hours on 9th January 2013 she had a cardiac arrest and was pronounced deceased at 09.25 hours later that day. A subsequent post mortem examination confirmed a combination of bronchopneumonia and the impact of her earlier fall led to her developing acute respiratory distress syndrome which proved fatal.
4	**CIRCUMSTANCES OF THE DEATH** See contents of section 3 above.
5	**<u>CORONER'S CONCERNS</u>** 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. During the course of the inquest evidence was heard that there is documentation missing from the hospital medical records, notably documentation that ought to have included observations recorded by medical staff on the afternoon prior to the death. Despite efforts made by the Trust, the missing documentation cannot be located. Although the inquest heard evidence that subsequent observations were noted to be at what was described as "normal levels", it is vital that records intended to record a patient's observations are readily available both to medical staff who continue to care for a patient, and for consideration during any subsequent post death review / investigation into events, as otherwise the integrity of such investigation may be jeopardised, potentially undermining the prospects of lessons being learnt where appropriate and future deaths may result. 2. Evidence was given by a Consultant Surgeon which raises concern as regards the level of care afforded to patients during the first week to ten days of January. The amount of time the Deceased spent on an assessment unit was longer than indicated by Trust guidance, which was attributed to a shortage of beds, and to the higher number of patients attending the hospital after the Christmas / New Year holiday season than may be expected at other times during the year which contributed to a delay in the Deceased being treated on a High Dependency Unit. Similarly, a decision having been appropriately made that she undergo an endoscopy procedure for which she would need to remain "nil by mouth", the Consultant acknowledged that the period of time she remained nil by mouth was "contributed to by the delay over Christmas" and that "she could have moved on to fluids sooner", the implication again being that the number of patients waiting until after the holiday season before attending the hospital was having an impact on the staffing levels during early January and therefore on the standard of care afforded to the patients. I was concerned that the Trust could do more to ensure that the care afforded to patients was not jeopardised due to staffing levels being unable to cope with a spike in the numbers of patients waiting until after the New Year to visit hospital.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 30th July 2014.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 To the Deceased's next of kin. 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	A.A.Wilson **Alan Anthony Wilson** **Assistant Coroner for Merseyside [Wirral]** **Dated: 02.06.14**