REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The CEO, Stockport NHS Foundation Trust:**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 7th May 2015 I commenced an investigation into the death of Freda Weston dob 7th December 1918. The investigation concluded on the 10th February 2016 and the conclusion was one of **Misadventure**. The medical cause of death was **1a Coronary artery thrombus causing myocardial infarction and small intestinal haemorrhage 1b Disseminated intravascular coagulation 1c Septrin to treat streptococcus mutans septic arthritis arising in a right total knee replacement. 11. Aortic stenosis.**
4	**CIRCUMSTANCES OF THE DEATH** **She was treated for a septic knee. A replacement joint was inserted about 15 years previously. It was treated with "Septrin" which led to disseminated intravascular coagulation causing her death at the hospital on the 29th April 2015.**
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. She was discharged from hospital after being started on the Septrin without allowing sufficient time to ensure that the new drug "suited" her.** **2. She was advised for teicoplanin on the 8th April at 17.10 hours yet she had not even been given the first dose thereof by 15.56 hours on the 9th April.** **3. There was a 48 hour delay in her being given any antibiotics.** **4. The junior doctor gave evidence that s/he was unable to "get round to seeing" this patient as there was insufficient doctor-time to do so on that shift. The doctor went on to say "this is not an uncommon situation". The hospital as a whole was being covered by one FY1 doctor and two SHO's, one of whom was 'clerking in' the new patients. This meant that the FY1 was covering 13 wards of the hospital. Clearly an impossible task.** **5. In general terms the matron reporting the Root Cause Analysis agreed that**

	on a scale of one to ten, where one is appalling and ten is excellent, "this case was very low down the scale indeed". **6. The "Escalation guidelines for the iBleep system were either unknown to the staff or were not adhered to.** **7. There was an acknowledged shortage of nurses at the time.** **8. The pharmacy staff did not give precise details of the drug which they were dispensing and the potential side effects thereof.** **9. The handover sheets on the ward are "shredded by the nurses" immediately after handover. Why cannot these be kept in a folder on the ward for at least 14 days should they be needed for reference purposes? I was told of the transition from paper to electronic notes. This seems to have been happening for a very long time and one wonders when it will be complete.**
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 19th April 2016. 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] (daughter of the deceased). I have also sent it to the **CQC** who may find it 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	**23.2.16** **John Pollard, HM Senior Coroner**