REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Mrs Ann Barnes, Chief Executive Officer,** Stockport NHS Foundation Trust, Stepping Hill Hospital, Poplar Grove, Hazel Grove, Stockport SK2 7JE
1	**CORONER** Andrew Bridgman, Assistant Coroner, for the coroner area of 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 September 2015 an investigation was commenced into the death of Geoffrey Ellis who died while an in-patient at Stepping Hill Hospital on 8th September 2015. The investigation concluded with an Inquest held on 12th January 2016 and 24th April 2016. The conclusion of the Inquest was: Misadventure contributed to by neglect Medical cause of death Ia Aspiration pneumonia b Vomiting secondary to Pseudo-Obstruction of Small Bowel c Recent Laparoscopic Nephroureterectomy for Kidney Tumour and Chronic Peritoneal Adhesions II Coronary Artery Atheroma, Hypertension
4	**CIRCUMSTANCES OF THE DEATH** On 3 September 2015 Geoffrey Ellis was admitted to the Urology Department, Stepping Hill Hospital the Consultant Care of [redacted] Consultant Urologist. Geoffrey Ellis was to undergo a left side laparoscopic nephro-uterectomy, removal of kidney and ureter. The operation was carried out on 3rd September 2015 and to all intents was uneventful and a success, albeit that it was necessary to complete the operation by means of open laparotomy. Geoffrey Ellis was admitted to Ward C6 that evening. I found that a failure to exam Geoffrey Ellis' abdomen and to detect distension, on and from 6th September 2015 and to treat hiccups possibly present for 24 hours but in any event present from the morning of 7th September until the late evening contributed either in combination or singularly, to Geoffrey Ellis' death on the morning of 8th September 2015.

5	**CORONER'S CONCERNS** During the course of the evidence it was discovered that nursing records and other clinical documents were not being written up adequately or at all. 1) A staff nurse, [redacted] advised me that she did not refer to the Patient Monitoring Chart, kept at the foot of the patient's bed at any time during her night shifts caring for Geoffrey, on 6/7th and 7/8th September. Neither to note the recent observations and information, nor to record her own observations. 2) [redacted] hand written entries in the clinical records were barely legible. The Inquest was adjourned on 12th January 2016 because [redacted] when giving his evidence, was unable to read the entries made by [redacted] As a consequence of the illegibility of the entry by [redacted] timed at 02:00 on 7th September, where she apparently notes, among other things, *"bowels opened"* (for the avoidance of doubt it was [redacted] evidence that the note reads bowels opened) and of her failure to complete the PNC it is clear that on the Ward Round at 09:00 there was a misapprehension that Geoffrey Ellis had still not opened his bowels for the 4 days following surgery. I fully appreciate the lack of any adverse outcome in consequence on this occasion as Geoffrey Ellis should therefore have been managed accordingly, on the basis that he had not. It does surprise me that these issues, 1. have not been identified or raised by those working alongside [redacted] 2. have not been identified and acted upon by those managing [redacted] 3. were not picked up by [redacted] when carrying out a review of the records on preparing a statement for the Inquest. In the circumstances I am concerned that [redacted] may not be alone in failing to complete documents such as the Patient Monitoring Chart and/or creating illegible or difficult to read clinical records. 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. – Illegible clinical records and/or a failure to complete important documents creates a serious risk of a breakdown in communication and misinformation within a patient's care pathway.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to develop a system, and to ensure its operation, to monitor clinical records and to identify and eradicate illegible record keeping and to identify and eradicate failures to complete important clinical records.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 8th July 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.

	I have also sent it to [redacted], daughter of Geoffrey Ellis. 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	**13.05.2016**	**Mr A Bridgman** **Assistant Coroner**