REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

This report is made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

Recipients

This report is being sent to:

- Legal Services Department, University of Manchester NHS Foundation Trust

Coroner

I am Jean Harkin, HM Assistant Coroner for the area of Manchester City.

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.

Investigation and Inquest

On 17 November 2015 I commenced an investigation into the death of Norma Edwina Holden, aged 64. The investigation concluded at the end of the inquest on 23 March 2016

The cause of death was found to be:

1a Septic Shock

I recorded an open conclusion.

Circumstances of death

A completed Record of Inquest is attached.

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.

During the inquest evidence was heard to the fact that Mrs Holden presented to the Accident and Emergency Department with a history of abdominal pain. Triage history stated swelling to face and mouth. It appears that mrs Holden had a swollen tongue and her speech was muffled.

[redacted] was unaware of the symptoms of swollen tongue and facial swelling.

I am concerned that the history taking is incomplete and not reported to treating doctors appropriately and that obvious symptoms applear to have not been noticed and actioned, such as possible anaphylactic shock, and appropriate tests conducted.

In addition, basic blood tests were not obtained for analysis of any infection/sepsis, to enable appropriate targeting of antibiotics.

Action should be taken

In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.

I am concerned that lack of such basic observations and tests may affect the future management of patients and ask that you investigate and respond.

Your response

You are under a duty to respond to this report within 56 days of the date of this report, namely by 20 June 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.

Copies and publication

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

- The family of Mrs Holden

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.

J Harkin **Date** 25th April 2016
H.M. Area Coroner – Manchester City Area