REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Department of Health, London
1	**CORONER** I am Ms L Hashmi, HM Area Coroner for the Coroner area of Manchester North.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 31st January 2017 (concluding on the 18th July 2017), I commenced an investigation into the death of **Ms Edith Robinson.**
4	**CIRCUMSTANCES OF DEATH** **The deceased was admitted to Accident and Emergency on the 13th June 2016, post fall. Clinical examination identified problems with the deceased's prosthetic hip, necessitating surgical intervention.** **Plans were made for surgery on the 16th June 2016 but were abandoned due to clinical reasons. The surgery was subsequently rescheduled but did not take place due to lack of theatre time.** **When the deceased showed signs of deterioration, action was not taken to rescue her. The deceased continued to decline and died at the Royal Oldham Hospital on the 20th June 2016.** **The subsequent Root Cause Analysis investigation identified 17 key areas of concerns including issues around documentary record keeping, early warning scores, assumptions around 'do not resuscitate' status, infection control and screening, escalation, senior review and care planning and communication. Care was outwith expectation.** **Expert evidence indicated that, on the balance of probabilities, the deceased had sepsis and acute kidney injury on admission. Both conditions were treatable but went untreated. Had treatment been instigated from the outset, then the deceased would not have died when she did.**
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:- Whilst the NHS Trust in this case has taken significant steps to remedy the problems identified during the course of its internal investigation, I remain concerned about the following:

1. **Consultant Review over Weekends** - During the course of the evidence, I heard that patients such as the deceased are not seen or reviewed by a Consultant over the weekend. I am concerned that this gap in care is putting patients at serious risk.

   The signs and symptoms of life-threatening illnesses (such as sepsis) are not being diagnosed and/or treated appropriately. Diagnosis and treatment is often time critical and requires significant clinical skill and expertise as signs can be subtle.

2. **Early Warning Scores** – again, during the course of the evidence it became apparent that there were problems with the Registered Nurses' ability to calculate early warning scores accurately. As early warning scores as inextricably linked to escalation and management of the critically ill/deteriorating patient, this gives me serious cause for concern. I was told that this problem is not just a local issue, but a national issue.

   I am also concerned that there is over-reliance placed upon tools of this nature, rather than the exercising of clinical/professional judgement. It is not the first time that problems relating to the calculation and use of early warning scores have become apparent during the course of an inquest.

3. **Record Keeping** - the standard of record keeping by both doctors and nurses was poor. This is a recurring theme. Given that accurate record keeping is vital to patient safety (particularly where nowadays patients are no longer continuously cared for by the 'parent' medical team for the duration of their hospital stay) I am concerned that poor record keeping is putting patient safety at risk.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 **the 13th September 2017**. 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:-

The deceased's family
Pennine Acute Hospitals NHS Trust
Royal College of Nursing
British Medical Association
NMC
GMC

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 from. 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 Date: 19th July 2017 Signed: