REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Ms Claire Molloy, Chief Executive, Pennine Care NHS Foundation Trust, Trust Headquarters, 225 Old Street, Ashton-under-Lyne, Lancashire OL6 7SR

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 28th October 2016, an inquest was opened into the death of Catherine Kennedy, who died aged 48 years at St James's University Hospital, Leeds on 14th October 2016. The investigation concluded at the end of the inquest which I heard between 5th and 9th March 2018.

The conclusion of the inquest was suicide.

CIRCUMSTANCES OF THE DEATH

Mrs Catherine Kennedy had a long history of bipolar affective disorder. On 30th September 2016, Mrs Kennedy agreed to a voluntary admission to hospital as a result of a deterioration in her condition, and was permitted four hours' escorted leave daily. On 4th October 2016, whilst on leave from Norbury Ward, Stepping Hill Hospital, Stockport, Mrs Kennedy was left alone at home by her husband while he collected their son from school. It is likely that during this period, Mrs Kennedy purchased and consumed in excess of 60 paracetamol tablets which she blended into a drink.

Mrs Kennedy returned to the ward and within three hours, she had vomited and told another patient that she had taken an overdose whilst off the ward. Despite this information promptly coming to staff members' attention, as a result of a number of serious failings in the care provided to Mrs Kennedy, she was not reviewed by a doctor until the following day, over fourteen hours after staff had first been told of the overdose.

By this stage, Mrs Kennedy was seriously ill. Mrs Kennedy was transferred initially to the Emergency Department at Stepping Hill Hospital before being moved to the Intensive Care Unit later on the 5th October 2016. On 6th October 2016, Mrs Kennedy was moved to a specialist liver unit at St James's University Hospital Leeds where she died as a consequence of the overdose on 14th October 2016.

Whilst it is unlikely Mrs Kennedy's life would have been saved had she received prompt medical attention and treatment on 4th October 2016, it is possible it may have been prolonged by a number of days.

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. –

In the course of the inquest, evidence was heard about a telephone conversation between a nurse on Norbury Ward and the on-call junior doctor for the wards. Miscommunication in the course of that conversation in combination with other factors, played a part in the fact that over 14 hours elapsed between staff first being informed of the overdose and Mrs Kennedy being reviewed by a doctor.

Whilst the Trust has taken a number of actions in response to its internal investigation into the circumstances of Mrs Kennedy's death, it is a matter of residual concern that sufficiently robust measures have not yet been taken to adequately reduce the risk of future deaths arising from miscommunications and assumptions occurring in the context of telephone conversations between ward staff and on-call doctors.

In particular, it is a matter of concern that the Trust does not appear to consistently have in use a communication paradigm (such as the SBAR paradigm introduced by the United States Navy and widely of application across the NHS) as to the content and documentation of key communications, particularly arising in the context of seeking action from an on-call member of staff not based on the ward.

ACTION SHOULD BE TAKEN

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

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 8th May 2018. 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 [redacted]

I have also sent it to the Healthcare Safety Investigation Branch, the Care Quality Commission, and NHS Resolution who may find it useful or of interest.

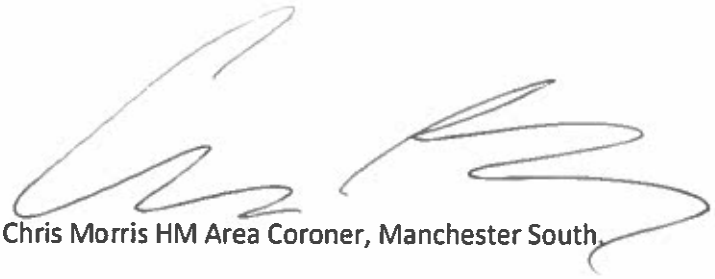
I am also under a duty to send the Chief Coroner a copy of your response.

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.

Dated: 13th March 2018

Signature:



Chris Morris HM Area Coroner, Manchester South.