REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Secretary of State for Health, Jeremy Hunt MP, House of Commons, London SW1A 0AA
1	**CORONER** I am Professor M Jennifer Leeming, HM Senior Coroner for the Coroner Area of Manchester West.
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 the 27th of July 2017 I commenced an investigation into the death of Jean Griffiths aged 70 years. The investigation concluded at the end of the inquest on the 6th March 2018. The conclusion of the Inquest was:- Natural Death
4	**CIRCUMSTANCES OF THE DEATH** On the 15th July 2017 Jean Griffiths died at Salford Royal Hospital having displayed symptoms of Acute Interstitial Pneumonitis. Her oxygen lead was found to be disconnected at the time, but this did not contribute to her death.
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. In the course of the Inquest I heard evidence from [redacted] who is a consultant in Respiratory Medicine at Salford Royal Foundation NHS Trust. [redacted] referred in his evidence to the British Thoracic Society's Emergency Oxygen Audit Report relating to a National Audit Period between the 15th August and the 1st November 2015. 2. [redacted] stated that the Audit Report revealed a threat to patient safety due to poor prescribing practice in relation to the prescription of oxygen.

	3. A key finding of the report was that 42.5% of patients receiving supplementary oxygen had no valid prescription. Without a valid prescription which includes a target range, [redacted] stated that there was a danger that patients might be given too little oxygen or too much oxygen and thus be placed at risk of increased mortality. 4. A copy of the relevant Audit Report is attached. 5. [redacted] evidence was that the pace of changing this poor prescribing practice needed to increase. 6. Although there was no evidence that Jean Griffiths' lack of oxygen prescription was in any way causative of or contributory to her death nevertheless this report is submitted with a view to preventing the deaths of other patients who might be at risk.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that 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 10th May 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:- 1. The Chief Executive, Salford Royal Hospital 2. [redacted] 3. [redacted] (husband) 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 **15th March 2018**	**Signed** **M Jennifer Leeming, HM Senior Coroner**