REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], Registered Manager, EAM Care Group/EAM House
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 18th July 2017 an investigation into the death of Miss Lea Louise Hunsley was commenced by HM Coroner Manchester City and thereafter, an inquest was opened. Subsequently jurisdiction was transferred, by agreement, to the coroner area of Manchester North.
4	**CIRCUMSTANCES OF DEATH** Against a backdrop of catastrophic birth injury (hypoxic ischaemic encephalopathy - HIE), sustained during the care of and secondary to the management of her mother's labour, Lea Hunsley (hereinafter referred to as Lea) had been diagnosed with profound Cerebral Palsy from around the time of her birth. Her complex healthcare needs included severe neurological impairment, resulting in significant effect upon her swallowing and putting her at risk of chest infections and aspiration. As a consequence of this, Lea required a gastrostomy and thereafter surgical intervention for oesophago-gastric dissociation (2015), in order to reduce these risks and keep pace with her nutritional requirements. On the 4th July 2016, Lea went into respite care. For the early part of her stay, she was well and content. On the morning of the 9th July Lea was sleepier than usual and when visited by her Grandparents, she gave sufficient cause for concern such that they sought the advice and opinion of the Registered Nurse (RN) on duty. The RN briefly examined Lea and took the view that all was well and in keeping with her general presentation. Upon further limited review later the same day, the RN's view did not change. Medical assistance/review/escalation was not sought. During the course of the afternoon/evening of the 9th, Lea became increasingly unsettled and by 21:15 was showing the signs and symptoms of marked abdominal distension and was sweating and groaning. Her feed line was vented, to limited effect. By 21:30, her abdomen was distended again and a second venting was carried out. Carers called the duty RN as Lea remained 'windy' and unsettled. Again, a limited examination was conducted. No referral, escalation or medical assessment/review was sought. At 22:45, Lea's breathing pattern changed and she became very unwell. She subsequently went into cardio-respiratory arrest. Cardiopulmonary resuscitation (CPR) was commenced and an ambulance was called at 23:12.

When Paramedics arrived, they noted that Lea's abdomen was significantly distended. On the balance of probabilities, the distention seen was not wholly attributable to the process of resuscitation. Lea was conveyed to the Emergency Department (ED) where advanced life support/resuscitation continued. Despite best efforts, Lea succumbed and died at the Wythenshawe Hospital Emergency Department at 00:10 hours on the 10th July 2016.

There were a number of missed opportunities on the 9th July 2016, which more than minimally contributed to Lea's death.

The medical cause of death (after post mortem) was:

1a) Small intestinal perforation close to site of Roux en Y anastomosis required as part of gastro-oesophageal dissociation

1b) Severe feeding problems requiring surgical intervention

1c) Effects of severe hypoxic ischaemic encephalopathy following asphyxia around the time of birth

2) –

I reached a narrative conclusion:

Died as a result of the rare but recognised complications of necessary medical intervention, resulting from a birth injury (HIE). Opportunities to assess, escalate and intervene were missed on the 9th July 2016 when it became apparent that there was a significant and sudden change in the deceased's clinical presentation and condition.

On the balance of probabilities, neglect more than minimally contributed to the deceased's death.

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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. EAM (a medical/nursing care facility) does not have a serious untoward incident (SUI) protocol.

Responding appropriately when things go wrong in the healthcare setting is critical to improving patient/service user safety, identifying individual and systemic weaknesses, reducing avoidable harm and thus, preventing future deaths.

2. Registered Nurse/s and Carers at EAM:

i) lack the ability to identify, recognise and act upon the deteriorating patient;

ii) in this case, did not escalate for medical review (no policy/protocol exists for the same);

iii) demonstrated a poor standard of basic (physiological) observation and monitoring

&

iv) failed to read and use the care records appropriately (in particular, the RN did not read important/critical entries on the 9th at all).

3. CQC Inspection - insufficient action has been taken with regard to the recommendations made within the last CQC inspection. During the course of the evidence heard at inquest, EAM accepted:

i) that the most recent inspection report had found the home to be inadequate on safety and requiring improvement in all other categories (effective, caring, responsive and well-led)

ii) that meeting the recommendations had proved challenging but that the organisation was working with the CQC on improvements. However the Home did not demonstrate any marked or sustained improvement in any of the aforementioned areas of concern.

This gives cause for concern in terms of the safety of other residents in EAM's care, whether children or adults and the prevention of serious harm/death.

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 by the 5th June 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.
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 - CQC - Central Manchester NHS Foundation Trust - NMC 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: 10th April 2018 Signed: