REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Executive of Tameside General Hospital.
1	CORONER I am Alison Mutch ,Senior Coroner, for the coroner area of South Manchester
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 17th July 2018 I commenced an investigation into the death of Michael William Flynn. The investigation concluded on 8th January 2019 and the conclusion was one of Narrative: Died from ischaemic heart disease following an elective surgical procedure where it was not recognised that he required clinical review, and the Early Warning Score (EWS) policy was not followed. The medical cause of death was 1a Ischaemic heart disease; 1bCoronary artery atheroma ;II Left total hip replacement , Anaemia, Type 2 diabetes mellitus, Hypertension
4	Michael William Flynn underwent an elective hip replacement operation at Tameside General Hospital. He required a blood transfusion during the operation. In recover his Early Warning Score (EWS) was not recorded. On arrival on the ward his EWS was 11. It steadily improved and at 09:40 on 13th July 2018, was 2. Subsequent EWS recording was carried out although the regularity required under the Trust's policies was not complied with. A fluid balance chart was requested. It was not completed as required under the Trust policy. On 15th July 2018 his EWS was 5 - subsequent monitoring that day did not take place in accordance with the Trust policy. On 16th July 2018 at 06:10 his EWS was 2. A further score should have been recorded 4 hours later. At 12:00 his next EWS was recorded at 5. The Trust escalation policy was not complied with. There

	was no review of Michael Flynn. By 21:00 on 16th July 2018 his EWS was 6. He had not been seen by a consultant since his operation and there had been no escalation on that day. At 22:00 and 00:00 his EWS was recorded at 6 and 5. These did not incorporate his blood pressure which is not documented. At 04:50 his EWS was 10. He then went into cardiac arrest and died at Tameside General Hospital on 17th July 2018.
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. – The inquest heard that 1. There was no monitoring of Mr Flynn's EWS in the post operative recovery area. Observations were taken randomly but not incorporated into an EWS. Trust policy was that this should have happened. Staff dealing with Mr Flynn therefore were unaware of his EWS scores. On arrival at the ward his initial score was 11 under the EWS system .He arrived with a standard care plan. 2. The trust had a clear protocol regarding monitoring and trigger points for regularity and escalation in relation to EWS. Whilst Mr Flynn was a patient on the orthopaedic unit the Trust policy was not adhered to. For example the inquest heard that in the 18 hours preceding his death he did not see a doctor and he was not reviewed despite the EWS scores requiring this to happen. 3. His final two EWS scores did not include all relevant information despite a visibly clinically deteriorating position. His penultimate EWS was recorded at midnight. That was five (and did not include blood pressure). A further score should have been taken 15-30 minutes later. It was not and no further scores were taken for a further 4 hours and 50 minutes. At 04.50 his score was recorded at 10. He then became unresponsive. 4. He was only seen by a Doctor when a crash call went out and not in the period when there was a deteriorating clinical picture contrary to the Trust policy. 5. The ward was staffed by ward doctors throughout the day but there was no documentation to suggest communication between the ward doctors and nursing staff in relation to Mr Flynn and his deteriorating picture 6. Mr Flynn was not seen by a consultant after he left the post operative area. A ward round should have taken place the day

	after his operation but did not take place because the consultant was otherwise engaged. No arrangements were made for it to be rearranged. 7. There was no evidence that the consultant had communicated with staff about Mr Flynn or that the relevant registrar had reviewed Mr Flynn on visits to the ward. 8. The inquest was told that the nursing notes indicated that drs had been asked to review Mr Flynn but that this was not reflected in the clinical notes. When requested reviews documented in the nursing notes did not happened there was no evidence of further escalation. 9. The trust had an ICU out reach team whose role was to support units such as the orthopaedic unit. However the team was not available when contacted due to staffing issues. Alternative escalations routes were not explored. 10. A fluid balance chart was requested and fluids prescribed. It was not completed fully and in particular the necessary calculations to understand Mr Flynn's fluid position were not made. The trust policy was not followed regarding completion. The doctor who saw Mr Flynn on the morning of 16th July 2018 prescribed further fluids without reference to the fluid charts.
6	ACTION SHOULD BE TAKEN In my opinion, action should be taken to prevent future deaths and I believe 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 7th March 2019. 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 Mrs Graveley Family of the deceased, The healthcare Safety Investigation Branch and The Secretary of State for Health 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.
9	Alison Mutch OBE HM Senior Coroner 10.01.2019