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Ref: CB

Date: 2 April 2019

Sent via email on 02 April 2019

Dear Mr Hobson

Inquest touching the death of Graham Tailby

I write in relation to the above inquest that was held before you on 8 March 2019.

Following the inquest, you issued a Regulation 28 report dated 19 March 2019, addressed to Professor Matthew Makin, Medical Director of North Manchester General Hospital, Pennine Acute Hospitals NHS Trust ("the Trust"). The Regulation 28 report is copied to Greater Manchester Mental Health NHS Trust c/o Hempsons solicitors.

Coroner's concerns

The matter of your concern is as follows:

The leader of the crash team gave comprehensive and clear evidence as to the appraisal of Mr Tailby's situation upon his emergency arrival on the ward in response to the crash call and the decisions that were then taken.

His evidence was that he whilst struggling to gain intravenous access to administer relevant drugs to Mr Tailby he had considered the possible use and assistance of a piece of equipment known as an intraosseous drill. The equipment however wasn't present on the crash trolley which had been brought to Mr Tailby's room.

In the event he was in fact able to secure intravenous access and proceed accordingly. He also acknowledged that whilst the use of an intraosseous drill was an option with which he was familiar, that might not be the case for others and in any event is not a core requirement of expertise of those involved in emergency responses such as that which took place.

The provision of the intraosseous drill on crash trolleys may provide another route of intervention for those familiar and trained in its use in other circumstances in the future, and having that option may prevent deaths in the context of emergency crash responses to wards for which the Trust has responsibility.

Response

Crash trolleys are managed by Pennine Care NHS Foundation Trust and not the Pennine Acute Hospitals NHS Trust. Consequently it is our view that the direction of the Regulation 28 report to the Pennine Acute Trust on this occasion is incorrect. May I respectfully recommend that the Regulation 28 report should be addressed to Pennine Care NHS Foundation Trust who are in a position to effect change following your recommendation.

The Trust has discussed this matter with HM Senior Coroner Mr Meadows and he kindly sent over full disclosure. As discussed it would have been beneficial if we had of been notified of the inquest as we would have been better placed to assist and been able to provide a response to explain that the trolleys are not serviced by ourselves. I also note the staff member who gave evidence was not working for the Trust at the time of giving evidence nor where the legal team aware that he had given a statement previously.

May I also draw to your attention that Regulation 28(3) of the Regulations states *"A report may not be made until the coroner has considered all the documents, evidence and information that in the opinion of the coroner are relevant to the investigation".*

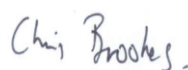
Furthermore, at this inquest, it is understood that you heard evidence from Greater Manchester Mental Health NHS Trust, but did not hear any live evidence from Pennine Acute Hospitals NHS Trust or hear any submissions on behalf of the Trust.

It was therefore unfortunate that the Trust was not aware of the Inquest, had not been made an Interested Person or provided with disclosure. Consequently the Trust was not provided the opportunity to submit any evidence to your investigation and was first aware of this inquest following receipt of the Regulation 28 report.

Had the Trust been invited to respond to this issue prior to the issuing of the Regulation 28 report, the correct information would have been provided so that the concerns raised would be directed to the appropriate body with the power to effect change and implement learning.

I am deeply sorry that Mr Tailby's family have had a further unnecessary delay in obtaining answers due to the Regulation 28 process. The Trust would have preferred to have addressed the concerns at the inquest for the benefit of Mr Tailby's family and your investigation and thus avoided the need to issue the Trust with a regulation 28.

Yours sincerely



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