REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1) Rt. Hon. Matt Hancock MP, Secretary of State for Health and Social Care, 39 Victoria Street, London, SW1H 0EU;
2) Professor Ian Cumming OBE, Chief Executive, Health Education England, 1st Floor, Blenheim House, Duncombe Street, Leeds, LS1 4PL.

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 1st June 2017, an inquest was opened into the death of Mr Nathan Mooney who died on 23rd May 2017 at Tameside General Hospital, Ashton-under-Lyne, aged 25 years. The investigation concluded at the end of the inquest which I heard between 14th – 17th January 2019.

At the end of the inquest, I recorded a narrative conclusion that Mr Mooney died as a consequence of a known complication of previous abdominal surgery which was not identified by treating clinicians during his lifetime.

CIRCUMSTANCES OF THE DEATH

Mr Mooney was essentially a fit and well gentleman. In 2015, he was diagnosed with a splenic cyst and elected to have his spleen removed. On 14th September 2015, Mr Mooney underwent a Splenectomy, in the course of which an iatrogenic defect was made to his diaphragm. This is a known complication of the surgery and one which was recognised at the time. The defect was repaired in the course of the operation.

Following recovery from the surgery, Mr Mooney did not experience any ongoing health problems.

On 20th May 2017, Mr Mooney developed severe abdominal pain of sudden onset, which is likely to have resulted from the diaphragmatic defect recurring, and his bowel becoming trapped in it. Mr Mooney attended Tameside General Hospital where he saw a locum Middle Grade doctor who referred him to the surgical team.

The surgical team on duty in the hospital overnight on that occasion consisted of a locum Middle Grade surgeon, and a Senior House Officer who had completed a Foundation Year 2 surgical rotation at the hospital, but was also working a locum shift.

The Senior House Officer reviewed Mr Mooney in conjunction with X-Rays which had been taken. The Senior House Officer formed the view that the X-Rays showed no abnormality, and discharged

Mr Mooney with advice to return if symptoms did not improve or worsened. This decision was taken without recourse to a more senior doctor.

A number of Mr Mooney's symptoms persisted over the following days and on 22nd May 2017, he attended his General Practitioner who after assessment and consultation with a senior colleague, decided to adopt a watch and wait approach, again giving advice to seek assistance if symptoms worsened.

On 23rd May 2017, Mr Mooney spoke to the General Practitioner by telephone following a clear deterioration in his condition. He collapsed at home whilst awaiting an emergency ambulance which conveyed him to hospital where he died despite attempts to resuscitate him.

A post mortem examination determined Mr Mooney died as a consequence of:

1) a) Colonic herniation and perforation;
   b) Iatrogenic diaphragmatic defect;
   c) Elective splenectomy (splenic cyst – operated on 14th September 2015).

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. –

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.

It is apparent that at the time of Mr Mooney's care, Tameside General Hospital was heavily reliant on locum doctors to cover shifts.

The court heard evidence of measures which have been taken locally to recruit and retain doctors to substantive posts, however significant reliance on locum doctors remains an issue. The court heard evidence from one of the Trust's Clinical Directors that this resulted from a lack of suitably skilled doctors in the UK labour market which in turn was compounded by a high attrition rate across a number of specialities whereby doctors do not complete their post graduate speciality training within the NHS (choosing instead, for example, to work overseas).

In addition to the obvious financial consequences of significant locum use for the NHS, the court heard that it can impact adversely upon continuity of care, and militate against development of established and effective relationships between clinical teams.

The Clinical Director expressed the view that the current position would be alleviated to a certain extent by implementation of a system whereby graduates of UK medical schools were (no doubt in consideration for financial or other support during training) tied-in to a specified period of NHS work following graduation. Whilst the Clinical Director was aware of previous discussions within the NHS about such a system, she was not aware of any plans to implement such a system.

It is noted the previous Senior Coroner for this Area, John Pollard, had an exchange of correspondence with the former Under Secretary for Care Quality, Ben Gummer MP, in 2016 in which similar issues were raised.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 23rd April 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

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to Mr Mooney's father,

I have sent a copy of my report to Tameside Integrated Care NHS Foundation Trust, Tameside Clinical Commissioning Group, and the Care Quality Commission, 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: 26th February 2019

Signature:

Chris Morris HM Area Coroner, Manchester South.