REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 3rd April 2019 I commenced an investigation into the death of Julie Ann Barrow. The investigation concluded on the 12th September 2019 and the conclusion was one of **Accidental Death**. The medical cause of death was **1a) Traumatic Brain Injury**
4	CIRCUMSTANCES OF THE DEATH Julie Ann Barrow had significant learning disabilities. She was to undergo an elective examination at the Manchester Royal Infirmary on 24th August 2018. On the 17th August 2018 she attended Stepping Hill Hospital with perianal pain and rectal bleeding. She was admitted. No reasonable adjustment care plan was completed. She was reviewed over the next few days with a plan to transfer to the Manchester Royal Infirmary for the elective procedure on 24th August 2018. On 23rd August 2018 the Manchester Royal Infirmary said she should stay at Stepping Hill Hospital for treatment. She was distressed by the decision. A CT scan at Stepping Hill Hospital on 28th August 2018 was followed by a discharge. On 8th September 2018 she was readmitted with suspected painful

	haemorrhoids. A planned examination on 11th September 2018 was cancelled after she had waited all day on nil by mouth. On 12th September 2018 it went ahead and identified haemorrhoids. No surgical intervention was deemed to be required. No best interests meeting took place. On 9th November 2018 she presented with further pain but was too distressed for a full examination to take place. On 12th November 2018 she was diagnosed with adjustment disorder in the context of the recent traumatic events around her bleeding, the investigations and the surgical procedures she had undergone. She was given diazepam and chlorpromazine to manage her anxiety and distress. These had a significant sedative effect on her. On 1st April 2019 she fell on the stairs at the family home. She was admitted to Stepping Hill Hospital and then Salford Royal Hospital. An un-survivable brain injury was diagnosed. She died at Salford Royal Hospital on 2nd April 2019.
5	<u>CORONER'S CONCERNS</u> 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.The inquest heard that despite two in-patient stays, there was no best interests meeting held to discuss her care; 2. On each of her admissions her parents took her needs passport in with her. The inquest was told that this should be used to develop the reasonable adjustments care plan and be accessible to all staff caring for her. On her first admission there was no reasonable care plan put in place despite the fact that she had clear and significant disabilities that would have benefited from an effective plan and her passport was available. Her passport location was not known by all staff caring for her; 3. Julie Ann Barrow was cared for devotedly in hospital by her parents who are in their 80s. Their evidence to the inquest was that Julie was never effectively communicated with by clinicians treating her and her needs not understood. So far as her needs were concerned she was

	"invisible" to staff. An approach that recognised just how traumatic a hospital stay and medical treatment was for her would have significantly reduced the trauma that led to her developing adjustment disorder. The consultant psychiatrist who gave evidence to the inquest was very clear that the pain and trauma of the hospital stays had caused the acute adjustment disorder; 4. Her parents stayed with her 24/7 to try and support her and reduce the trauma. Despite their age; their importance to her and the need for them to stay with her, staff at the trust expected them to sleep overnight on standard hospital bedside chairs. It was only when a complaint was escalated that attempts were made to find them alternatives to the chair; 5. The inquest was told by the safeguarding team that cuts by the Local Authority that had resulted in the loss of the learning disability liaison role, had reduced the ability of the safeguarding team to support people with learning disabilities within the hospital.
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 25th November 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 Miss Barrow's parents, 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** **30.09.2019**