REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive Northern Care Alliance 2. Oldham Clinical Commissioning Group 3. Royal College of Nursing 4. Royal College of Pathologists 5. Chief Coroner of England and Wales
1	**CORONER** I am Ms Joanne Kearsley, Senior 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 1st November 2019 I I concluded the Inquest into the death of Christopher Byron who died on the 9th January 2017 in the Royal Oldham hospital. The conclusion of the Coroner was Christopher Byron died as a result of Misadventure contributed to by neglect. In box 3 the following was recorded: "*In 1996 Christopher Byron was diagnosed with Multiple Sclerosis. This had been well managed until the beginning of 2016 when Mr Byron became less mobile. From March 2016 onwards he was bed ridden and had several admissions to hospital. During 2016 Mr Byron was under the care of the District Nurses. Due to his immobility he developed pressure sores which became infected. The development of infected pressure sores was in part due to a lack of continuity in the care of Mr Byron by the District Nursing team. In addition there was a lack of consideration of his weight loss and nutritional status. Earlier referral to the Tissue Viability nurse should have taken place. By the 29th November 2019 Mr Byron had developed an infection which required hospital admission. He was discharged from hospital on the 23rd December 2016 but readmitted on the 25th December 2016.* *On the 30th December 2016 Mr Byron was prescribed an intravenous iron infusion for suspected iron deficiency. The authorisation and administration of this Iron infusion was not recorded anywhere on Mr Byrons medical records except the Electronic Prescribing Medications Administration Form (EPMA). There were no clinical entries by any Doctors or nurses.* *On the 9th January 2017 a second iron infusion was authorised. This was not clinically indicated and in any event, in line with trust policy should not have been prescribed as it was only 9 days after the first infusion.* *This prescription would not have been authorised if the authorising Doctor had been aware of the first infusion. The prescribing Doctor and Pharmacist did not note the first prescription of Monofer on the EPMA system.* *On both occasions when iron was authorised there was a lack of adequate consideration and assessment of the risks and benefits for Mr Byron who had a number of allergies and hypersensitivity to various medications, was receiving antibiotics for chronic infections and was prescribed Ramipril.* *Following the administration of the iron infusion on the 9th January 2017 Mr Byron should have been observed for 30 minutes. This did not occur and within minutes he went into cardiac arrest. He was found unresponsive and died.*
4	**CIRCUMSTANCES OF DEATH** The circumstances leading up to Mr Byron's death are as set out above. In addition to these matters

following his death a post mortem examination was carried out by [redacted] on the 18th January 2017. A number of blocks of histology were taken for examination.

In a post mortem examination report dated the 24th February 2017 [redacted] provided a cause of death as 1a) Acute Myocardial Infarction

1b) Severe Coronary Artery Atheroma

2) Bronchopneumonia and Pressure Sores.

An Inquest was opened due to concerns raised by the family as to the development of the pressure sores. During the course of the subsequent investigation it transpired as part of the Post mortem examination [redacted] had also taken samples to conduct a Mast Cell Tryptase test. The results of this clearly indicated Mr Byron was suffering from anaphylaxis at the time of his death. The outcome of these test results were not reference in the post mortem examination. In addition the evidence indicated the presence of a number of other significant errors in the post mortem report. For example, [redacted] described the bladder and prostrate, Mr Byron had in fact had both of these removed in previous medical procedures.

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:-

1. **The Northern Care Alliance**

(i) District Nurses and TVN

1. The Court heard evidence that since the death of Mr Byron the District Nursing and Tissue Viability Nurses (TVNs) are now managed as part of the Northern Care Alliance and are jointly located. However there is no documented policy for the referring of patients from the District Nurses to the TVNs. "Unofficial" referrals could occur by way of conversations within the office and there is no policy to ensure these are recorded in writing and recorded in the patients notes. The Court heard evidence that such a referral was thought to have occurred in September 2016 but this was not documented anywhere.
2. Likewise if a referral is sent by email there no instruction to staff that such email must be uploaded into the patients records in order for it to be clearly seen by all workers that the patient has been referred.
3. Shortage of staff. One of the reasons there was a lack of continuity in the care of Mr Byron was the shortage of staff and the increased workload on the remaining staff. The Court was advised there remains a shortage of staff within the Tissue Viability Nurse team.

(ii) Hospital In-patient

1. In this case the Trust Guideline 'Patient Blood Management of Medical Patients' sets out the Pathway for the Management of Anaemia. In addition to this Trust documents there is NICE guidance for Anaemia – iron deficiency (revised 2018). Both of these documents include as a key factor the obtaining of ferritin levels, albeit the question as to the interpretation of such results will be dependant on the patients presenting condition. On the 30th December 2016 no sample was taken to check the ferritin levels.
2. In addition there was no evidence that on the 30th December or the 9th January 2017 the pharmacist checked Mr Byrons ferritin level. The Court heard from the Clinical lead pharmacist that she would expect this to be done. There was a clear difference between the advice and expectations of the Pharmacist and the Clinical team.
3. The Court heard of discussions which take place between the Pharmacists and clinicians. These can take place at times when the pharmacist is off the ward. In these circumstances there is no ability for the pharmacist to record such discussions. There was no record anywhere of any discussions on the 30th December 2016 or the 9th January 2017 and any such advice provided, so there was no way of confirming if such conversations had taken place.
4. The Court heard the Trust Guideline 'Patient Blood Management of Medical Patients' indicated the patient was to be observed for 30 minutes during the administration of the iron infusion. Due to a lack of recording the nurse who administered the iron infusion on the 30th December 2017 could not be identified. The nurse on the 9th January 2017 gave evidence to the Court that this was the first time she had administered an iron infusion and she was advised by the Sister to "treat it as a blood transfusion" whereby his observations were taken before and immediately after commencement of

the infusion and then observations taken every 15 minutes. Hence Mr Byron was left alone during the administration of the iron infusion. The Court heard the policy was unclear as to whether it meant nurses had to remain with the patient constantly for 30 minutes.

5. In addition for out-patients who may receive an iron infusion the Court received evidence that they would be handed a buzzer. The Court would question how this would be of use should a patient suffer a cardiac arrest such occurred with Mr Byron. Points 4 and 5 link into the Regulation 28 to the Royal College of Nursing also.

Oldham Clinical Commissioning Group

1. The Court heard evidence that at times there was a lack of appropriate dressings in order to treat Mr Byrons infected pressure sores. The Court heard evidence the District Nurses cannot order more than two weeks worth of dressings for any individual patient and cannot hold extra stock. In Mr Byrons case due to the severity and location of the pressure sores there were times when he used more dressings, especially if they came away from the wounds. This could lead to a shortage and meant him having to wait for dressings. In someone with severe pressures sores the requirement to have access to the appropriate dressings is important. The Court heard this instruction regarding the ordering of dressings is governed by the Clinical Commissioning Group.

Royal College of Nursing

1. In the most recent guidance from the Royal College of Nursing dated May 2019, "*Iron Deficiency and Anaemia in Adults*" the instruction to nurses is for them to "observe the patient for 30 minutes". The Court heard evidence from the Divisional Director of Nursing for the Northern Care Alliance who told the Court, in his view this instruction to nurses is unclear. This instruction was felt to be open to interpretation as to whether this means nurses should physically remain with the patient constantly for 30 minutes. If this is what is meant then it was suggested the instruction could be made more specific.

Royal College of Pathologists and the Chief Coroner for England and Wales

1. The quality of the post mortem examination report produced by [redacted] was wholly unsatisfactory and proven inaccurate. This meant both the bereaved family and the Trust were initially provided with an inaccurate medical cause of death. As a direct consequence the ability to learn lessons in order to prevent future deaths was not captured in a timely manner. It was not until the Coroner obtained a report from [redacted] in 2018 that anaphylaxis was offered as a potential cause of death. Even then, the Court was left having to consider the totality of the evidence and it was not until the Inquest that a finding of fact as to the medical cause of death was made.
2. It should be noted the quality of [redacted] post mortem practice has been and remains questionable in over 20 Inquests within the North Manchester Coronial area. This is not an isolated case. In this particular case there was clear evidence that the post mortem failings directly impacted on potential lack of clinical learning to prevent future deaths.
3. It is noted there is no regular (independent) peer review of coronial autopsy reports and processes in order to maintain consistency of agreed standards, governance and accountability as was advised within the 2006 National Confidential Enquiry into Patient Death and Outcome (NCEPOD) and reiterated within the Hutton review of forensic pathology of England and Wales in 2015.

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 20th January 2020. 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 legal representatives for Mr Byron's family. 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.
-	Date: 5th November 2019 Signed: Joanne Kearney