REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Dr Jackie Bene, Chief Executive, Royal Bolton Hospital NHS Foundation Trust, Minerva Road, Bolton, BL4 0JR
1	**CORONER** I am Alan Peter Walsh, Area Coroner, for the Coroner Area of Manchester West.
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 8th May 2015 I commenced an Investigation into the death of Mollie Bentham, 90 years, born 27th December 1924. The Investigation concluded at the end of the Inquest on 14th December 2015. The medical cause of death was 1a) Peritonitis, 1b) Ruptured ischaemic distal large bowel. The conclusion of the Inquest was Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** 1. Mollie Bentham died at Rivington View Nursing Home, Albert Street, Horwich, Bolton on the 1st May 2015. 2. On the 12th February 2015 Miss Bentham was admitted to the Royal Bolton Hospital, Bolton with lower respiratory tract infection and acute on chronic kidney disease. She suffered with confusion due to delirium and she had episodes of seizures. Following treatment at the Hospital Miss Bentham was transferred to Darley Court Intermediate Care Centre, Shepherd Cross Street, Bolton on the 6th March 2015 where she received further treatment, including treatment for Norovirus infection. 3. Prior to the 23rd April 2015 plans were being considered for Miss Bentham's discharge from Darley Court to a Nursing Home. On the 23rd April 2015 the family of Miss Bentham had noticed that Miss Bentham was suffering with some abdominal pain and the family reported the abdominal pain to nursing staff at Darley Court. However

the concerns of the family were not recorded in the nursing notes nor in the medical notes. The concerns were not brought to the attention of the medical team and no examination by the medical team was conducted in relation to the family concerns.

4. On the 24th April 2015 Miss Bentham had a medical review which showed that her CRP, which is a marker of infection, had risen to 178 and her white cell count, also sign of infection, had risen. There was a documented discussion with the family at 17.00 hours on the 24th April 2015 when the family, once again, mentioned the abdominal pain but the pain was not referred to in the documented note of the meeting.

   Prior to the meeting with the family at 17.00 hours on the 24th April 2015 Professor Baker, Consultant Geriatrician, had reviewed Miss Bentham at 10.30 hours on the same day but the review by Professor Baker made no mention of abdominal pain and the previous concerns of abdominal pain mentioned by the family were not brought to the attention of Professor Baker. Miss Bentham was not sufficiently communicative to bring the pain to the attention of Professor Baker and the plan noted by Professor Baker at 10.30 hours on the 24th April 2015 did not refer to abdominal pain or any examination in relation thereto.

5. On the 26th April 2015 a Healthcare Assistant noted that Miss Bentham had a hard area to the left side of her abdomen and complained of pain. The Healthcare Assistant informed the nursing staff of her finding and Miss Bentham was given morphine sulphate in relation to the pain.

   The 26th April 2015 was a Saturday and over the same weekend Miss Bentham was visited by two on call doctors, including an out of hours General Practitioner but the doctors did not make a note of their attendance. A note was made in the nursing notes that the out of hours General Practitioner was called by the nursing staff as there was a hard mass to the left side of Miss Bentham's abdomen and her pain score had increased.

6. The Matron for Darley Court Intermediate Care Centre gave evidence that a doctor based at the Centre would be present at the Centre on a Monday to Friday from 9.00am to 5.00pm and on a Saturday and Sunday from 9.00am to 1.00pm. Outside those hours a request for a medical review must be addressed to the out of hours GP service. The out of hours GP service will conduct an initial triage and a General Practitioner will attend subject to appropriate triage.

7. On the 27th April 2015, which was a Monday, Miss Bentham was reviewed by [redacted], who is a member of the medical team based at Darley Court Intermediate Care Centre. [redacted] did not make a note of the attendance and there was no note that the attendance of the out of hours General Practitioner over the weekend and Miss Bentham's abdominal pain were brought to [redacted] attention.

8. On the 27th April 2015 a Multi-Disciplinary Team Meeting was held and Miss Bentham was discussed at the Meeting. The note of the Meeting

did not refer to those present at the Meeting nor in relation to any action to be taken or the persons to take any action. The note of the Multi-Disciplinary Team Meeting simply noted fast track paperwork and the fact that Miss Bentham had been accepted at Rivington View Nursing Home.

9. On the 28th April 2015 a medical review identified that the abdomen was found to be tender but not in one specific place and the abdomen was described as soft, meaning no rigidity as would be expected with peritonitis. In view of the fact the patient had been constipated for some six days prior to the 28th April 2015 laxatives were prescribed as well as all previously prescribed medications.

10. On the 29th April 2015 Miss Bentham was transferred to Rivington View Nursing Home, Albert Street, Horwich, Bolton where she deteriorated and died on the 1st May 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:-

1. During the Inquest evidence was heard that

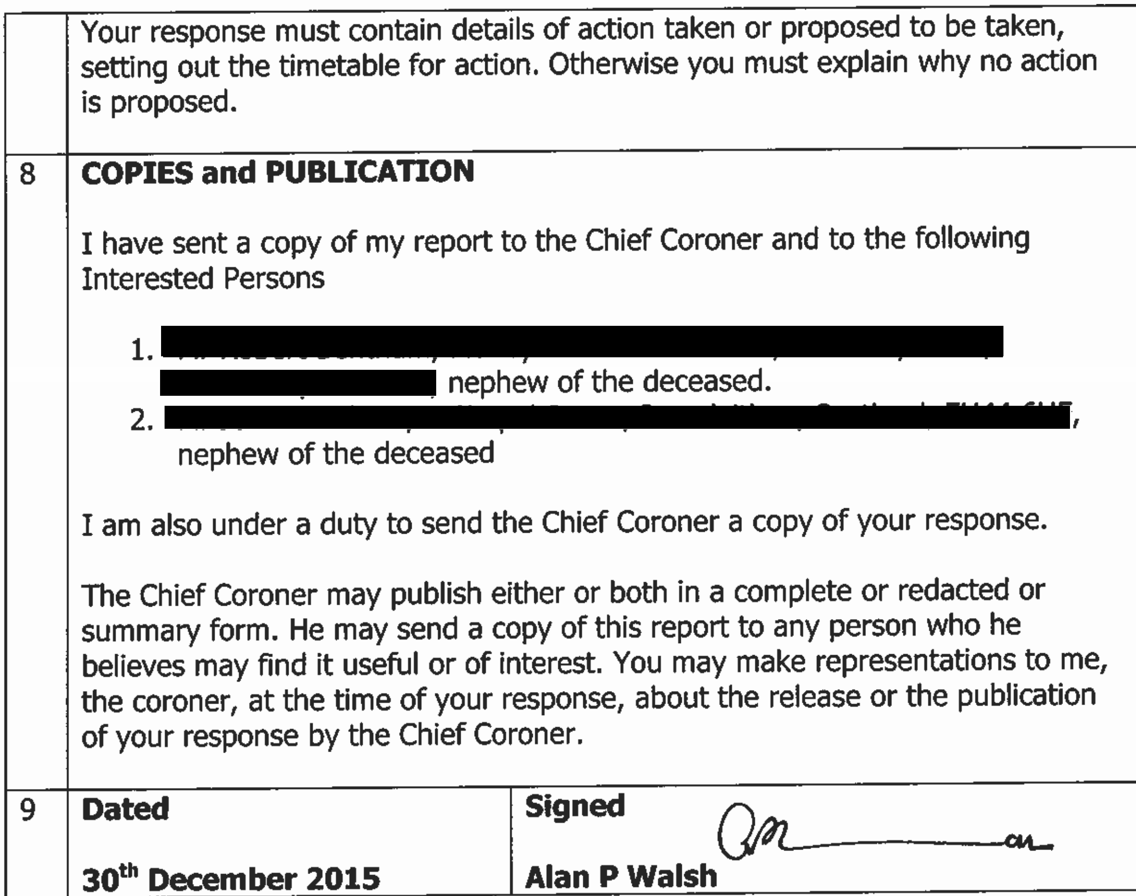
   i. The notes at Darley Court Intermediate Care Centre did not refer to the family concerns expressed to the nursing staff from the 23rd April 2015 onwards and the notes did not include a note from the out of hours General Practitioner, who attended Darley Court on the 26th April 2015, nor the attendance of [redacted] on the 27th April 2015. The notes did not make any reference to abdominal pain suffered by Miss Bentham until the 28th April 2015, even though the family expressed concerns with regard to abdominal pain on the 23rd April 2015.

   ii. There was no evidence of liaison between the nursing staff and the medical staff at Darley Court Intermediate Care Centre, particularly in relation to the concerns expressed by the family and with regard to the attendance of the out of hours General Practitioner on the 26th April 2015.

   iii. There was no evidence of handovers at shift changes as between nursing staff and medical staff particularly in relation to the concerns expressed by the family and the attendance of the out of hours General Practitioner on the 26th April 2015.

   iv. The notes of the Multi-Disciplinary Team Meetings, including the Meeting on the 27th April 2015, did not give details of who was present at the Meeting, the actions to be taken following the Meeting together with the person who was given responsibility to

	taker the actions and a timescale in relation to the actions. The above concerns are particularly relevant in relation to a patient, like Miss Bentham, who was unable to communicate with either nursing staff or medical staff. In such circumstances and in the absence of documented and noted information in relation to family concerns a condition suffered by the patient may be left untreated without consideration by a reviewing doctor or a Multi-Disciplinary Team Meeting. v. The above issues raise training issues in relation to staff, both nursing and medical, at Darley Court Intermediate Care Centre. vi. The evidence raised concerns that there is a risk that future deaths will occur unless action is taken to review the above issues, particularly where known symptoms observed by the family are not brought to the attention of the reviewing medical team and no investigations are conducted with regard to the observed symptoms. 2. I request you to consider the above concerns and to carry out a review with regard to the following:- i. The quality of the notes made by nursing and medical staff at Darley Court Intermediate Care Centre. ii. Liaison between the nursing staff and members of the medical team in relation to patients, particularly in relation to symptoms observed by health professionals and members of the family. iii. The system of handovers, particularly with regard to passing information between healthcare professionals at the end and the commencement of a shift. iv. The conduct of Multi-Disciplinary Team Meetings, particularly with regard to notes to refer to those present, actions to be taken, the person allocated to take the actions and a timescale in relation to such actions. v. The training of all healthcare professionals at Darley Court Intermediate Care Centre in relation to the above matters.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or your organisation 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 24th February 2016. 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 1. [redacted] nephew of the deceased. 2. [redacted], nephew of the deceased 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	**Dated** **30th December 2015**	**Signed** **Alan P Walsh**