REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Clare Molloy, Chief Executive, Pennine Care NHS Foundation Trust**
1	**CORONER** I am Jason Wells, Assistant 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 19th July 2018 an investigation was commenced into the death of ALLAN WILLIAM CUNLIFFE (dob 13th August 1941). The investigation concluded at the end of the inquest on 10th October 2019. **The narrative conclusion of the jury at inquest was:** **"Insufficient record keeping and communication probably led to an avoidable death"** **The medical cause of death was** **1 a) Sepsis** **1 b) Perforated bowel** **1 c) Bowel perforation due to adhesions**
4	**CIRCUMSTANCES OF THE DEATH** (1) Allan Cunliffe (AC) had a history of bowel problems and mental health issues. On 30th March 2018 he was admitted to Summers Ward (part of Pennine Care NHS FT) under the MHA with psychotic symptoms. Towards the end of May consideration was being given to discharge. (2) On 7th June AC was felt to be constipated and was admitted to Tameside Hospital for 10 days. Sigmoid volvulus was diagnosed and treated. AC was discharged to Summers Ward, with a 6 week outpatient appointment. (3) The jury made the following findings of fact (box 3): "Allan Cunliffe became ill on 17th July 2018 in Summers Ward. Inadequate actions followed which contributed to a delay in presenting to A&E. Failure include: inadequate communication between nursing and medical staff; a lack and/or incomplete calculations of NEWS scores; a failure to adhere to the NEWS protocol, especially re further regular observations. These failures were probably causative to Allan Cunliffe's death, in that surgery prior to 22.30 probably would have resulted in his survival Further failures that were not causative include: the ruling out of bowel obstruction on the afternoon of 17th July 2018; a delay in starting oxygen at 02.00 on 18th July 2018; the request for an ambulance 'within an hour' rather than Category 1 urgent at 02.30". (4) AC was transferred to Tameside Hospital, arriving at 04.09. He was resuscitated and sigmoid volvulus was diagnosed and treated with a sigmoidoscopy - in fact, a review of the x-rays suggest that this was wrong and showed free air indicating perforated bowel. (5) AC deteriorated. He died in A&E at 07.03 on 18th July 2018.

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 could 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) **Pennine Care NHS Foundation Trust.** The physical care of vulnerable patients on Summers Ward was poor. Whilst the experience of different junior doctors will inevitably vary, communication between the doctors and nurses was poor and the recording of clinical observations/ NEWS score and action thereon (designed to alleviate some of the clinical decision making) was inaccurate/ lacking. There was further confusion regarding the administration of oxygen, with at least one nurse being apparently unaware of the mandatory training.
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 17th June 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. I have also sent it to 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.
9	 **Jason Wells** **HM Assistant Coroner** **22.04.2020**