REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: 1) Rt. Hon. Steve Barclay MP, Secretary of State for Health and Social Care; 2) [redacted], Chief Executive, Pennine Care NHS Foundation Trust

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 8th April 2022, I opened an inquest into the death of Corinne Haslam who died on 18th March 2022 at Tameside General Hospital, Ashton-under-Lyne, aged 55 years. The investigation concluded with an inquest which I heard between 13th and 16th March 2023.

The inquest determined that Mrs Haslam died as a consequence of:-

1) a) Acute left ventricular failure;
b) Myocardial ischaemia and acute exacerbation of chronic obstructive pulmonary disease
c) Left ventricular hypertrophy

d) II) Pulmonary thromboemboli (treated); Agitation arising in the context of severe and enduring mental illness

The conclusion of the inquest was one of Natural Causes.

CIRCUMSTANCES OF THE DEATH

Mrs Haslam died on 18th March 2022 at Tameside General Hospital, Ashton-under-Lyne, as a consequence of complications arising from myocardial ischaemia and an acute exacerbation of Chronic Obstructive Pulmonary Disease, against a background of undiagnosed left ventricular hypertrophy. Mrs Haslam's death was contributed to by physiological consequences of pulmonary thromboemboli which had been treated, and agitation in the context of severe and enduring mental illness.

Mrs Haslam was admitted to Taylor Ward, Tameside General Hospital in January 2022 following an acute deterioration in her mental health which could not be safely managed in the

community. Whilst initially an informal patient, Mrs Haslam was subsequently detained under the Mental Health Act.

Mrs Haslam reported a range of physical symptoms on the ward including chest pain and breathlessness, and attended the Emergency Department at Tameside General Hospital on 7th March 2022 when an acute exacerbation of COPD was diagnosed and treatment started.

On 13th March 2022, Mrs Haslam returned to the Emergency Department with similar symptoms, and pulmonary thromboemboli were suspected due to abnormal blood results. Anticoagulant treatment was prescribed and continued to be administered following Mrs Haslam's return to Taylor Ward.

On 17th March 2022, Mrs Haslam became breathless again and was initially managed on the ward by means of monitoring, nebulisers and limited oxygen therapy. Following a significant deterioration at around 22:00, Mrs Haslam was transferred back to the Emergency Department by ambulance, dying there in the early hours of the following morning.

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. –

<u>To the Secretary of State for Health and Social Care</u>

1. The court heard evidence as to the barriers which exist and make it difficult for staff working on mental health wards to obtain input from physical health specialists without sending a patient to hospital via the Emergency Department.

   Whilst there are occasions where review in an Emergency Department is most appropriate, the court also heard evidence that these can be extremely busy and intensive environments which may not be a conducive to delivering care for patients experiencing severe and enduring mental illness;

2. It is a matter of concern that Mental Health Trusts and Acute Trusts operate different (apparently incompatible) electronic records systems. The absence of such a unified records system creates obstacles as to the transfer of important clinical information between mental health and physical health specialists (and vice versa), with an inherent risk to patient safety arising from such information being held in silos.

<u>To the Chief Executive of Pennine Care NHS Foundation Trust</u>

3. It is a matter of concern that ward-based nursing staff do not appear to have been provided with clear and unambiguous guidance as to the circumstances when a risk assessment for

Venous Thromboembolism ('VTE') should be undertaken following admission to a ward, and the circumstances in which such risk assessment should be repeated.

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.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 15th September 2023. 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, [redacted] together with [redacted] and Weightmans LLP.

I have also sent a copy to the Care Quality Commission and Tameside Metropolitan Borough Council 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: 21st July 2023

Signature: Chris Morris HM Area Coroner, Manchester South.