REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. ██████████ Chief Executive Greater Manchester Mental Health Trust 2. ██████████ Chief Executive Officer of NHS England
	CORONER I am 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 7th October 2020, I commenced an investigation into the death of Rowan Louis Thompson. Rowan died on the 3rd October 2020. The investigation concluded on the 31st October 2022. The medical cause of death was confirmed as 1a) Cardiac Arrythmia 1b) Severe Hypokalaemia of unknown cause. A jury recorded a narrative conclusion which noted that that Rowans death was contributed to by neglect, in that there was a failure to communicate the finding of blood tests analysed at Salford hospital on the 2nd October which showed a life-threatening severe hypokalaemia.
4	**CIRCUMSTANCES OF DEATH** Rowan was a detained patient in the Gardner Unit at Prestwich hospital. This is one of four national forensic medium secure units for adolescents (aged 11-18). Its patients are often high risk (either to themselves or others) and have been accused of some of the most serious criminal offences. On the 3rd October 2020 Rowan was found in his room and it was thought he was having a seizure. CPR was commenced and paramedics called. Rowan died shortly after his arrival at North Manchester General Hospital. During the course of the investigation it became apparent blood test results had been available at Salford Royal hospital 24 hours earlier which indicated Rowan was suffering from severe hypokalaemia a medical emergency. There had been a failure to communicate those results in part due to errors at Salford and also at GMMH. During the course of the evidence the court heard of the failure by at least four staff members to undertake observations on Rowan on the morning of the 3rd October 2020. In addition witnesses confirmed that records were falsified to show the observations had been undertaken. During this shift no deputy ward manager or ward manager were on duty. The court heard there is no commissioning for deputy or ward managers to work at weekends. Both nurses working that day were still in their preceptorship being newly qualified. At least one, likely both had never been in a situation where they were faced with a medical emergency and having to consider CPR. The Court heard evidence in respect of the calling and arrival of the ambulance. It was clear that there was a delay in the paramedics attending Rowan due to it being unclear on the Prestwich site where the Gardner unit was, a lack of persons looking out for the paramedics and then them not being able to swiftly enter the locked unit.

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	Following Rowans death a number of investigations were undertaken. There was no sufficient consideration of the emergency response following Rowan being located in his room. Finally the court heard evidence as to the audit of the observation sheets which were (and continue to be) undertaken by managers. An investigation following Rowan's death highlighted a further 6 staff who in the three week period prior to the 3rd October 2020 failed to conduct observation checks. Despite this there is no ongoing audit of CCTV and the current audit of the observation logs will not highlight the falsifying of checks and documentation.
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. System by which observations and documentation are audited lacks rigour and is ineffective. 2. At the time of the CCTV review and investigation following Rowan's death there was a missed opportunity for management to understand the gravity and nature of the situation. There was no higher level investigation, so for example: a) Whether the staff who failed to complete observations/falsify records did so when working a particular shift ie night shift b) Whether the staff who failed to complete observations/falsify records did so when working weekends rather than during the week c) Whether there was any correlation between missed observations / falsifying of records and shifts when there was no deputy or ward manager on duty. 3. Given the specialist nature of the Gardner, the fact that this is a high risk environment and somewhere where the situation can change in an instant given the nature of the patients the experience of the staff in charge on the 3rd October 2020 was a concern. There was no rationale other than commissioning why a deputy or ward manager was not working at a weekend (when there are less activities to occupy the patients). The evidence heard suggested to the court that a more experienced nurse was always required on this unit.
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 27th December 2022. 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:- 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.

9	Date: Tuesday 1st November 2022. Signed:

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