REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], **Department of Health And Social Care, 39 Victoria Street, London, SW1H 0EU** 2. [redacted] **Chief Executive, General Medical Council, Regent's Place, 350 Euston Road, London NW1 3JN** 3. **President of the Faculty of Physician Associates, Royal College of Physicians, 11 St Andrews Place, Regents Park, London NW1 4LE**
	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 17th July 2023, I commenced an investigation into the death of Susan Pollitt. Mrs Pollitt died on the 16th July 2023. The investigation concluded on the 29th July 2024. The medical cause of death was confirmed as 1a) Spontaneous Bacterial Peritonitis 1b) Prolonged Insertion of Ascitic Drain 1c) Non Alcoholic Liver Cirrhosis 2) Type 2 Diabetes Mellitus, Osteoarthritis and Fracture of the Humerus. The Inquest concluded that Mrs Pollitt died as a result of an unnecessary medical procedure contributed to by neglect.
4	**CIRCUMSTANCES OF DEATH** On the 3rd July 2023 Mrs Pollitt was admitted to the Royal Oldham Hospital (the Hospital) following a collapse at her home address. She was treated for a number of medical issues including acute kidney injury. During her admission, she developed ascites. The Consultants involved in her care decided an ascitic drain was not required at that time. On the 11th July, a junior doctor reviewed Mrs Pollitt and decided that an ascitic drain should be placed. The Court found that this procedure was not clinically indicated at that time. The Physician Associate who undertook the procedure was not aware of the local Hospital Guidance on the insertion of ascitic drains or that the drain should remain in place for no longer than six hours. Mrs Pollitt's drain remained in place for 21 hours before being removed The Physician Associate had also directed that the drain be clamped due to a concern that the loss of fluid could cause a drop in blood pressure. This was unwarranted given the moderate level of fluid which had been drained and the Court heard that the Physician Associate did not appreciate that clamping a drain increased the risk of infection. Mrs Pollitt developed bacterial peritonitis and died on 16th July 2023. The situation was compounded by Mrs Pollitt's placement on a respiratory ward rather than a gastroenterology ward since there was a lack of understanding and awareness across all the staff on the respiratory ward including the medical team as to the management of ascitic drains.
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. There is no regulatory body with oversight of Physician Associates. It is understood that this is currently the subject of a consultation by the General Medical Council.

2. The Physicians Associate Managed Voluntary Register held by the Faculty of Physician Associates (FPA) is voluntary. Whilst employers are encouraged to check the register there is no duty to do so, nor is it clear how the FPA would be made aware of any concerns relating to an individual Physician Associate.

3. There is no national framework as to how Physician Associates should be trained, supervised and deemed competent. This is placing both patients, Physician Associates and their employers at risk. The court heard that since the death of Mrs Pollitt the Northern Care Alliance have put in place a local trust framework. Unlike all other clinical roles there is no national guidance save for very recent guidance issued by the British Medical Association (March 2024).

4. There remains limited understanding and awareness of the role of a Physician Associate both amongst medical colleagues, patients and their families. The lack of a distinct uniform and the title "Physician" gives rise to confusion as to whether the practitioner is a doctor.

5. In June 2022 the Physicians Associate had been signed off as competent for the insertion of ascetic drains. This sign off was completed by a liver nurse specialist using a competency form which was provided by the FPA. Whilst the competency form assessed the technical aspect of placing the drain, it did not include competency around the wider aspects of care such as taking consent, risk factors and after care.

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 25 September 2024, 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:-
- Family of Mrs Susan Pollitt
- Northern Care Alliance

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: 31 July 2024 Signed: