

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. [REDACTED] Secretary of State for Health and Social Care. House of Commons London SW1A 0AA 2. [REDACTED] Chief Executive NHS England NHS England, PO Box 16738, Redditch, B97 9PT 3. M [REDACTED] Medical Engineer Philips Electronics UK Ltd Ascent 1, Aerospace Boulevard, Farnborough, GU14 6XW.
1	CORONER I am Timothy William Brennand, HM Senior Coroner, for the coroner area of Greater 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 the 2nd day of January 2025, I commenced an investigation into the death of MELANIE JAYNE WALKER, Aged 43 years. The investigation concluded at the end of the inquest on the 14th of October 2025. The medical cause of death was: - 1a Combined Drug Toxicity [REDACTED] The conclusion of the inquest was a short form conclusion of 'Drug related' death.

CIRCUMSTANCES OF THE DEATH

The deceased had a complex medical history that included co-occurring established diagnoses of Bi-Polar Affective Disorder, recurrent episodic low mood, anxiety and depression with long standing drug and alcohol dependency syndrome. She had received active community-based treatment and care by local mental health and addiction service providers that had also included previous voluntary and involuntary in-patient phases of hospitalisation pursuant to the provisions of the Mental Health Act 1983.

In 2024, the deceased was in a phase of progressive deterioration with a nuanced relapse profile triggered by her personal circumstances and remission into recreational drug misuse as a coping mechanism. She had become non-concordant with her prescribed depot medication, that exacerbated her deterioration. By October 2024, her depot and lithium medication had been replaced with Olanzapine – an anti-psychotic medication with which she had become concordant. Between the 9th and 17th of December 2024, for reasons that remain unclear, the deceased had relapsed and reverted to recreational drug misuse, [REDACTED]

On the evening of the 17th of December 2024, following concern for her welfare, the deceased was eventually discovered on Trafford Street, Farnworth in a collapsed and partially responsive condition and admitted to the Royal Bolton Hospital, Minerva Road, Farnworth. Her admission urine screening test showed the presence of [REDACTED]

[REDACTED] She was treated in the Resuscitation Department where she was monitored and observed actively between her admission and 4am – her clinical observations being stable. At 4.45 am she was discovered collapsed and unresponsive on the trolley within her cubicle and found to be in cardiac arrest – but as this event had not been monitored or directly observed, the downtime of her cardiac arrest cannot be established, but was sufficient for her to sustain an irreversible hypoxic brain injury.

Nursing staff were unable directly to observe the deceased by reason of an operational emergency concerning another patient within the Resuscitation Department. The evidence also established that the electrical monitoring equipment did not trigger any alarm from her heart monitor for reasons that cannot be established precisely, but were considered to be associated with the consequence her earlier attempts, in a state of confusion and agitation, of her observed efforts to remove the electronic monitoring devices attached to her, combined with a sub-optimal operational design that gave rise to the inadvertent disconnection of the monitoring equipment that had not been appreciated by clinical staff.

Once her cardiac arrest was diagnosed, she was resuscitated and was to return to spontaneous circulation, albeit she was profoundly unconscious. Despite optimal care, she failed to show improvement or recovery of her neurological function. Repeated CT imaging of her brain showed no reversible cause of her loss of neurological function. After nine days of observation, with family consent, she had her life support withdrawn and she subsequently died on the 26th of December 2024.

The evidence established her cardiac arrest to have been caused by a recognised complication of the combined toxicity of both previous and recent self-ingested illicit cocaine and benzodiazepines but the precise quantity, concentration, time and circumstances of the recent ingestion prior to her hospitalisation cannot be established, but is likely to have been at recreational or therapeutic levels, in keeping with her recognised relapse profile associated with her complex mental ill health and co-occurring illnesses.

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. Whilst the deceased had been fitted with a heart monitor whilst being assessed in the busy Resuscitation Department of the hospital, she experienced a cardiac event that ought to have triggered her hearty monitor to alert clinicians to this medical emergency, in fact, this did not occur. 2. A Patient Safety Incident Investigation (PSII) had been commissioned by the Hospital Trust determined: a. Where, an untoward event – such as an abnormal reading, or (as in this case) the monitor lead was inadvertently disconnected, this creates a blue 'in op' alert with a 'bloop' type sound (as opposed to a continuous alarm) – with the consequence that the ECG lead is unable to detect a reading and is therefore inoperable. b. The 'in op' alert creates a blue banner to alert staff. Once acknowledged (by the staff member pressing the button) this does not re-alert, even if the lead remains disconnected, c. Accordingly, there is a risk that a lead could remain disconnected, if the reason for the staff pressing 'acknowledge' is to acknowledge an abnormal reading. d. Whilst Royal Bolton Hospital Trust have mitigated the identified patient safety issues and it understood that the manufacturers (Philips) are undertaking to reconfigure their monitors so that when an ECG lead is removed this creates a 'yellow alert' that will ensure that the monitor will re-alarm in the scenario of a patient removing the lead when unobserved – the evidence established that this risk remains an issue for other hospital trusts in the interim. e. Royal Bolton Hospital have identified the need for patients who are deliberately or inadvertently removing monitoring equipment will be the subject of additional support, such as a 1:1 Health Care Assistant. 3. There remains an ongoing concern that until these heart monitoring machines are re-configured, and staff made aware and trained as to their current deficiencies, with no mitigating arrangements in place, that a patient can suffer a fatal cardiac event in any clinical setting and an erroneous assumption made by health care staff that a patient is being appropriately monitored.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you and/or your organization 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 28th November 2025. 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] Son 2. [REDACTED] Mother 3. [REDACTED] Chief Executive of Bolton NHS Trust I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	Dated: 17/10/2025 [REDACTED] Timothy William BRENNAND Senior Coroner for Manchester West