REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) [redacted], Chief Executive, Great Western Hospitals NHS Foundation Trust. 2) [redacted], Chief Executive and Registrar, The General Medical Council.
1	CORONER I am Chris Morris, Area Coroner for 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 5th May 2021, Alison Mutch OBE, Senior Coroner for Greater Manchester (South) opened an inquest into the death of Billy Longshaw who died on 7th March 2021 at Stepping Hill Hospital, Stockport aged 22 years. The investigation concluded with an inquest which I heard on 21st February 2022. The inquest concluded with a Narrative Conclusion to the effect that Mr Longshaw died as a consequence of complications of an undiagnosed sigmoid volvulus.

4	CIRCUMSTANCES OF THE DEATH Billy Longshaw died at Stepping Hill Hospital, Stockport on 7th March 2021. Mr Longshaw had a complex medical history, including significant learning disabilities. A post-mortem examination undertaken by Dr [redacted], Consultant Histopathologist, determined that the medical cause of Mr Longshaw's death was: 1) a) Acute bowel obstruction; b) Ischaemic sigmoid volvulus. 2) Cardiomyopathy due to D2-Hydroxyglutaric aciduria. Mr Longshaw had been taken to the Emergency Department of Great Western Hospital, Swindon, following experiencing sudden onset abdominal pain and an episode of vomiting on a car journey. In the Department, Mr Longshaw was found to have mostly normal physiological observations, and his abdominal examination was considered to be normal by the junior hospital doctor who saw him. Mr Longshaw was permitted to leave the Department without basic blood tests being taken, any diagnosis being made, or serious abdominal pathology being fully excluded. On the balance of probabilities, the sigmoid volvulus which led to Mr Longshaw's death was present (albeit at an early stage) when he was assessed in Swindon.

5	CORONER'S CONCERNS The MATTERS OF CONCERN are as follows. – To the Chief Executive, Great Western Hospitals NHS Foundation Trust 1) Notwithstanding Mr Longshaw died within 24 hours of being seen in the Emergency Department at Great Western Hospitals, Swindon, in circumstances where he was permitted to leave without basic blood tests being taken, any diagnosis being made, or serious abdominal pathology being fully excluded, it is a matter of concern that the Trust has not undertaken a detailed investigation into the care and treatment provided to him. Prompt, rigorous and effective investigations into serious clinical incidents are essential to deriving learning and improving patient safety; 2) The '48 Hour Report for Significant incidents resulting in Moderate Harm and above' prepared by an ED Consultant and others is fundamentally and obviously flawed (even when read against the Trust's own medical records), prefaced as it is by the assumption that 'the patient self-discharged against medical advice'. The Trust's (limited) review of this matter represents a missed opportunity to consider vital issues such as the presentation of patients with significant learning disabilities to the Emergency Department, and the practical application of the Mental Capacity Act 2005 in this clinical setting. To the Chief Executive and Registrar, The General Medical Council 3) Mr Longshaw's death raises issues as to the adequacy of education provided to medical students as to the Mental Capacity Act 2005, and doctors' of all levels familiarity with the practical application of this legislation in clinical settings, and accompanying guidance such as that produced by the General Medical Council in this regard.
6	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.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th May 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 Mr Longshaw's parents. I have sent a copy of my report to Dr [redacted], Medical Director of Bath, North East Somerset, Swindon and Wiltshire CCG and 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	Dated: 16th March 2022 Signature:  Chris Morris HM Area Coroner, Greater Manchester (South).