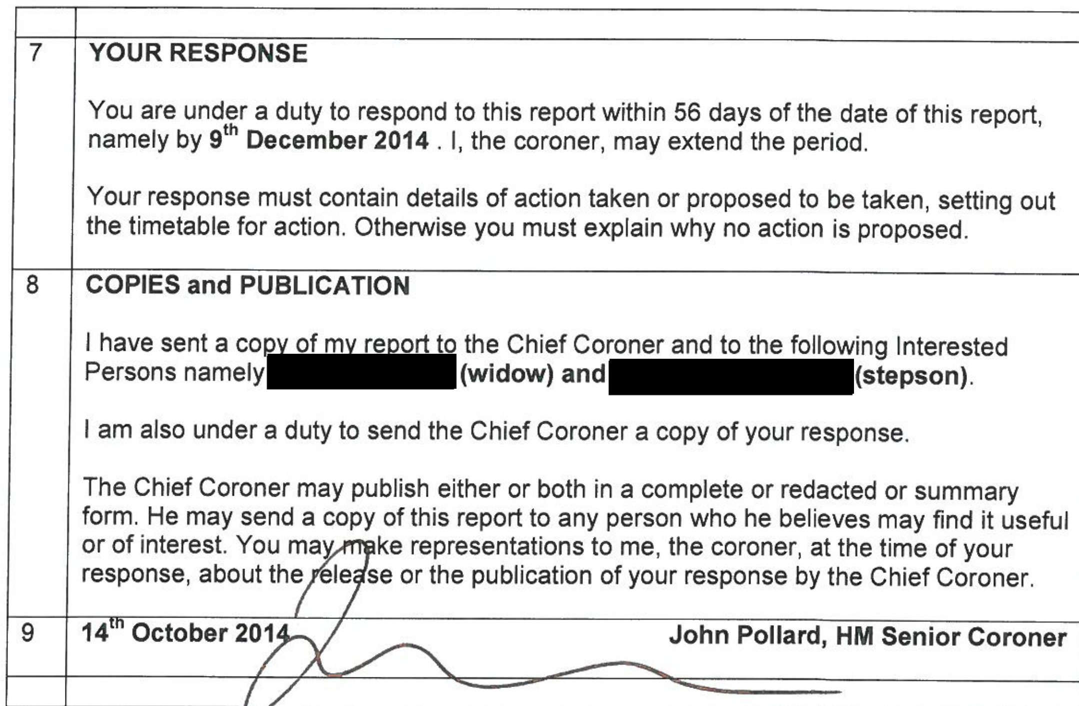
## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

| | |
|---|---|
| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: The Chief Executive, Tameside Hospital NHS Foundation Trust.** |
| 1 | **CORONER**<br><br>I am John Pollard, senior coroner, for the coroner area of South Manchester |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On **20th May 2014** I commenced an investigation into the death of **Alan Charles Peck** dob **19th October 1942**. The investigation concluded on the 7th October 2014 and the conclusion was one of Natural Causes. The medical cause of death was **1a Adenocarcinoma of the colon (resected) with liver metastases and post-operative wound infection 2. Coronary artery atheroma.** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>**Mr Peck had been an in-patient at Tameside Hospital for a period of approximately six weeks during which time he had a hemi-colectomy performed. Thereafter he was discharged from the hospital to the Willow Wood Hospice.** |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br>1. **Whilst a patient on the surgical ward at Tameside Hospital, it was noted by his family that although he was prescribed medication to be delivered by syringe driver, the said driver was unconnected under the patient's bed thus meaning that the essential drugs and analgesia were not being delivered to him.**<br><br>2. **When he was discharged and transferred from the hospital to the hospice, a nurse grabbed the syringe driver which was attached to his bed, and said that that could not be transferred with him. He was thus deprived of his medications for the duration of that transfer** |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. |



| | |
|---|---|
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by **9th December 2014** . I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely **(widow) and** **(stepson)**.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **14th October 2014** **John Pollard, HM Senior Coroner** |
| | |