

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO: Chief Executive, Stockport NHS Foundation Trust.</b></p>
1	<p><b>CORONER</b></p> <p>I am John Pollard, senior coroner, for the coroner area of South Manchester</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 11<sup>th</sup> September 2014 I commenced an investigation into the death of <b>John Michael Matthews</b> dob 1<sup>st</sup> March 1934. The investigation concluded on the 8<sup>th</sup> January 2015 and the conclusion was one of <b>Natural Causes</b>. The medical cause of death was 1a Aspiration Pneumonia 1b Haemorrhagic Hydrocephalus 1c Spontaneous Subarachnoid Haemorrhage 11. Diabetes, Hypertension.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <ol style="list-style-type: none"> <li>1. <b>Whilst in the Emergency Department at Stepping Hill Hospital, he was triaged without the triage nurse having seen the ambulance Patient Report Form.</b></li> <li>2. <b>The doctor having care of him in the E.D. was a locum doctor working his first (and only) shift at the hospital. That doctor told me that he could not find the PRF nor could he access the complete computerised system.</b></li> <li>3. <b>It was agreed by the ED consultant giving evidence that neurological observations ought to have been instituted, but they were not.</b></li> <li>4. <b>There was an unnecessary and to some extent unexplained delay in sending him for a CT scan of his head.</b></li> </ol>

6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by <b>26th March 2015</b>. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely [REDACTED] (family of the deceased).</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p><b>29.1.15</b> [REDACTED] <b>John Pollard, HM Senior Coroner</b></p>