REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive, Tameside Hospital Foundation NHS Trust.**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 3rd September 2014 I commenced an investigation into the death of **Paul Moroney** dob 7th November 1961. The investigation concluded on the 21st January 2015 and the conclusion was one of "He died from the abuse of alcohol". The medical cause of death was 1a Dilated Cardiomyopathy 1b Chronic Alcoholism 11. Liver Cirrhosis and Steatosis
4	**CIRCUMSTANCES OF THE DEATH** **On the 27th August 2014 he attended at Tameside Hospital by ambulance . the ambulance proceeded to the hospital with full emergency equipment in operation, and the patient was given oxygen in the ambulance. Once at the hospital blood was taken and a bed-side X-ray was done. There was concern that he had had a blood clot, and it was arranged that he should return to the hospital the following day for the administration of blood thinning agents.** **Shortly after returning home, his breathing got worse and a second emergency ambulance was called. The ambulance staff asked the patient why he had discharged himself from hospital and he told them that he had been discharged by the doctors.**
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. Whilst at the hospital on the first occasion, no oxygen saturations were monitored or recorded 2. Having been put on oxygen in the hospital, this was discontinued and he was sent home without his Oxygen saturations being monitored 3. When he was re-admitted to the hospital there was no record available to the staff about his previous oxygen levels.

6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st April 2015. 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 [redacted] (Brother of the deceased). 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	**04.02.15** **John Pollard, HM Senior Coroner**