	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Department of Health 2. Messrs. Weightmans 3. North West Ambulance Service 4. Family of the deceased
1	**CORONER** I am Simon Nelson, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 20th February 2013 I commenced an investigation into the death of **Colin Moulton** for whom the cause of death was confirmed at Inquest at being that of 1a) Bronchopneumonia with Hypothermia; Alcoholic Liver Disease and Ischaemic Heart Disease, whilst not causative of death, all being contributory factors. At an Inquest hearing on the 25th June 2015, the Inquest was concluded with the following narrative – 'Colin Moulton was discovered deceased within 25 feet of the perimeter wall of the Irwell Unit within the grounds of Fairfield General Hospital Bury shortly after 9am on the 14th February 2013. He had been admitted to the Accident and Emergency Department of Fairfield General shortly before 16:00hrs on the 13th February. Whilst en-route to the Accident and Emergency Department on the 13th February, paramedics observed that Mr Moulton was clearly unwell, suffering from abdominal pains and tachycardia and was becoming increasingly confused. By reason of ineffective communication between paramedic and nursing staff, Mr Moulton was incorrectly triaged and accorded a lower priority than was appropriate. Crucially, Mr Moulton's confusion went unrecognised with the result that when he attempted to leave the department, there was no formal capacity assessment; no discussions to involve a clinician; no consideration of the involvement of a member of the security staff and no formal documentation completed- all of which amounted to sub-optimal nursing care. The evidence does not show whether Mr Moulton would have remained within the department had the correct procedures been followed but more likely than not, the provisions of the Trust's missing person policy would have been invoked. By reason of the missed opportunities to render effective care, Mr Moulton's death was contributed to by neglect.
4	**CIRCUMSTANCES OF DEATH** As above
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. When Mr Moulton was admitted to A & E on the 13th February 2013, critical information was conveyed by means of a verbal handover from the paramedic to the receiving triage nurse. Following this incident, The Pennine Acute Trust now requires the receiving triage nurse to have access to and have sight of the paramedic pro-forma with the additional requirement that those actions be documented. It would be helpful if an additional copy of the paramedic pro-forma could be given to and remain with the receiving triage nurse. 2. At approximately 5pm on the 13th February 2013, a number of administrative staff, whilst en-route home saw Colin Moulton within the hospital grounds near to the Irwell Unit. They perceived him to be ' in difficulty'. One of the staff members called for the assistance of an ambulance which duly attended and the paramedics on board apparently were unable to locate Mr Moulton. Had the Ambulance Trust notified the Hospital Trust of their presence within the hospital grounds, this may have tied in with earlier concerns in relation to Mr Moulton of which the Hospital Trust was aware. The Ambulance Trust is requested to consider whether in the future, third parties such as Hospital Trusts might be notified in such circumstances.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 4th September 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:- **1.** The Department of Health **2.** Messrs. Weightmans **3.** North West Ambulance Service **4.** Family 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 from. He may send a copy of this report to any person who he believes may find it usefulor 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	Date: 10th July 2015 Signed: