	Hours doctors who had no knowledge of the patient, rather than his own GP Practice. When, in what circumstances, should a paramedic seek the advice of a doctor who is not in attendance, as to whether the patient is to be taken to hospital?(NWAS) **2. The GP attended the patient on the 24th June and she assumed that he had been seen by a doctor on the 22nd because the records showed that he had been seen by a "practitioner". In fact he had only been seen by the paramedic. This assumption very much detrimentally influenced her subsequent decision making.(Haughton Thornley Medical Centres).** **3. On the attendance on the 24th, the doctor noted that the patient had had a fall, but she did not realise it was an unwitnessed fall, so the force and detail thereof was not known by anyone. She noted that the patient found it "was too painful for him to move or to sleep", and she said it was "evident that he was in agony with pain for him to turn in bed" (sic). She did not ascertain from the care staff that the patient's chest was "pulsating when breathing", a classic sign of a flail chest. She conceded that facing the same situation now, she would have admitted him to hospital. This is clearly an area where further training is required.(Haughton Thornley Medical Centres)**
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 **20th January 2016**. 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), Care UK, and Haughton Thornley Medical Centres. I have also sent it 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	**25.11.15** **John Pollard, HM Senior Coroner**

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: North West Ambulance Service NHS Trust and to Haughton Thornley Medical Centres (GP Practice)**
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 21st July 2015 I commenced an investigation into the death of Thomas Anthony Collins dob 9th October 1970. The investigation concluded on the 18th November 2015 and the conclusion was one of **Accidental Death**. The medical cause of death was 1a Sepsis and Multi-organ failure 1b Pneumonia and Adult Respiratory Distress Syndrome 1c Fractured Ribs 11 Alcoholic Liver Disease .
4	**CIRCUMSTANCES OF THE DEATH** **Mr Collins lived in a Care Home as a result of his ill-health due to drinking excess alcohol for many years. In the home, on the 22nd June 2015, he fell and damaged his chest. He was attended by his own GP on the 24th June 2015, who, despite the obvious serious and intense pain felt by the deceased, declined to admit him to hospital. A paramedic attended him on the 22nd June 2015, and this paramedic felt it necessary to obtain an opinion from a doctor, so he contacted the Out of Hours Service even though the GP surgery where the deceased was registered was in fact open. The OOH GP then purported to give informed advice to the paramedic, even though he could not examine the patient. It was decided not to take the patient to hospital.** **The cardio-thoracic surgeon gave evidence to me that if the patient had been taken to hospital on the 22nd when the injury occurred, "he would still be around today"** **On the 25th June he was eventually taken to Tameside Hospital, and on the 26th he was transferred to the Tertiary Unit for chest medicine, was then in the ITU until he transferred back to Tameside on the 6th July 2015, and he died there on the 15th July.**
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. **The attending paramedic lacked the confidence to make a clinical decision, which I accept can happen, but he then contacted the Out of**