REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive, Tameside Hospital NHS Foundation 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 19th August 2015 I commenced an investigation into the death of Derek Edward Hare dob 15th August 1937. The investigation concluded on the 13th January 2016 and the conclusion was one of **Misadventure**. The medical cause of death was 1a Multi organ failure 1b Chest and abdominal sepsis 1c Colonic Anastomotic Failure treated by surgery on 19.6.15: Embolization on 17.4.15 after Colectomy for diverticulitis on 14.1.15 11 Ischaemic Heart Disease.
4	**CIRCUMSTANCES OF THE DEATH** **Mr Hare was subject to severe abdominal pains and he was admitted to the hospital in January 2015 and was operated on for a colectomy. Thereafter he asked a numerous occasions to see the surgeons again as he was still in pain and was passing blood per rectum, but was refused/denied the chance to see the doctor. Eventually he was looked at and it was determined that one of his major blood vessels needed embolization. This embolization was done at Wythenshawe Hospital and on his return to Tameside he underwent a colonoscopy to examine the bowel. The embolization had compromised the blood supply to that part of the bowel where the anastomosis had been formed, and when the bowel was inflated for the colonoscopy, it caused the anastomosis to fail leading to a loss of bowel content and the development of sepsis in the abdomen and the chest.**
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. **It would appear that throughout his various admissions to the hospital, two completely separate sets of "notes" were open and being used. Thus when the doctor tried to refer to the notes in court he could not do so and had to seek a short adjournment to find the relevant entry. If this were the case when the patient was in the hospital, it is hardly surprising that errors were made and staff members were not clear as to what would comprise the optimum care for this patient.**

	2. **The deceased incessantly asked for appointments at the hospital because he knew that his abdomen was "not right", yet he was constantly refused/denied such an appointment. This meant that it is possible that the problem which he had was diagnosed much later than might have been the case, and the outcome might have been different.** 3. **On the 5th May 2015 he was admitted via emergency ambulance to TGH with abdominal pains. On the 6th May it was determined that he did not need an emergency colonoscopy and the "urgency was not there". He was sent home. He attended on the 19th June and had to undergo a laparotomy when the problem of the broken anastomosis was discovered and he died on the twelfth August. It was agreed by one of the consultant surgeons giving evidence to me that it would have benefitted his care to have kept him in hospital on the 6th May.**
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 17th March 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 Person namely [redacted] (brother of the deceased). I have also sent it to the **CQC** 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	**20.1.16** **John Pollard, HM Senior Coroner**