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 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 15th June 2015 I commenced an investigation into the death of David Michael little dob 27th June 1943. The investigation concluded on the 28th June 2016 and the conclusion was one of **Natural Causes contributed to by Neglect**. The medical cause of death was 1a Bronchopneumonia 1b Small Bowel Obstruction 1c Small Bowel Ischaemia.
4	**CIRCUMSTANCES OF THE DEATH** **Mr Little was admitted to hospital with abdominal pains. He was thought to have a mass in his small bowel. His condition worsened and a scan revealed a blockage due to ischaemic bowel. There were considerable delays in the performing and reporting of the scan to the surgeons and therefore in the insertion of the NG tube. At the optimal time the chance of mortality was 3.3% and by the time the operation was actually considered, the chance had risen to over 65% and it was deemed too late to do anything.**
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. **There was strong evidence of a failure by the hospital staff to keep clear records of when an inpatient was to be taken to "radiology", for what purpose, whether the procedure had been carried out, whether the patient had been returned to the ward. In the present case, Mr Little was taken 'by mistake' in the belief that he was another patient, and it was only on arrival at radiology that this was realised when they decided to proceed with his scan which had been planned for the following day.** 2. **The hospital had no clear diagnostic pathway or monitoring plan on admission, the staff appeared not to be trained to recognise the symptoms of a blocked bowel nor the potential seriousness thereof nor to be aware of the dire consequences of failure to diagnose and treat appropriately.**

	3. **Where there is a differential diagnosis of two or more potential conditions, the staff simply treated the least serious and assumed that was the correct diagnosis rather than taking the most serious and working backwards from that standpoint.** 4. **The communication between and among staff generally was poor but especially between the radiology department and the clinicians and nurses. There was little or no good communication with the family which led to additional distress for them at a time of great sorrow.**
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 **23rd August 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], son of the deceased, [redacted]. I have also sent it to **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	**28.6.16** **John Pollard, HM Senior Coroner**