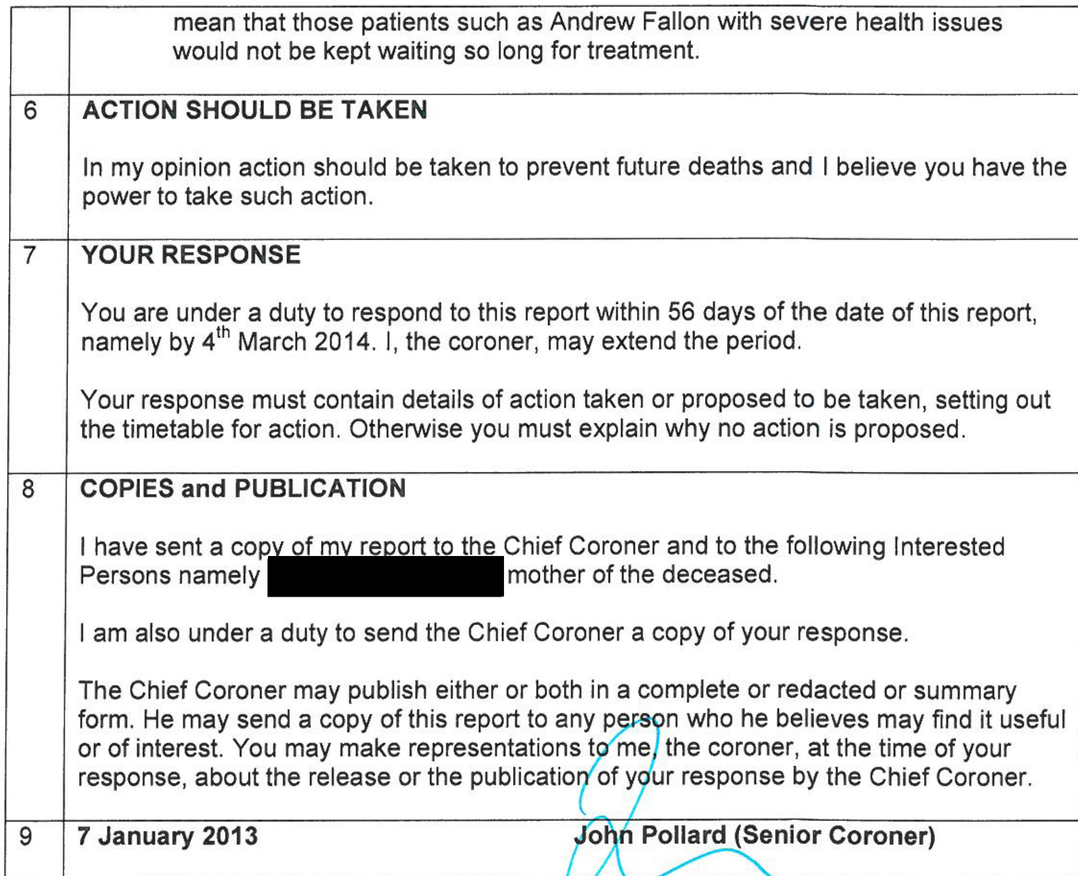
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Chief Executive, Stockport NHS Foundation Trust.**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of Manchester South.
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 26th November 2012 I commenced an investigation into the death of Andrew John Fallon born on the 18th June 1977. The investigation concluded at the end of the inquest on 23rd October 2013. The conclusion of the inquest was that he died from natural causes, the medical cause of death being 1a bronchopneumonia 1b post resuscitation of cardiac arrest 1c hypokalaemia due to gastroenteritis and Part 11 Becker's muscular dystrophy.
4	**CIRCUMSTANCES OF THE DEATH** On the 9th November 2012 he was admitted to Stepping Hill Hospital with a history of four days vomiting and abdominal pain and was diagnosed as having gastroenteritis. Later that same day he suffered a cardiac arrest and although he was resuscitated he was left with severe neurological damage and needed full support on the ITU. He showed no improvement and ventilator support was withdrawn and he died on the 15th November.
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. I heard evidence from the medical staff and others that the staffing levels within the Emergency Department were such that the doctors simply could not cope with the volume of work, thus leading to inordinate delays in treating the patients. I was specifically informed that there were, as is frequently the case, numerous patients at the Emergency Department with what can only be described as minor or trivial complaints. 2. It appeared to me during the course of the evidence that a very effective solution/help would be for there to be a Primary care facility staffed by GP's within or immediately adjacent to the ED. This would enable the triage nurse to allocate those minor conditions to the Primary care facility. This would then



	mean that those patients such as Andrew Fallon with severe health issues would not be kept waiting so long for treatment.
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 4th March 2014. 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] mother 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	**7 January 2013** **John Pollard (Senior Coroner)**