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 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 29th January 2013 I commenced an investigation into the death of James Hadfield Withers (dob 16/8/26).The investigation concluded at the end of the inquest on 19th September 2013. The conclusion of the inquest was "In October 2012 Mr Withers was diagnosed as suffering a recurrence of carcinoma of the bowel. He was admitted to hospital for a resection of the affected area on the 11th December 2012: Immediately post operatively he was treated on the ITU and made very good progress. He was then transferred to the surgical ward and his condition generally deteriorated thereafter: During his time on this ward and after his return to the ITU there were a number of occasions of poor communication with the family of the deceased; he was thought to be classified as DNAR when a doctor mistook him for another patient; little or no explanation was given to the family as to his actual DNAR status and/or as to why it was deemed appropriate as to why and when it was decided to take him off ventilation. On the 27th January 2013 he died as a result of his diseased heart, contributed to by the stress of the necessary operation to remove the cancer" The medical cause of death was 1a Congestive Cardiac failure 1b left ventricular failure 1c valvular heart disease (aortic stenosis) 2. Open extended right hemi-colectomy for invasive colonic adenocarcinoma .
4	**CIRCUMSTANCES OF THE DEATH** **The circumstances are apparent from the conclusion as outlined above**
5	**<u>CORONER'S CONCERNS</u>** 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 a delay of five days between the Cardiologist being requested to see the patient and actually attending the patient 2. Various of the medical/nursing notes appear to have gone missing

	3. The patient's DNAR status was fixed without any reference to/discussion with his family. Whilst it is appreciated that this decision is for the doctor alone, good practice would require that the family be kept up to date with all such decisions 4. One of the doctors admitted that he had assumed an incorrect DNAR status based on the fact that he had two separate pieces of paper in his pocket and had looked at the wrong one. 5. There was generally poor communication between nursing and medical staff (inter se) and between medical/nursing staff and the family of the patient.
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 8th 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 :- [redacted] (daughter of the deceased). 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	**7th January 2014** **John Pollard** **HM Senior Coroner**