REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive, University Hospital of South Manchester 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 **16th December 2013** I commenced an investigation into the death of **STEPHEN GOODHALL** d.o.b. **8TH August 1934**. The investigation concluded on the **24th April 2014** and the conclusion was one of **ACCIDENTAL DEATH**. The medical cause of death was **1a Pneumonia and 2 Lumbar Vertebral fracture**
4	**CIRCUMSTANCES OF THE DEATH** **On the 19th October 2013 at his home address, Mr Goodhall fell on the stairs and fractured his lumbar spine. He was taken to Wythenshawe Hospital and admitted. Thereafter he contracted hospital acquired pneumonia on several occasions and on the 8th December the outreach nurse from ITU told his family that there was a bed for him in ITU, but then the ITU Consultant declined to accept him, for reasons not made known to the family. He was subsequently taken to ITU on the 10th December when he remained hypotensive despite having had 11 litres of fluid, was developing a worsening metabolic acidosis, was oliguric, had a worsening kidney function and was again suffering a hospital acquired pneumonia. He died two days later.**
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. – **There does not appear to be a clear policy in place to determine candidacy for ITU and there appears to have been a contradictory message from the nursing and medical staff.**
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. **It would appear that a much clearer set of criteria needs to be set forth to determine eligibility for ITU and the process needs to be far more clearly explained to the relatives of the patient. They could then know whether they ought to seek to appeal the decision making process.**

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **19th June 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] **(daughter 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	**Date** 24.4.14. **John Pollard, HM Senior Coroner**