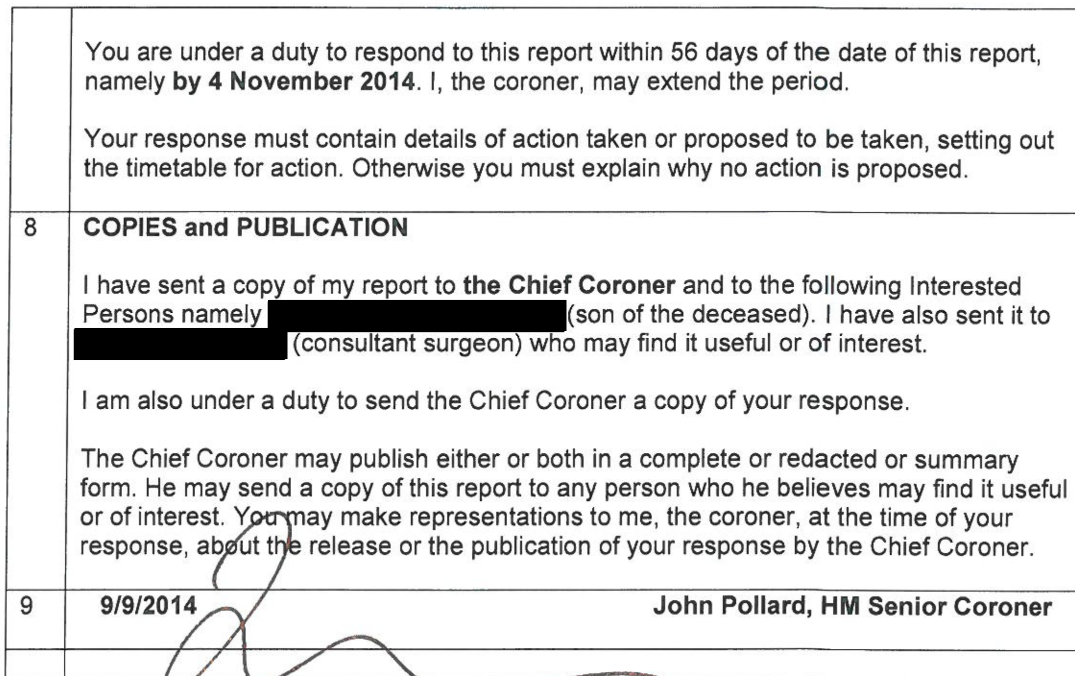
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive Officer, Stockport NHS Foundation Trust:** **Chief Executive Officer, N.W.A.S. NHS 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 30th April 2014 I commenced an investigation into the death of **ROSALIND ANN ADSHEAD** born 22ND February 1945. The investigation concluded on the 29th August 2014 and the conclusion was one of **MISADVENTURE**. The medical cause of death was 1a Pneumonia 1b Intra-abdominal adhesions and intestinal strictures (operated) 1c Previous gastric adenocarcinomas (operated)
4	**CIRCUMSTANCES OF THE DEATH: In 2007 Mrs. Adshead underwent a total gastrectomy and then in 2014 she was found to have severe adhesions from that earlier surgery, which were causing strictures.**
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. **During the course of her treatment at Stepping Hill Hospital it was considered that she needed to be moved to Manchester Royal Infirmary for her further care. She had developed an anastomotic leak from the site of the operation and needed to have a covered oesophageal stent to block the leak. She was a very severely ill lady at this stage, yet the move between hospitals took place in the very early hours of the 21st March 2014. The consultant surgeon into whose care she was transferred told me in evidence that "it is not safe to transfer such a patient in the early hours of the morning", that the transfer at this time "did add to the anxiety and distress in the middle of the night" and that "the shortage of ambulances in the normal working day is not a valid excuse".**
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 4 November 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 (son of the deceased). I have also sent it to (consultant surgeon) 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	**9/9/2014** **John Pollard, HM Senior Coroner**