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 **27th June 2014** I commenced an investigation into the death of **HAROLD PENNY** dob 22ND June 1940. The investigation concluded on the **21st November 2014** and the conclusion was one of **MISADVENTURE**. The medical cause of death **was 1a. Massive Pulmonary Embolism 1b. Lower Limb Deep Vein Thrombosis 1c. Massive Bladder Distension due to Obstruction by Displaced Urinary Catheter 11. Benign Prostatic Hypertrophy.**
4	**CIRCUMSTANCES OF THE DEATH** **Mr. Penny was admitted to the hospital on the 12th June 2014 and remained there until his death on the 20th. During that time, inter alia, he went for a u/s/s and then a CT scan of his bladder. These revealed a grossly distended bladder and a misplaced urinary catheter. This situation could have been remedied by the radiologist there and then, but it was not even reported to the treating clinicians until too late.**
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 seems to be no system in place to require the radiology department either to rectify the situation themselves if that is possible, nor to urgently report back to the treating clinicians in a case where, for example, they find that a urinary catheter has become displaced and is causing a blockage.**
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 **19th January 2015**. 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 have also sent it to the **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	**24th November 2014** **John Pollard** **HM Senior Coroner**