REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Chief Executive, Pennine Acute Hospitals NHS Trust
1	**CORONER** I am Ms L Hashmi, Area Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 19th February 2015 I commenced an investigation into the death of Mr James Mc Manus.
4	**CIRCUMSTANCES OF DEATH** Against the backdrop of pre-existing comorbidities, the deceased was admitted to the Royal Oldham Hospital on 8th October 2013 with a diagnosis of acute lower limb ischaemia that necessitated urgent medical intervention. Thrombolysis therapy was commenced on 9th October but stopped on 10th October due to the development of bleeding. Therapy was recommenced on 18th October. In the early hours of the 20th October the deceased began to show signs of hypovolaemic shock. Fluid resuscitation was initiated. Thrombolysis therapy was not discontinued until 14:00 the same day. Trust protocols were not followed and the resuscitation process was sub optimal. No consultation took place with a Consultant Haematologist. The deceased continued to deteriorate. He died on 3rd November 2013 as a result of the recognised but rare complications of necessary medical intervention.
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 am concerned about the lack of knowledge, application and implementation of key protocols by Trust staff – in particular, guidelines for the management of bleeding associated with thrombolytic therapy and the management of massive blood loss.

6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 the 11th May 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:- - The deceased's family - The Chief Coroner for England & Wales 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 from. 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: 13th March 2015 Signed: [redacted]