REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive, Central 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 7th September 2015 I commenced an investigation into the death of Leslie Alan Summerfield dob 15th February 1934. The investigation concluded on the 11th January 2016 and the conclusion was one of **Accidental death**. The medical cause of death was 1a Subdural Haematoma 11 Clostridium Difficile Infection, Previous Stroke: Anticoagulation Therapy .
4	**CIRCUMSTANCES OF THE DEATH** **He was admitted to Trafford General Hospital at the end of June 2015 and within the last two weeks of his life he suffered some relatively minor trauma which led to a subdural haematoma. The consultant pathologist concluded that the injury had occurred whilst he was a patient in the hospital.**
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 **MATTER OF CONCERN** is as follows. – **The Consultant Physician giving evidence to me indicated that she felt he needed an urgent endoscopy and that such a facility used to be available on site at Trafford, and indeed the equipment and staff members are still there, but only for use as a planned facility, not as an urgent request. If this is the case, is it safe to continue to treat patients with this type of illness at a hospital where the Management has withdrawn this essential service? In fact he was transported by ambulance to and from the Manchester Royal Infirmary despite the fact that he was a very sick man. The urgent endoscopy was not done at the MRI and he was sent back to Trafford for a "planned" endoscopy to take place.** **At the very least this caused him considerable unnecessary discomfort, and at worst may have weakened him such as to aggravate his pre-existing co-morbidities.**

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 by17th March 2016. 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] (wife 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	**20.1.16** **John Pollard, HM Senior Coroner**