ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive, Portsmouth Hospitals NHS Trust** **Queen Alexandra Hospital** **Southwick Hill Road** **Cosham PO6 3LY**
1	**CORONER** I am David Clark Horsley, senior Coroner for the Coroner area of Portsmouth and South East Hampshire.
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 22nd July 2016 I commenced an investigation into the death of Christopher Allen MacMORLAND (D.O.B. 13/10/1951). The investigation concluded at the end of the inquest on 1st November 2016. The conclusion of the inquest was: Medical cause of death: - Ia: Multiple Organ Failure - Ib: Sepsis - Ic: Spontaneous Bacterial Peritonitis and Pelvic Abscess - II: Myocarditis, Cardiac Hypertrophy, Chronic Obstructive Pulmonary Disease and Oesophagectomy for Carcinoma of the Oesophagus 2012. Coroner's Conclusion as to the death: Death due to Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** Mr MacMorland was admitted to Queen Alexandra Hospital between 14th and 20th October 2015 having had difficulty feeding. A feeding tube was inserted and he returned home. He was readmitted to the hospital on 10th November 2015 with abdominal pain and distension, feeling generally unwell. Despite treatment, his condition deteriorated and he died at the hospital on 5th December 2015.
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. – I was told in evidence at the Inquest that despite Mr MacMorland being under the care of consultant gastroenterologists during his final admission to hospital he was at no time treated in a specialist gastroenterology ward - even though the consultants had during

	that time requested such a transfer on five separate occasions. Given the nature of his medical problems, from the evidence I heard, I am of the opinion that he could have benefitted from the expertise and facilities available in a gastroenterology ward which might have had an effect on the outcome. I was also told that it is common for consultants' requests for patient transfer to specialist wards not to be implemented.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 11th January 2017. 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: - Mr MacMorland's wife - [redacted] Consultant Upper GI Surgeon 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	**16th November 2016** **David Clark Horsley**