REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Sir David Dalton, Chief Executive, Salford Royal Foundation Trust
1	**CORONER** I am Professor M Jennifer Leeming, Senior Coroner, for the Coroner Area of Manchester West
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 19th May 2017 I commenced an investigation into the death of Rodney Hampshire, 78 years of age. The investigation concluded at the end of the inquest on 15th September 2017. The conclusion of the inquest was Rodney Hampshire died as a consequence of naturally occurring heart and kidney disease precipitated by the challenge of surgery for Colorectal Cancer and Hernia Repair. The cause of death was: 1a) Ischaemic Heart Disease 2) Resection of Metastatic Colorectal Cancer and Parastomal Hernia Repair, Hypertension related Chronic Kidney Disease (Stage 3), Bronchopneumonia.
4	**CIRCUMSTANCES OF THE DEATH** On the 12th May 2017 Rodney Hampshire underwent bowel surgery at Salford Royal Hospital following which he was admitted to the Intensive Care Unit where he remained until the 15th May 2017 when he was transferred to a surgical ward. On the 16th May 2017 he suddenly deteriorated and sustained a cardiac arrest.
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 inquest evidence was given that the division of surgery at Salford Royal Foundation Trust is conducting a review examining the benefits of having a small number of monitored beds on the surgical wards such as the ward to which Mr Hampshire had been transferred. Whilst there was no evidence that this would have affected the outcome in this case, evidence was given that monitored beds of the type envisaged would potentially save lives.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or 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 21st November 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 [redacted], daughter of deceased. 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	**Dated** **26th September 2017**
	Signed MJennifer Leeming **Professor M Jennifer Leeming**