REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	THIS REPORT IS BEING SENT TO: • Sir Mike Deegan, Chief Executive, Central Manchester University Hospitals, NHS Foundation Trust • Sir Bruce Keogh, Medical Director, NHS England • Sir David Behan CBE, Chief Executive, Care Quality Commission Copied for interest to: • Family of Mr Stephen George Coulson
1	**CORONER** I am Dr Rashid Sohail, H.M. Assistant Coroner for the Manchester City Area.
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	**INQUEST** I concluded the inquest into the death of Stephen George Coulson on 4th October 2017 and recorded that he died from: 1a Hypoxic brain injury 1b Acute left ventricular failure 1c Idiopathic left ventricular hypertrophy on background of opioid toxicity
4	**CIRCUMSTANCES OF THE DEATH** The deceased was admitted to Manchester Royal Infirmary on 30th December 2015 with abdominal pain. He had a complex past medical history which included operations for diverticular disease and a twisted bowel. He had also sustained severe spinal & nerve damage following a fall for which he was on long term opioid treatment including oral Oramorph and Fentanyl patches. On the 31st December 2015, following review by the Colorectal Surgical Team, his Fentanyl patch prescription was increased from 50mcg to 75mcg with a view to discharging him home with subsequent follow up for a pre-arranged colonoscopy. The deceased had been noted to be self-administering his own Oramorph whilst he had been in the hospital ward. Prior to his discharge a 75mcg Fentanyl patch was applied, though there is no record of his current 50mcg patch having been removed as was required by Trust policy. Later that morning he had telephoned his wife in a somewhat confused and agitated state. The deceased's wife queried whether he should be discharged in that state and was so informed by the nursing staff. There was a policy in place at Manchester Royal Infirmary at the time such that patients exhibiting a change in presentation and/or symptoms of confusion required clinical observation before being discharged. It has been documented that the nurse had discussed this with the House Officer on call who suggested it would be due to the increased dose of Fentanyl. Despite this concern being raised the deceased was not seen or reviewed by any member of the surgical team prior to his discharge on December 31st. Nor was this lack of review escalated to a senior member of the surgical team. The deceased required assistance from his wife to reach his bedroom at home. The deceased was awoken by his wife at 23.30hrs on December 31st 2015 as they had been agreed earlier so they could see the New Year celebrations, but he stated that he was too tired and sleepy. At 03.00hrs his wife awoke to find the deceased unwell, an ambulance was called and the deceased was found to be in cardiac arrest. Resuscitation was commenced and he was taken to the Manchester Royal Infirmary. He was admitted to the ICU where despite

	treatment he died on 1st January 2016. A High Level Investigation conducted by the Trust found that no lessons needed to be learned. However, during the course of the inquest it became apparent from the evidence that lessons could be learnt by the Trust.
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) Controlled drugs – the system in place for the administration, documentation and audit of processes associated with the use of controlled drugs 2) Observation policy – the lack of escalation of the need to admit patients for observation and review should they fulfil the criteria to require continued observation / review prior to discharge 3) High Level Investigation – the witness did not accept that any lessons could be learnt from the investigation surrounding the death of the deceased.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 Wednesday 27th December 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 Interested Persons. I have also sent it to organisations 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	**Signed:**  **Dr Rashid Sohail** **27th October 2017**