REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Trust Chief Executive, Manchester University NHS Foundation Trust

CORONER

I am Chris Morris, Area Coroner for Greater Manchester (South).

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 10th September 2025, I opened an inquest into the death of His Honour Bruce Caulfield who died at Trafford General Hospital, Trafford, on 19th August 2025 aged 80 years. The investigation concluded with an inquest which I heard on 4th February 2026

Having heard evidence at the inquest, I determined His Honour died as a consequence of:

1)a) Myocardial infarction

b) Coronary artery disease

II Acute on chronic subdural haematoma (operated), hypertension, frailty

At the end of the inquest, I recorded a narrative conclusion, finding that His Honour Bruce Caulfield died as a consequence of complications arising from coronary artery disease against a background of complex health problems including an acute on chronic subdural haematoma which required surgery and resulted in the need to withhold anti-platelet medication.

CIRCUMSTANCES OF THE DEATH

His Honour Bruce Caulfield died on 19th August 2025 at Trafford General Hospital, Trafford as a consequence of complications arising from coronary artery disease against a background of an acute on chronic subdural haematoma which required surgery, hypertension, and frailty.

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. In relation to events leading up to His Honour's death at Trafford General Hospital on 19th August 2025, I am concerned as to how long transpired between a family member expressing concerns about a significant change in his

condition and requesting a review by a doctor, and any medical review actually taking place;

2. Having considered all of the evidence before the inquest with the utmost care, I am concerned that the approach to intentional rounding at Wythenshawe hospital in conjunction with other relevant nursing practices is insufficient to ensure vulnerable patients (such as those with cognitive impairment or the inability to eat or drink without assistance) receive adequate hydration and nutrition whilst on the wards; and

3. Whilst the Ward Manager's local investigation in relation to the circumstances of a fall His Honour sustained on Doyle Ward, Wythenshawe hospital on 30th July 2025 has resulted in an important change in practice as regards to communication between physiotherapy and nursing professionals as to agreed sitting-out recommendations and prominent documentation of these, I am concerned that comparable measures may not be in place across the Trust as a whole.

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.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **2nd April 2026** 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner, together with His Honour's widow on behalf of the family, and the Care Quality Commission and NHS Greater Manchester ICB who may find it useful or of interest.

The Chief Coroner may publish either or both in a complete or redacted or summary form. She 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.

Dated: **5th February 2026**

Signature: Chris Morris, Area Coroner, Manchester South.