Coroners
Manchester South

17 September 2013

Chief Executive
Stockport NHS Foundation Trust
Poplar Grove
Stockport
SK2 7JE

Our ref: JSP/KA/00677-2013
Your ref:

Dear Chief Executive

RE: Alva JULLIEN (Deceased)

I am the Senior Coroner for the coroner area of Manchester South and 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.

On 15 March 2013 I commenced the investigation into the death of Alva Jullien born on 6 January 1923. The investigation concluded at the end of the Inquest on 22 August 2013 and the conclusion which I reached was that of a Narrative verdict in the following terms:-

> 'Mrs Jullien died as a result of pneumonia which she developed following on from recumbency. During her care in the hospital opportunities were missed which might have optimised her chances of survival.'

During the course of the Inquest I heard evidence (very helpful as ever) from [redacted] from the Emergency Department, [redacted] (from the Medical Department), [redacted] (Consultant Physician), [redacted] (Ward Manager), [redacted] (Staff Nurse), [redacted] (Physiotherapist) and [redacted] (Ward Manager).

The particular issue which caused concern to me and which in my view demonstrably had a bearing on the death of the deceased was the fact that this patient was admitted to the hospital following a fall at home. Without going into the detail it was accepted by a number of members of your staff that she could and indeed ought to have been discharged from the hospital as she was medically fit for discharge. No home assessment was carried out and therefore she was detained/retained in the hospital during which time she became recumbent and this of course led to her development of pneumonia. She was then made 'nil by mouth' with, in my view, entirely insufficient evidence that that was the appropriate course to take and indeed she was placed on the Liverpool Care Pathway according to the evidence of [redacted]

John S Pollard LI.B. Hons, Senior Coroner

Joanne Kearsley LI.B. Hons Grad.Dip Psych, Area Coroner

[redacted]

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There was clear evidence at the Inquest that [redacted], daughter of the deceased, was not only able but willing to look after her mother in the home environment had her mother been discharged and it seemed clear to me from the evidence on a balance of probabilities that the deceased might well have survived had she have been discharged from hospital much earlier and that this discharge did not take place simply because of a lack of communication between the various health professionals and the want of a decision for discharge being taken.

I believe that your Trust should take action to ensure that lines of communication and decision-making processes are far more clearly set out and understood by the various specialties and disciplines and I look forward to receiving your response to this matter within the 56 day period stipulated by law.

I shall send a copy of my report to the Chief Coroner's Office and to the Coroners' Society of England and Wales for publication on the website and I have also sent a copy of it to [redacted] daughter of the deceased. Copies of your response will be similarly disseminated.

The Chief Coroner may, at his discretion, publish either my letter or your response or both in a complete or redacted or summary form. He may send a copy of my report to any person who he believes may find it useful or of interest. You may make representations to me, as Coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.

I look forward to hearing from you please.

Yours sincerely

John S. Pollard
Senior Coroner

Cc to:

1. Chief Coroner
2. [redacted]
3. [redacted]