## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: The Chief Executive, Tameside Hospital NHS Foundation Trust** |
| 1 | **CORONER**<br><br>I am John Pollard, senior coroner, for the coroner area of South Manchester |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 14th October 2013 I commenced an investigation into the death of Nellie Travis, date of birth 13th March 1927. The investigation concluded on the 28th February 2014 and the conclusion was Accidental Death. The medical cause of death was 1a Haemorrhagic cerebral infarction and 2 Pneumonia, fractured neck of femur sustained following a fall, chronic bronchitis and emphysema, idiopathic anaemia. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>She was admitted to hospital for the problem of her anaemia. On the 2nd October 2013 she was rising from her bed in the hospital ward when she fell and broke her hip. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows – During the course of the evidence I was told that there is a Falls Risk Assessment tool used by the hospital, but in this case it had been completed and assessed by a 'bank nurse' who was not an employee of the Trust. The evidence given by the senior member of the nursing staff was to the effect that the operation of the Falls Risk Assessment Tool is very subjective and depends upon an individual opinion of the nurse completing it as to how high the falls risk is shown to be. It was agreed that such a document is of very little use at all and that a more objectively assessed tool needs to be adopted. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. It is essential that full information is passed promptly to the GP practice of a patient being discharged. |

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| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 30th April 2014. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely [redacted] (son and next-of–kin).<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **5th March 2014** **John Pollard, HM Senior Coroner** |
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