	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive, Tameside General Hospital
1	**CORONER** I am Joanne Kearsley Area Coroner, for the Coroner Area of Manchester South.
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 the 04.01.2013 I commenced an investigation into the death of Barbara White date of birth 12.06.1935. The investigation concluded at the end of the inquest on 05.11.2013. The conclusion was that the deceased died as a result of Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** On the 8th December 2012 the deceased presented to Tameside Hospital with symptoms consistent with biliary colic. She was assessed and a treatment was put in place. On the afternoon of the 9th December 2012 her clinical presentation began to deteriorate and she was reviewed by a doctor. Blood tests, x-rays and observations were requested. There was no subsequent review of tests requested, nor were any nursing observations carried out. At 6am on the 10th December when nursing observations were carried out the PARS score was incorrectly recorded and there was therefore a failure to note a significant deterioration in Mrs White's condition. At 07.05am her PARS score was 0 and she required emergency intervention. Following this her condition deteriorated and despite extensive intervention by the Intensive Care Unit she died on the 2nd January 2013.
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. There was a lack of clinical observations for a period of 12 hours on the 9th December. In addition no nursing observations were carried out during this period of time. 2. At 6 am Mrs White's PARS score was recorded as 2 when this should have been 5 which if correctly recorded would have led to medical intervention. 3. There was a shortage of staff on duty on the Surgical Unit on the night of the 9th December. There was only one auxillary nurse who was not familiar with the Surgical Unit. This Unit is one step down from the High Dependency Unit and the patients require a high level of nursing care. However, there was a lack of escalation of this issue to the Night Nurse Practitioner. 4. There was a lack of information in the patient's medical records following the handover from the day staff to the night staff. Following the review of Mrs White on the 9th December when further tests had been requested there was a lack of any further clinical consideration and no escalation to a consultant. At the Inquest I heard evidence from Dr [redacted] who was the SHO on duty during the night and who had received the handover from the day staff. Her evidence was the she had no recollection of Mrs White being mentioned at the handover and was unaware that there were outstanding investigations.
6	**ACTION SHOULD BE TAKEN** I believe that this level of information should be mandatory in all Care establishments and in my opinion action should be taken to prevent future deaths and I believe your organisation, has 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 10th March 2014. 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, namely the family of the deceased, [redacted] at Hempsons Solicitors (on behalf of the Trust) and to the Coroners' Society Website.

	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	**13 January 2014**	**Joanne Kearsley** **HM Area Coroner**