REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Managing Director, Sunrise Medical Limited, Wollaston, West Midlands.** **The Manager, Faversham Nursing Home, 59, Church Road, Urmston.**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 18th April 2013 I commenced an investigation into the death of **MARJORIE PHILLIPS** dob 9TH July 1928. The investigation concluded on the 18th September 2014 and the conclusion was one of a narrative verdict. The medical cause of death was 1a Type 2 respiratory failure 1b Left sided pneumonia 1c Multiple rib fractures (left) 11. Chronic obstructive Pulmonary Disease and osteoarthritis
4	**CIRCUMSTANCES OF THE DEATH** **The deceased who was a lady of 82 years of age, was being hoisted from her bed into a wheel chair when she fell from the hoist and landed on the metal supporting legs of the hoist. She died from resultant pneumonia several days later.**
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. – **During the course of the evidence I heard from an Inspector of the Health and Safety Executive that the sling had a tendency to "bagging" at the sides and if Mrs Phillips had leant her weight over to one side of the sling, this combined with the tendency of the sling material to "bag" might have allowed her to fall from the hoist.(FOR SUNRISE MEDICAL LIMITED)** **In-house training is given to the staff at Faversham Nursing Home in connection with matters relating to Health and Safety. It was apparent that the staff had not heeded the training or had not fully understood it as to the use of hoists. The training was said to include the fact that no-one should be lifted in a hoist when only one staff member was present. This was clearly not the case when Mrs Phillips was lifted.(FOR FAVERSHAM NURSING HOME)** **When a very serious untoward incident had occurred and Mrs Phillips had fallen and was in obvious severe pain, there was no clear guidance as to how the emergency services should be called and by whom that decision could be taken.**

	This resulted in her not being taken to hospital as quickly as should have been the case.(FOR FAVERSHAM NURSING HOME)
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **14TH November 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 [redacted] **daughter of the deceased**. 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	**18th September 2014** **John Pollard, H.M. Senior Coroner**