REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive, Tameside NHS Foundation Trust:**
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 22nd August 2013 I commenced an investigation into the death of **Elsie Mallalieu** dob 4th May 1937. The investigation concluded on the 13th November 2014 and the conclusion was one of **Accidental Death**. The medical cause of death was 1a Bronchopneumonia 11. Hip fracture leading to dynamic hip screw; stroke disease
4	**CIRCUMSTANCES OF THE DEATH** **On the 12th August 2013 Mrs Mallalieu fell at her home address and broke her hip. She was admitted to your hospital via the Emergency Department and thereafter was in the Trauma Unit and on Ward 41.She died four days after admission.**
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. During the course of her relatively short stay in the hospital she was moved to Ward 41 which, as agreed in evidence by senior medical staff, was an inappropriate ward for her.** **2. She was entirely dependent on high flow oxygen, but none of the staff on ward 41 was trained to use this equipment.** **3. The medical and nursing notes on ward 41 were woefully inadequate, and failed to record some of the most basic care which was, or ought to have been, given.** **4. Whilst the staffing levels on ward 41 probably met the National Guidelines, it was clear that the ward was exceptionally busy both as to numbers of patients, but also as to the complexity of their conditions. There were only two qualified staff available and they simply could not cope (an example of this was that she had her observations taken at 8.30 pm approximately, and not thereafter for the whole of that night shift. A doctor attended her at**

	approximately 2.30 am and "guessed" her observation scores or alternatively used those of several hours earlier. Her PARS score at 8.30 pm was recorded (wrongly) as 4 (it was in fact 6) and by the following morning day shift it had risen to 10) **5. A Consultant agreed with my conclusion that this patient was "written off" and that a DNAR should not have been placed and that she could have been escalated to ITU/HDU where the infection which in fact led to her death, might have been treatable. Whilst on ward 41 she was administered antibiotics for this condition but the nursing staff had failed to "turn on "the drip delivering the drug.**
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 **12th January 2015**. 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] (Son and daughter-in-law). I have also sent it to **CQC** who may find it useful or of interest. 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	**17th November 2014** **John Pollard, HM Senior Coroner**