REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Secretary of State for Health.**
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 19th September 2014 I commenced an investigation into the death of **Elizabeth Muriel Leah** dob 24th May 1927. The investigation concluded on the 10th February 2015 and the conclusion was one of **Accidental Death**. The medical cause of death was 1a Aspiration pneumonia 1b Fracture right femur 11. Advanced dementia
4	**CIRCUMSTANCES OF THE DEATH** **On the 2nd July 2014 she fell at the Care Home where she was resident and broke her femur.**
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. – **On the occasion when she fell, an ambulance was called using the 999 system. On describing the circumstances, the Care Staff were told that they would get a call back from NHS within 60 minutes. They were also informed that there would be a delay of up to 6 hours for the ambulance to arrive. 50 minutes later the ambulance service called back and advised that she should be taken to hospital in a Taxi.** **This meant that an 87 year old lady with severe dementia and a broken leg, was delivered to the hospital Emergency Department in a wheelchair in a Taxi.** **When I questioned the Ambulance service Manager about this, she was very candid and accepted that the problem is that they do not have sufficient ambulances or staff available and that they are working "at 100%" all the time.** **This problem is exacerbated by the delays in getting patients into the A and E Departments, which in turn is exacerbated by the bed blocking throughout the hospital systems.** **These are not problems which can be alleviated locally, but require an urgent input and direction from Central Government.**

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 16th April 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] **(daughter of the deceased)**. I have also sent it to the Chief Executive, Tameside Hospital NHS Foundation Trust 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	**19th February 2015** **John Pollard, HM Senior Coroner** [redacted]