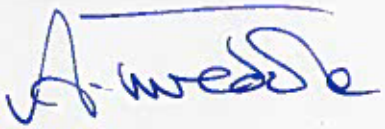
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **County Durham and Darlington NHS Trust, Darlington Memorial Hospital, Hollyhurst Road, Darlington DL3 6HX**
1	**CORONER** I am Andrew Tweddle Senior Coroner, for the coroner area of County Durham and Darlington
2	**CORONER'S 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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 3rd September 2014 I commenced an investigation into the death of Andrea Jane Thirkell, aged 51 years. The investigation concluded at the end of the inquest on 27th March 2015. The conclusion of the inquest was "The effects of a fall".
4	**CIRCUMSTANCES OF THE DEATH** The deceased had an unwitnessed fall in a nursing home and was taken to hospital. After an examination she was deemed fit for discharge at 19.25 hours. She did not leave the department until 23.03. She arrived back at the nursing home at 23.07 and at 23.25 was found to be unresponsive by the nurse at the nursing home at 23.43 an ambulance arrived at the nursing home and she arrived back at the hospital at 00.16. She was then found to have a serious head injury, was kept comfortable and died later that day.
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) Although considered to be medically fit for discharge at 19.25 hours she did not leave the department until 23.03 and during that time she was not subject to any structured form of monitoring or observation although nursing staff may have seen her during that time. Evidence was given that since this incident staff have been reminded that patients should be subject to formal observations if there is a delay in discharge. Although I was told this I am unclear as to whether there is a formal trust policy in place in this regard. (2) The deceased did not leave the department until 23.03. Evidence was given that it is common for patients to be discharged late on a night either home or to a care home knowing that there is likely to be nursing care available. The evidence I heard was that there was no formal trust policy or written guidance with regard to the issue of late at night discharge and what other factors need to be taken account of in considering whether it is safe to discharge a patient at such time and in what circumstances. The evidence was that each senior doctor will apply his or her own medical discretion and combined with the pressures on a busy department I am concerned that this could lead to inconsistent or potentially erroneous decisions being made.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 26th May 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 - Quality Care Commission I have also sent it to [redacted] 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	**30 March 2015**  **Andrew Tweddle LL.B.** **HM Senior Coroner** **County Durham and Darlington**

SCHEDULE 5 paragraph 7

ACTION TO PREVENT OTHER DEATHS

1)Where—

(a)a senior coroner has been conducting an investigation under this Part into a person's death,

(b)anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and

(c)in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,

the coroner must report the matter to a person who the coroner believes may have power to take such action.

(2)A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.

(3)A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner.

Regulations 28 and 29

Report on action to prevent other deaths

28.—(1) This regulation applies where a coroner is under a duty under paragraph 7(1) of Schedule 5 to make a report to prevent other deaths.
(2) In this regulation, a reference to "a report" means a report to prevent other deaths made by the coroner.
(3) A report may not be made until the coroner has considered all the documents, evidence and information that in the opinion of the coroner are relevant to the investigation.
(4) The coroner—
(a) must send a copy of the report to the Chief Coroner and every interested person who in the coroner's opinion should receive it;
(b) must send a copy of the report to the appropriate Local Safeguarding Children Board (which has the same meaning as in regulation 24(3)) where the coroner believes the deceased was under the age of 18; and
(c) may send a copy of the report to any other person who the coroner believes may find it useful or of interest.
(5) On receipt of a report the Chief Coroner may—
(a) publish a copy of the report, or a summary of it, in such manner as the Chief Coroner thinks fit; and
(b) send a copy of the report to any person who the Chief Coroner believes may find it useful or of interest.

Response to a report on action to prevent other deaths

29.—(1) This regulation applies where a person is under a duty to give a response to a report to prevent other deaths made in accordance with paragraph 7(1) of Schedule 5.
(2) In this regulation, a reference to "a report" means a report to prevent other deaths made by the coroner.

(3) The response to a report must contain—
(a) details of any action that has been taken or which it is proposed will be taken by the person giving the response or any other person whether in response to the report or otherwise and set out a timetable of the action taken or proposed to be taken; or
(b) an explanation as to why no action is proposed.
(4) The response must be provided to the coroner who made the report within 56 days of the date on which the report is sent.
(5) The coroner who made the report may extend the period referred to in paragraph (4) (even if an application for extension is made after the time for compliance has expired).
(6) On receipt of a response to a report the coroner—
(a) must send a copy of the response to the report to the Chief Coroner;
(b) must send a copy to any interested persons who in the coroner's opinion should receive it; and
(c) may send a copy of the response to any other person who the coroner believes may find it useful or of interest.
(7) On receipt of a copy under paragraph (6)(a) the Chief Coroner may—
(a) publish a copy of the response, or a summary of it, in such manner as the Chief Coroner thinks fit; and (b) send a copy of the response to any person who the Chief Coroner believes may find it
useful or of interest (other than a person who has been sent a copy of the response under paragraph (6)(b) or (c)).
(8) A person giving a response to a report may make written representations to the coroner about—
(a) the release of the response; or
(b) the publication of the response.
(9) Representations under paragraph (8) must be made to the coroner no later than the time when the response to the report to prevent other deaths is provided to the coroner under paragraph (4).
(10) The coroner must pass any representations made under paragraph (8) to the Chief Coroner who may then consider those representations and decide whether there should be any restrictions on the release or publication of the response.