REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: (1) [redacted] Managing Director, L and M Healthcare, Westgate House, 1st Floor, 44, Hale Road, Hale WA14 2EX: (2) Ms. Karen James, CEO, Tameside Hospital 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 11th November 2015 I commenced an investigation into the death of Edith Kirkham dob 28th November 1929. The investigation concluded on the 18th February 2016 and the conclusion was one of **Accidental Death**. The medical cause of death was 1a Congestive cardiac failure 1b Ischaemic Heart Disease 11. Pneumonia, Fractured neck of femur.
4	**CIRCUMSTANCES OF THE DEATH** **On the 13th August 2015 she fell at her home address and broke her hip. She was taken to hospital and it was operated upon. She was making good progress post operatively until she was moved to intermediate care where she was not mobilised as had been advised by the surgeon. She died in North Manchester General Hospital some 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. – 1. **The intermediate care arrangement at Darnton House, I was informed, was a joint venture between L and M Health care and Tameside Hospital, but there seems to have been inadequate planning and unclear rules as to the level and type of management required for the patients/residents. Was the required standard that of a hospital or that of a care home. No-one seemed to know and this led to general uncertainty.** 2. **Perhaps as a result of the problems highlighted at (1) above, the ward appears to have been inadequately staffed, both as to numbers of staff and the level of expertise thereof.** 3. **The staff, or some of them, who gave evidence at the inquest, had either failed to read the medical/nursing notes, or if they had so read them, they had failed to understand them. The consultant surgeon had clearly indicated that the patient was to mobilise and was able to fully weight-bear, however for the whole of the week she spent in this ward she was nursed in bed and not mobilised at all.**

	4. There was no apparent handover from the hospital to this ward, as to the individual needs of the patient, and the staff were therefore placed in an impossible position. **5. Mrs Kirkham was moved to the intermediate care ward on a Friday preceding a bank-holiday weekend, and despite the clear indication that she was to have physiotherapy, none was arranged for four days after her arrival.** **6. Despite the request from me as HM Senior Coroner, it appears that no records were available relating to the whole of her stay in this ward.**
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 19th April 2016. 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 **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	**23.2.16** **John Pollard, HM Senior Coroner**