REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive, Doncaster and Bassetlaw Teaching Hospitals NHS Trust** 1.
1	**CORONER** I am Miss Stephanie Haskey, Assistant Coroner for the Coroner area of Nottinghamshire
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** An Inquest into the death of Kathleen McGeary was held on 29 January 2019.
4	**CIRCUMSTANCES OF THE DEATH** Mrs McGeary died on 6th March 2018 as a result of head injury sustained in a fall at Tuxford Manor Care Home on 5th March 2018. She had been admitted to Tuxford Manor after discharge from Bassetlaw and District General Hospital (BDGH) on 2 March 2018.
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. There was little evidence that Mrs McGeary (who suffered from dementia and was vulnerable) was fully and properly assessed, investigated, diagnosed and treated before discharge. 2. No clinician took clear responsibility for discharge decision making. The recording of the identity of the discharging clinician was incorrect and communication between clinicians and nursing staff was unclear. 3. The electronic discharge summary was inadequate and no paper discharge summary was produced. No explanation was given for this omission. 4. Mrs McGeary left hospital by hospital arranged transport without the antibiotics she had been prescribed for a suspected UTI. No explanation was given for this failing. 5. At Inquest there appeared a culture of acceptance of the above failings and omissions without any corresponding will or effective plan to address them.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 29th April 2019. 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: Tuxford Manor Care Home The CQC Nottinghamshire County Council Adult Social Care Mrs McGeary's Family will be given a copy if they so request. 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	**Stephanie Haskey,** **Assistant Coroner for Nottinghamshire, 26th February 2019.**