REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive, Stockport 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 9th February 2015 I commenced an investigation into the death of **Frederick Sutton** dob 13th September 1930. The investigation concluded on the 14th July 2015 and the conclusion was one of **Accidental death**. The medical cause of death **was 1a Myocardial Infarction 1b Coronary Artery Atheroma 11. Fractured right hip (Traumatic)**
4	**CIRCUMSTANCES OF THE DEATH** **On the 3rd February 2015 at his home address he fell and broke his hip. He may have suffered a myocardial infarction at the same time. He was admitted to hospital and died approximately 12 hours 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 staffing levels in the hospital during his stay seemed to be less than optimal.** **(2) Whilst there is a procedure for escalation of the shortage of staff, this was either not fully understood or not properly put into effect.** **(3) There was clear evidence that a nurse had failed to read (or read properly) the nursing notes.** **(4) The computerised note keeping system used in the Emergency Department is not able to "talk to" the system which covers the rest of the hospital.** **(5) The patient required the administration of cyclazine and there was an obvious problem with the (lack of) training of the staff in this regard.** **(6) The patient suffered a cardiac arrest and there was a lack of understanding amongst nursing and medical staff as to how this ought to have been responded to.** **(7) There seemed to a lack of training amongst the staff as to the**

	administration of certain prescribed drugs, both as to the appropriate amount thereof and the method of delivery. **(8) There was a general lack of care as to the accuracy of the information held by the hospital as to next-of-kin details, where the wife of the deceased was shown as n.o.k when in fact she had died in 2008.**
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 **22nd October 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 **C.Q.C**. 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	**27.8.15** **John Pollard, HM Senior Coroner**