

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b> [REDACTED] Proprietor Bourne House, 12 Taunton Road, Ashton-under Lyne, OL7 9DR</p>
1	<p><b>CORONER</b></p> <p>I am John Pollard, senior coroner, for the coroner area of South Manchester</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 24<sup>th</sup> April 2015 I commenced an investigation into the death of <b>May Hall</b> dob 6<sup>th</sup> February 1931. The investigation concluded on the 3<sup>rd</sup> September 2015 and the conclusion was one of <b>Accidental Death</b>. The medical cause of death was 1a Subdural Haematoma with midline shift 11. Type two diabetes mellitus, chronic kidney disease and angina.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p><b>She fell twice on the night of the 11<sup>th</sup> / 12<sup>th</sup> April 2015. On both occasions she banged her head. She later died from a subdural haematoma.</b></p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. – <b>The Bourne House staff indicated that they were not aware of a policy for reporting falls and for calling the ambulance or emergency doctor. There should be clear training as to how any fall should be addressed by the staff and they should sign to confirm that they have received such training which should be regularly reviewed.</b></p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 28<sup>th</sup> October 2015. I, the coroner, may extend the period.</p> <p>Your response must contain details of action taken or proposed to be taken, setting out</p>

	the timetable for action. Otherwise you must explain why no action is proposed.
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Person namely [REDACTED] (Niece of the deceased). I have also sent it to CQC who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>3.9.15 <span style="float: right;">John Pollard, HM Senior Coroner</span></p> 