Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 SALFORD ROYAL HOSPITAL FOUNDATION TRUST** **2 NHS ENGLAND**
1	**CORONER** I am Michael James Pemberton, HM Assistant Coroner for the coroner area of Manchester (West).
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 1 August 2024 I commenced an investigation into the death of Anne Taylor aged 95. The investigation concluded at the end of the inquest on 7 November 2024. The conclusion of the inquest was Accident, and the medical cause of death was Traumatic Intracranial Haemorrhage.
4	**CIRCUMSTANCES OF THE DEATH** On 17 July 2024, the deceased was on a short holiday break in Blackpool at a hotel with her son sharing a twin room. In the late evening, she banged her head on a bedside cabinet as she turned in bed and then fell out of the bed. She got back into bed, with no complaint of injury. She appeared fine on the following day with no complaints of feeling unwell and spent the day undertaking activities. The planned holiday break ended the day after on Friday 19 July 2024 and she returned home. At 18:30 on 19 July she telephoned her daughter and said she did not feel well. Her son and daughter went to her home and found she had slurred speech. An ambulance was called and she was conveyed to Salford Royal Hospital. During a wait to be seen the deceased became agitated and elected to leave the hospital prior to being assessed after being told of the likely waiting time. It was planned that she would return the following morning when the emergency department was less busy. She returned to hospital on 20 July via ambulance and was assessed. A CT scan found she had suffered a traumatic brain injury with bilateral acute subdural bleed and midline shift. Neurosurgical advice deemed her not fit for acute surgery and she was treated medically, deteriorating over the next week. End of life care was commenced on 29 July 2024, and she passed away on 31 July 2024 at Salford Royal Hospital
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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. During evidence, it was heard that the deceased had elected to leave the Hospital on Friday 19 July because of waiting times, before being clinically assessed. 2. There was no consideration of whether secondary investigations could be undertaken during the waiting time for example CT scan which would likely be required by a clinician in order to make a diagnosis. 3. No evidence was provided that the deceased's capacity to decide to leave the hospital was assessed given the history of suspected head injury. 4. Reference was made to a new standard operating procedure being developed relating to patients leaving the hospital before a clinical assessment occurs, but it was unclear what this will include.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 3 January 2025. 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 [redacted] I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 8 November 2024**  **Michael James Pemberton** **His Majesty's Assistant Coroner** **Manchester (West)**