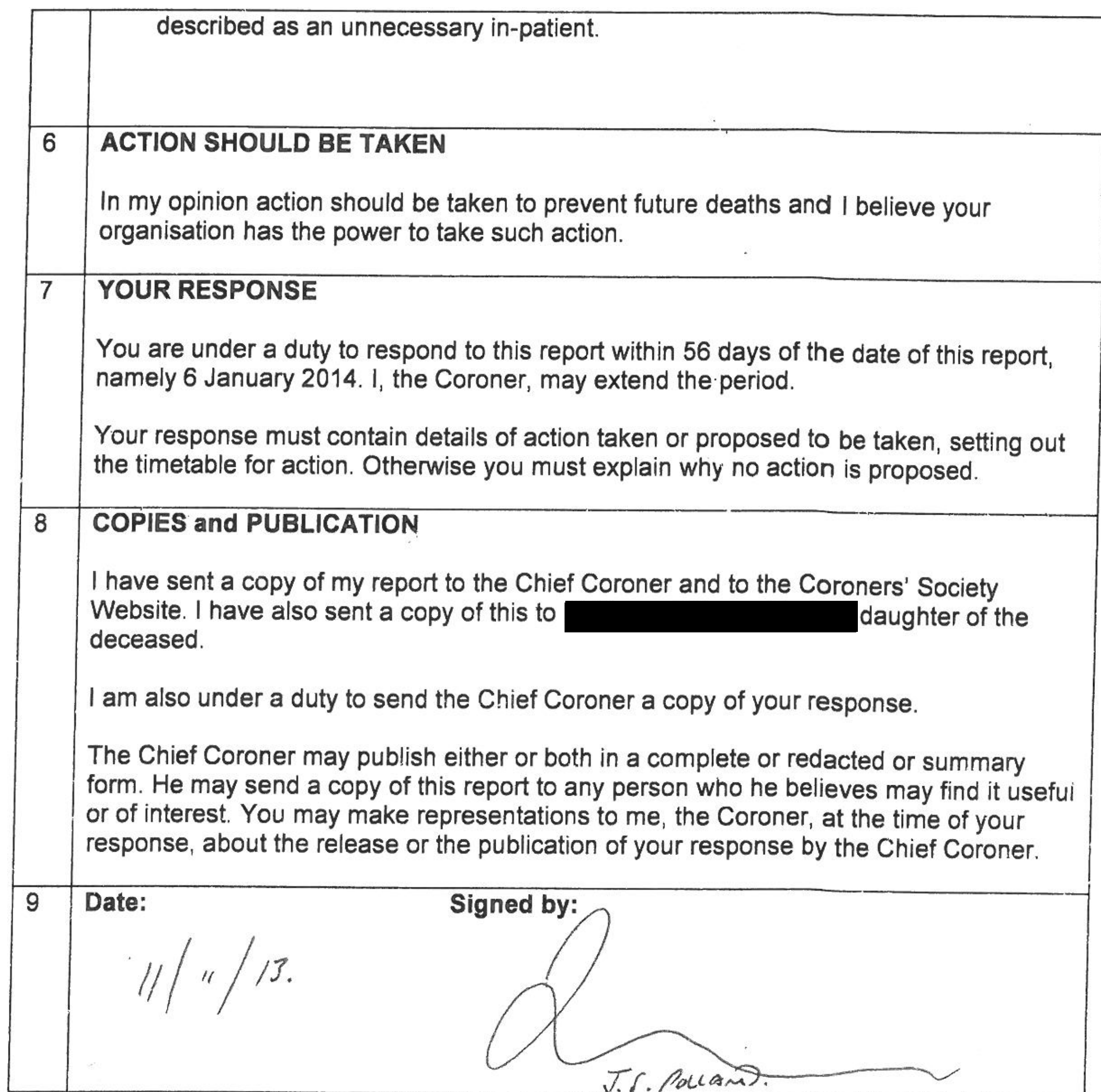
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive, Royal Bolton Hospital**
1	**CORONER** I am John Pollard, Senior Coroner for the Coroner Area of Manchester South.
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 the 19th of December 2012 an investigation was commenced into the death of William Joseph Wilkinson. The investigation concluded at the end of the Inquest on 9 September 2013. The conclusion of the Inquest was that the deceased died an accidental death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Wilkinson slipped on the pavement whilst he was out shopping on or about the 9th of December 2012 and he fractured his ankle. He was admitted to the hospital and thereafter complications occurred leading to his death.
5	**CORONER'S CONCERNS** A number of issues were raised by members of staff and others about the care at the Royal Bolton Hospital. The **MATTERS OF CONCERN** are as follows. – (1) I was told that despite one-to-one nursing being required for Mr Wilkinson and indeed being ordered, this is not always available. There was clear evidence that had such nursing standards been available Mr Wilkinson may not have developed the problems which led to his death. (2) Members of staff reported that they sometimes find it difficult if not impossible to log onto the computer system in the hospital and therefore cannot record matters as they should be recorded. This is apparently due to the inadequacies of the system rather than the inabilities of the individuals. (3) A Fluid Balance Chart was ordered to be kept and it was accepted that this was not done and an incomplete Fluid Balance Chart resulted. (4) It was agreed that there was no direct orthopaedic input available at the Emergency Department at the hospital and that it would be sensible for this to have been available. Had this been available Mr Wilkinson would probably not have been admitted to the hospital in the first place with a fractured ankle and therefore would not, presumably, have developed clostridium difficile leading to his death. He was



	described as an unnecessary in-patient.
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 6 January 2014. 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 Coroners' Society Website. I have also sent a copy of this to daughter of the deceased. 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	**Date:** 11/11/13. **Signed by:** J.S. Pollard.