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** **Arrowe Park Hospital** **Arrowe Park Road** **Upton** **Wirral** **Merseyside** **CH49 5PE**
1	**CORONER** I am André Rebello, Senior Coroner, for the area of Liverpool
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 5th March 2013 an investigation commenced into the death of **Charles Gavin BRADLEY**, Aged **73**. The investigation concluded at the end of the inquest on 3rd March 2014. The conclusion of the inquest was Ia Subdural Haematoma Accidental death
4	**CIRCUMSTANCES OF THE DEATH** On Thursday 21st February 2013, Charles Gavin Bradley fell in an unwitnessed fall in the Assessment Unit at Arrowe Park Hospital, at about 18.00, sustaining head injuries which proved fatal. He had been transferred from Leeds Teaching Hospital to Arrowe Park Hospital the same day. There had been some confusion in the Primary Care Trust in Leeds in that no wheelchair was provided for the transfer. When he arrived at Arrowe Park Hospital, in spite of a communication from the bed manager at Arrowe Park Hospital delaying his transfer for a day, to 21st February 2013, there was no bed available at Arrowe Park Hospital.
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. –

	During the investigation and inquest into Mr Bradley's death it was found that the record-keeping and communications at Arrowe Park Hospital were inadequate, ineffective making them unsafe. This was evidenced by findings that though Leeds Teaching Hospital had effective records as to the arrangements for the transfer of Mr Bradley to Arrowe Park on the 21st February 2013, when Mr Bradley arrived at Arrowe Park they were not expecting him. This is likely to have caused added worry and stress to his rehabilitation plan. It is further evidenced by the inadequate recording of his fall on the 21st February 2013. From the evidence it was unclear as to whether it was witnessed or not, was it in a bathroom and if so why was there mention of a filing cabinet near where he lay? In other cases the matters reported could result in fatalities. Documentation, recordkeeping and communications are core basic skills for all who work in healthcare. Neither the HEALTH aspect nor the CARE aspect of a health care service can be delivered without these basic skills. It would be helpful to see a cross Trust action plan with regard to the improving documentation, record-keeping and communication in the response to this report
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 12th May 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 following Interested Persons [redacted] The Chief Executive, Leeds Teaching Hospitals The Healthcare Ombudsman I have also sent it to the Coroner's Society of England and Wales, which 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	 **André Rebello** **Interim Senior Coroner for the** **Wirral Coroner Area** **Dated: 17th March 2014**