REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive Tameside NHS Foundation Trust** **Chief Executive, Tameside MBC**
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 5th April 2013 I commenced an investigation into the death of **Leslie Alfred Pates** dob 21st February 1932. The investigation concluded on the 29th January 2014 and the conclusion was that he died from Natural Causes. The medical cause of death was 1a Sepsis 1b Pressure sore 1c Immobility/stroke 2 Vascular dementia, Chronic Obstructive Pulmonary Disease, Hypertension, Stroke.
4	**CIRCUMSTANCES OF THE DEATH** On the 11th December 2012 he was admitted to Tameside General Hospital Medical Assessment Unit, later being placed on wards 42 and 43. He was eventually discharged home on the 22nd January 2013 against the wishes of his family. The Consultant heading up his care accepted that he did not see the patient prior to his discharge, that he had no grounds for saying that "the family were happy for him to go home" and that there was no reasonable analysis made by the hospital and others as to his fitness to return home. The social worker conceded that there had been no meeting with the family to discuss discharge (as should be the case), that matters "were not in place from a Social Services position" and that there had been no liaison between social services and the District Nurse teams. On the 27th January 2013 he had to be transferred from his home to a Nursing Home and by the 17th February 2013 his condition was so bad that he was re-admitted to Tameside General Hospital by 999 ambulance. A doctor at the hospital supplied an MCCD to the coroner which gave the cause of death on the 2nd April 2013 as sepsis when I heard evidence from the consultant chest physician that he found the patient on the morning of the 2nd April 2013 to be apyrexial with clean pressure sore.
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.There has been a complete breakdown in effective communication between the hospital and the family of the deceased. 2. Neither the hospital staff nor the social services staff took any, or any proper, account of the wishes and views of the family prior to the discharge home of the patient. 3. The patient who was aged 80 years was sent home with severe pressure sores and without the facility of a pressure relieving mattress. 4. Tameside Social Services failed completely or adequately to consider the views of the family of the deceased before determining and bringing into effect a plan for his discharge. 5. The required "meeting" between Social Services and the family prior to discharge from hospital, simply never took place.
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. It is essential that full information is passed promptly to the GP practice of a patient being discharged.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 30th March 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 namely [redacted] 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	**30 January 2014** **John Pollard, HM Senior Coroner**