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, South Tees NHS Trust
1	CORONER I am Anthony Gerard Eastwood, area coroner, for the coroner area of Teesside
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 13 December 2010 I commenced an investigation into the death of Noel Williams aged 88 years of age. The investigation concluded at the end of the inquest on 9 October 2013. The conclusion of the inquest was Noel Williams died as the result of an accident.
4	CIRCUMSTANCES OF THE DEATH At or about 08.00 hours on 2 December 2010 at Norlands, Church Lane, Ormesby the deceased fell and sustained a fracture of the neck of the right femur which despite surgical repair led to her death.
5	<u>CORONER'S CONCERNS</u> 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 course of the evidence given in this Inquest evidence was received that there had been a failure of communication in communicating the results of haemoglobin level tests. It was further revealed by the evidence that the haemoglobin level was an important factor in considering a patient's fitness for surgery. The evidence further revealed that had the information concerning the most recent haemoglobin tests carried out on the deceased passed the surgery <u>may</u> have been delayed or alternative treatment plans put in place. Whilst the evidence did also indicate that there were risks in delaying surgery there nonetheless had been an admitted failure to communicate the results of recent haemoglobin tests to the anaesthetist and surgeon performing the index surgery. Clearly if the results of a haemoglobin test are an essential part of the assessment of fitness for surgery then the ability to communicate the most recent tests indicates a potential failure which could cause or contribute to future deaths.

6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe your organisation had 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 10 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 ~~[NAMES]~~ 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	13 March 2014 [SIGNED BY CORONER]