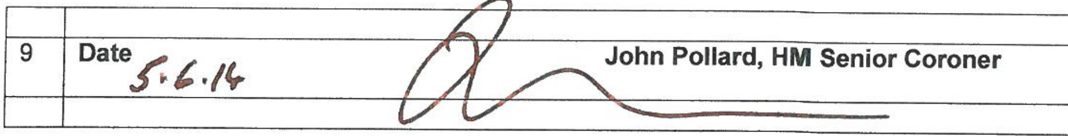
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive, Central Manchester University Hospitals NHS Foundation Trust**
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 **21st February 2014** I commenced an investigation into the death of **THOMAS PATRICK MAHER dob 5th March 1928**. The investigation concluded on the **4th June 2014** and the conclusion was one of **ACCIDENTAL DEATH**. The medical cause of death was **1a Chest Sepsis 1b Hospital Acquired Pneumonia 1c Left Acetabulum fracture of the hip 11 Alzheimer's Disease, old age, atrial fibrillation, chronic anaemia and CVA.**
4	**CIRCUMSTANCES OF THE DEATH** **On the 3rd of February 2014 whilst he was a patient at Trafford General Hospital, Mr Maher fell whilst on the ward and inter alia he fractured his acetabulum.**
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. **All the nursing notes, observation charts and pressure ulcer charts for the period 20th December 2013 to 29th January 2014 are missing, and despite a widespread search by the hospital, it has proved impossible to locate them. This had the effect of hampering the High Level Investigation and potentially the inquest itself.** 2. **On a number of occasions during his stay in the hospital, the falls risk assessment and the bed rails assessment were not updated per policy.** 3. **As a result of his perceived propensity to fall and to get out of bed, Mr Maher had a TAB alarm attached. It subsequently transpired that when he fell and broke his pelvis, this alarm had been removed and placed on his bed. If this were removed by a member of staff, then this would indicate a potentially negligent act; if removed by the patient then surely the alarm should activate to show that it is no longer offering protection.** 4. **On or around the 3rd February, a discussion took place between the**

	treating doctor at Trafford and an orthopaedic specialist at MRI, during which it was agreed that a bed was available at MRI and that Mr Maher would be transferred. The ambulance was ordered to transport him and Mr Maher was taken and placed in the vehicle. In fact it then transpired that there was no bed available so he had to be taken from the vehicle and returned to the ward at Trafford General. **In the course of his evidence to me, the consultant Physician stated "we have major problems getting patients transferred to MRI and other hospitals, we frequently have to wait 3 or 4 days for transfer of a patient who should have gone immediately". He then went on to state that in his opinion the ability to transfer patients between divisions of the same trust should be 'second to none' and in fact it is less than adequate.** **5. On returning to the ward the doctors had prescribed oral morphine but the nursing staff were not trained/confident in giving this so the prescription had to be altered to oral morphine.** **6. On the 5th February 2014 [redacted], elderly care consultant, read Mr Maher's notes and said that the complex discharge ward was not the appropriate place for Mr Maher to be and that he should be transferred to a medical or orthopaedic ward. Why was he on the inappropriate ward in the first place?** **7. After he sustained the fall in hospital, there was a delay of almost four hours before his next of kin was informed.** **8. There is an apparent major problem with regard to patient notes where those at MRI are 'paper based' whereas those at Trafford are electronic. I was told that it will be at least two years before this situation is reconciled. This is inherently dangerous in that the treating doctors may not have the up to date notes available to them. Both senior doctors who gave evidence to me described the system of transfer of notes between hospitals as "impossible".**
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **1st August 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	Date 5.6.14	John Pollard, HM Senior Coroner