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.** Sir David Dalton, Chief Executive, Salford Royal Foundation Trust
1	**CORONER** I am M Jennifer Leeming, HM Senior Coroner , for the Coroner Area of Manchester West
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 26th February 2014 I commenced an investigation into the death of Martin Leslie Dean, aged 42 years. The investigation concluded at the end of the inquest on 9th September 2014. The conclusion of the inquest was that Martin Leslie Dean died as a consequence of a naturally occurring intracerebral haemorrhage together with a complication of necessary treatment for that condition.
4	**CIRCUMSTANCES OF THE DEATH** On the 13th December 2013 Martin Leslie Dean suffered an intracerebral haemorrhage at his home address, [redacted] Timperley, Altrincham, following which he was transferred to Salford Royal Hospital where a shunt and a feeding tube were inserted.
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 Inquest evidence was given that a number of visitors to the Critical Care Ward where Martin Leslie Dean was a patient were not washing their hands on entering the ward. Further evidence stated that the most effective single precaution that could be taken to prevent infection was hand washing. The evidence continued by revealing that it would be possible to station volunteers at the entrances to wards particularly at the entrances to Critical

	Care Wards where patients might be especially susceptible to infection in order to ensure that visitors did not enter the wards without washing their hands. As volunteers could be used for this function, it was stated that it would be a precaution that could be achieved at little or no cost.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 17th November 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] – Wife of deceased [redacted] – Parents 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	**Dated** **22nd September 2014**	**Signed** **M Jennifer Leeming**