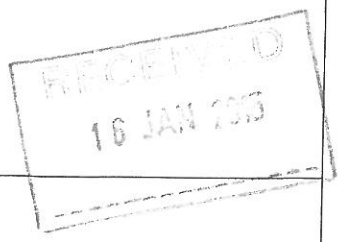
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Bamford Grange Nursing Home 
1	**CORONER** I am Christopher Murray, Assistant Coroner, for the Coroner Area of Manchester South.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 27 June 2014 I commenced an investigation into the death of George Hulme date of birth 3rd March 1926. The investigation concluded at the end of the Inquest on 2nd December 2014. The conclusion was that the deceased died as a result of natural causes.
4	**CIRCUMSTANCES OF THE DEATH** On 25th June 2014 Mr Hulme was assaulted by a fellow resident at Bamford Grange Nursing Home. He subsequently collapsed and required CPR. Ambulance staff from North West Ambulance Service attended the scene and requested the file relating to the injured person. The injured person was incorrectly identified and the wrong file was retrieved for another resident with a DNR in place. CPR subsequently ceased on the basis of the information on file.
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) Agency members of staff on duty did not have any information to assist with the identification of residents. Whilst a system of key cards is supposed to operate within the home, the agency staff on duty had no such card to identify residents.

	2) Agency members of staff are supposed to have an induction and tour of the home upon their first visit. This did not take place adequately to sufficiently familiarise the staff with the residents or any method of correctly identifying residents. **3)** An incorrect file was retrieved resulting in potentially inappropriate treatment of an unconscious resident. **4)** The residents' rooms are not clearly marked internally or externally to denote who resides in the room giving rise to confusion over identification in the event of emergency treatment being required by an unconscious resident attended to by staff or medical practitioners not familiar with their identity.
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 12th March 2015. 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 Mr Hulme and Stockport Environmental Health Offices. 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	**8 January 2015** [redacted] **Christopher Murray** **HM Assistant Coroner**