REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive Officer, Peaks and Plains Housing Trust, Macclesfield.**
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 6th February 2015 I commenced an investigation into the death of **Kathleen Eaton** dob 18th December 1929. The investigation concluded on the 19th June 2015 and the conclusion was one of **Accidental death**. The medical cause of death was 1a Subdural and Subarachnoid Haemorrhage 1b Recurrent Falls 11. Congestive heart failure vertebra-basilar insufficiency
4	**CIRCUMSTANCES OF THE DEATH:** **On the 26th January 2015 she fell in the bedroom of her home. She called her emergency carers by use of her alarm. The carer attended , used a blow-up 'hoist' (ELK) to raise her into a position where she could be put back to bed. The carer carried out peremptory checks and then left the deceased to await the arrival of her regular carers who were expected some two hours later. She was later taken to hospital where she was found to have suffered damage to and around her brain.**
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. The emergency trust link officer employed by Peaks and Plains conceded that she had no formal training in assessing medical issues. In her statement she had said "I am fully first aid trained" yet in evidence it emerged that she had received this training after the date of this death. It would also appear that her earlier First Aid certificate may well have expired 2. She stated that she was unaware of any set policies or procedures in place for assessing and dealing with head injury cases. There was nothing in writing advising as to when it is appropriate and/or necessary to summon an ambulance. 3. The property where the deceased was resident is situated in Disley and I was told it is approximately 15 miles from the base in Macclesfield. I was also told that the officer was able to travel there in 20 minutes in what she had already

	told me were snowy conditions. I find this hard to believe and wonder whether an adequate service can ever be provided at that geographical distance.
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 by17th August 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] (son 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	**22nd June 2015** **John Pollard, HM Senior Coroner**