REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Nurse, Pennine Acute Hospitals NHS Trust
1	**CORONER** I am Ms L J Hashmi, Area Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 23rd January 2015 I commenced an investigation into the death of **Joyce Hartford**
4	**CIRCUMSTANCES OF DEATH** The deceased was a frail lady with a number of pre-existing co-morbidities. She suffered a fall at her place of residence which resulted in a fracture, necessitating operations to repair this. Unfortunately the deceased's overall health continued to deteriorate and she died on the 23rd January 2015 at her home address. A (non-invasive) post mortem medical examination took place and the medical cause of death was given as: 1a) Pneumonia 2) Right neck of femur osteoporotic fracture (operated), Caecal carcinoma
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. During the course of the inquest hearing it became apparent that the nursing tools (in particular, the 'Purpose T'), assessments, records, associated documentation and nursing discharge summary were incomplete and/or inaccurate. Whilst I was told that the Trust, to its credit, had been conducting audits since the Summer of 2014 in order to improve nurse record keeping, Mrs Hartford died in January 2015 and the evidence at inquest did not disclose any material improvement in overall standards. As this was not the first case over which I had presided that involved concerns arising from record keeping that fell below expectation (over and above the aforementioned) I

	considered that I was under an obligation to bring this to your attention.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 **the 9th September 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:- - The family of the deceased - The Chief Executive Pennine Acute Hospitals NHS Trust - Nursing & Midwifery Council (for information only) - Pennine Care Trust 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 from. 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: 15th July 2015 Signed: [redacted]