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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Tameside Hospital NHS Foundation Trust: Secretary of State for Health:**
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 14th May 2015 I commenced an investigation into the death of Hilda Haughton dob 23rd June 1921.The investigation concluded on the 26th October 2015 and the conclusion was one of **Accidental Death**. The medical cause of death was1a Peritonitis, acute subdural haematoma, bronchopneumonia 11 Perforated duodenal ulcer, chronic obstructive pulmonary disease.
4	**CIRCUMSTANCES OF THE DEATH** **On the 26th April 2015 she was admitted to Tameside General Hospital with a diagnosis of pneumonia and acute exacerbation of her COPD. Two days later a fire door was inadvertently electronically released during a momentary power failure due to a thunder storm, and the door struck her, knocking/pushing her to the floor where she sustained serious head injuries.**
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. **Mrs Haughton having sustained the head injury on the 28th April, some 7 days later she was able to fall out of her bed because the cot sides had not been raised as they should have been, and there was a lack of candour by the hospital staff, and this , inter alia, deprived the family of the possibility of seeking a second opinion as to her injuries.(Tameside)** 2. **The fire-doors are held open by electro-magnets. These are designed to be released remotely to contain any fire which may break out in the hospital. I was told that this type of door fastener is common to very many hospital wards around the U.K. The length of time it takes for the doors to close affects the speed and power with which they move. This time has been increased at Tameside hospital from 3 seconds to 6 seconds. Is this an adequate response and should this issue be raised with all hospitals having these door fasteners? (Secretary of State)**

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 **29th December 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 representing her family) and to the British Standards Institute (Who I am told set the standards for the type of door in question). I have also sent it to **the Care Quality Commission** who may find it useful or of interest. 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	**29.10.15** **John Pollard, HM Senior Coroner**