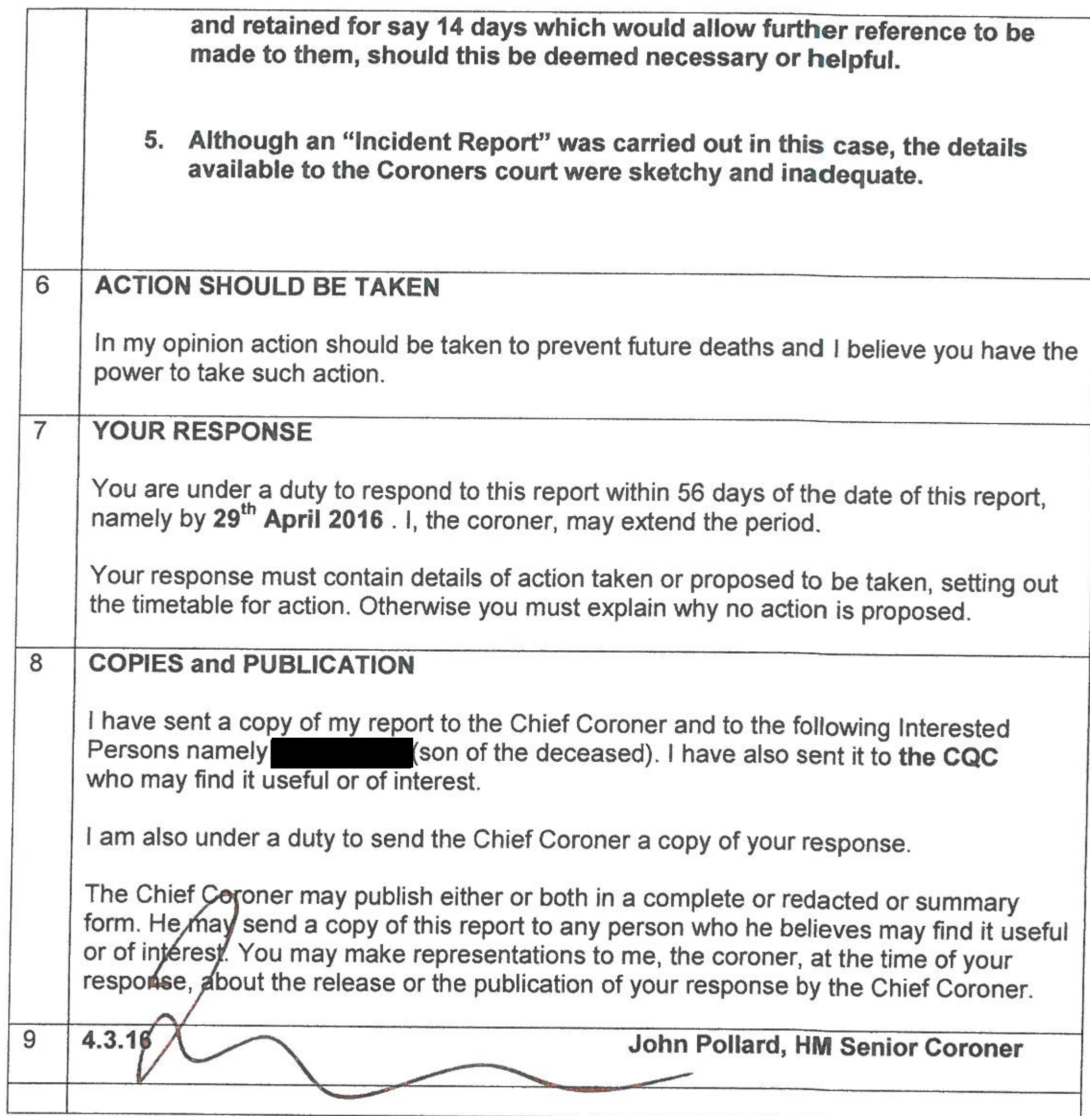
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive, Tameside Hospital NHS Foundation Trust**
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 23rd September 2015 I commenced an investigation into the death of **Ranjan Raman Mistry** dob 11th March 1947. The investigation concluded on the 2nd February 2016 and the conclusion was one of **Accidental Death**. The medical cause of death was 1a Subdural Haemorrhage 11. Chronic hyponatraemia, Type 2 diabetes mellitus, Ischaemic Heart disease and Chronic kidney disease.
4	**CIRCUMSTANCES OF THE DEATH** **Ms Mistry was admitted to the hospital with low sodium levels and high blood pressure. Whilst in hospital she fell on three separate occasions and in one of these falls she sustained injury to her head which led to the bleed which proved fatal on the 21st September 2015.**
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 evidence showed that there was no, or no sufficient, assessment of her Falls Risk.** 2. **The Neurological observation charts were either never completed or had been lost from the notes.** 3. **There was clear evidence that the medical staff were not reading (or even looking at) the nursing notes, and the nurses were similarly not looking at the medical entries.** 4. **The hand-over sheets for each shift were being shredded by the nurses as soon as the shift was completed. Whilst it is appreciated that these cannot be placed on the record of an individual patient for reasons of confidentiality, there is no reason why they could not be filed on the wards**



	and retained for say 14 days which would allow further reference to be made to them, should this be deemed necessary or helpful. 5. **Although an "Incident Report" was carried out in this case, the details available to the Coroners court were sketchy and inadequate.**
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 April 2016** . 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 █████ (son of the deceased). I have also sent it to **the CQC** 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	**4.3.16** **John Pollard, HM Senior Coroner**