## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: The Chief Executive Tameside Metropolitan Borough Council, The Chief Executive Tameside General Hospital.** |
| 1 | **CORONER**<br><br>I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 9TH December 2016 I commenced an investigation into the death of Derrick Lawrence Brocklehurst .The investigation concluded on the 17th May 2017 and the conclusion was one of:<br><br>**Narrative: Died from a recognised complication of immobility the reasons for which are unclear.**<br><br>**The medical cause of death was: 1a) Pulmonary Embolus; 1b) Deep Vein Thrombosis; 1c) Immobility ;II Cerebrovascular Disease, Ischaemic Heart Disease, Pressure Ulcers** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>**On the 14th October 2016 Derrick Brocklehurst was admitted to Tameside General Hospital via ambulance. NWAS raised safeguarding concerns. At A&E he was examined and discharged home. A social care package was in place. On the 16th November 2016 Mr Brocklehurst and his wife met social services at their home address. They stopped all social care. They were considered to have capacity. Social care stopped subsequently. On the 28th November 2016 NWAS were called to the address. Derrick Brocklehurst was found in his chair incontinent. There was faeces and urine covering the chair. He indicated he had been immobile since his return from hospital. He was admitted to Tameside General Hospital. He had a grade 4 pressure ulcer to his sacrum and his left heel. He was given anti coagulation therapy. On the 2nd December 2016 he died from a pulmonary embolus.** |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br>1. There was no documentation available of the carer visits. The care provided and any issues with the provision of care could not be established. They were not recovered by Social Services when care stopped. There was no system for recovery of care notes when care ceased.<br>2. No discharge summary was provided by Tameside General Hospital to the GP after the deceased was seen in A and E. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 31st July 2017. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely [redacted], wife of the deceased, who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **Alison Mutch**<br>**HM Senior Coroner**<br>**5th June 2017** |