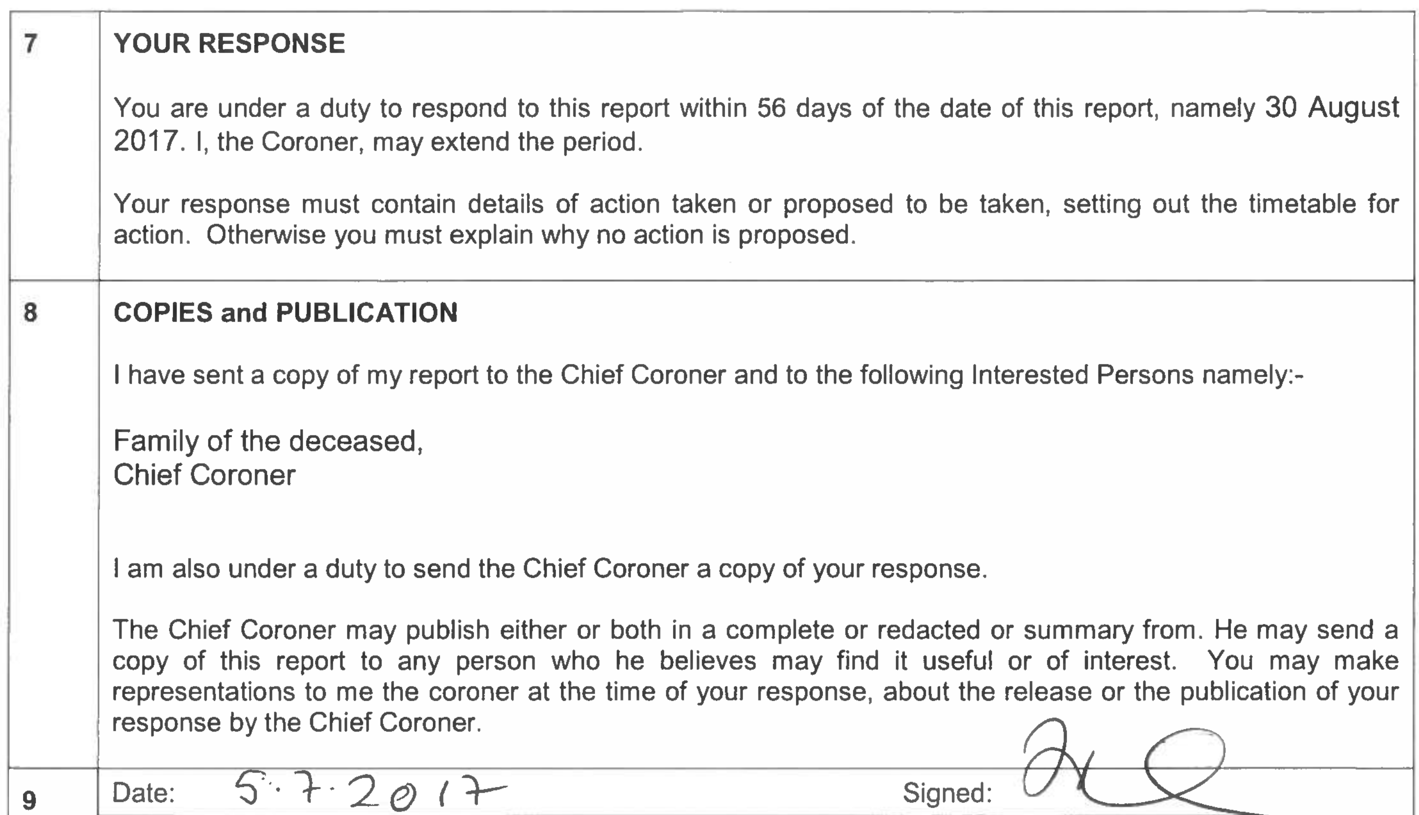
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive of Pennine Acute NHS Trust
1	**CORONER** I am Julie Robertson, Assistant 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 1 June 2016 I commenced an investigation into the death of **Patricia Norfolk**. An inquest was held and concluded on 8 March 2017.
4	**CIRCUMSTANCES OF DEATH** The deceased was admitted to Royal Oldham Hospital on 13 May 2016 following discovery of a fractured neck of femur. The deceased had 2 unwitnessed falls in March 2016 and she attended Royal Oldham Hospital on 18 March 2016. However, the fracture was not discovered until 2 months later in the absence of X-ray investigation on presentation to Royal Oldham Hospital in March 2016. The deceased developed an infection following surgery and she continued to deteriorate despite appropriate medical intervention. She died from bronchopneumonia following discharge from the hospital to Braeside Care Home. Fact of death was confirmed at 20:30 pm on 27 May 2016 My conclusion at inquest was that the deceased died from a recognised complication of necessary medical intervention.
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:- That patients, such as the deceased, were not being receiving a daily senior clinician review. I have been appraised of the developments that the Trust is aspiring to in relation to senior daily reviews and decision making and recognise the steps the Trust is taking to recruit appropriate staff to undertake such reviews. However, I remain concerned regarding what happens to patients in the interim period pending recruitment and appointment.
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 30 August 2017. 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:- Family of the deceased, Chief Coroner 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: 5.7.2017 Signed: