REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Elizabeth House (Oldham) Limited, 35 Queens Road, Oldham, OL8 2AX
1	**CORONER** I am Catherine McKenna, 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 28 November 2017 I commenced an investigation into the death of Thomas Allan Ratchford. The inquest concluded on 26 April 2018. The medical cause of death was 1a) Sepsis 1b) Osteomyelitis 1c) Infected sacral pressure sore 2) Type 2 Diabetes, Chronic Obstructive Pulmonary Disease, Parkinsons Disease Dementia and Immobility I recorded the following Narrative Conclusion: "Against a background of long-term immobility and a number of co-morbidities, the Deceased died as a result of an injury sustained during respite care and contributed to by inappropriate use of a hoist for pressure relief."
4	**CIRCUMSTANCES OF DEATH** Mr Ratchford had a number of medical conditions including Parkinsons Disease Dementia which meant that he had been immobile for 6 years before his death. For most of that time he had been cared for at home by his wife with the support of carers and District Nurses. On 4 October 2017, he was admitted to Marland Court Residential Home for a period of respite care. During the admission, he developed a deep tissue injury which extended from his sacrum, around his rectal area, to his inner thighs. The carers at Marland Court Residential had been using the hoist to elevate Mr Ratchford from his seat in the mistaken belief that this would provide pressure relief. It is more likely than not that this practice contributed to his death.
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:- The use of the hoist to provide pressure relief is not one that was either recognised or recommended by the Tissue Viability Nurse who gave evidence at the inquest. It was a practice that had been adopted by the carers at Marland Court Residential Home without obtaining advice

	from either the hoist manufacturers or the District Nurses. Had advice been taken, the carers would have been informed that it was not recommended. The matter of concern that neither the Home Manager or the carers had received sufficient training in moving and handling and pressure relief.
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 **6th July 2018**. I, the Assistant 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] • Care Quality Commission • Adult Social Care, Rochdale Borough Council • Pennine Acute 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 usefulor 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: 11 May 2018 Signed: