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| | <p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1) Chief Executive, Haywood Hospital, Stoke-on-Trent 2) NHS England</p> |
| 1 | <p>CORONER</p> <p>I am Emma Serrano Area Coroner for Stoke-on-Trent & North Staffordshire Coroner's Court</p> |
| 2 | <p>CORONER'S LEGAL POWERS</p> <p>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.</p> <p>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</p> |
| 3 | <p>INVESTIGATION and INQUEST</p> <p>On 04/03/2021 I commenced an investigation into the death of Harold Blackshaw, aged 72. The investigation concluded at the end of the inquest on 6th August 2021.</p> <p>The conclusion of the inquest was Harold Blackshaw, who passed away on the 1 March 2021, at Trentham House Nursing Home, Chivelstone Grove, Trentham, Stoke-on-Trent, from COVID-19 had a past medical history of falls and Parkinson's disease. On the 12 December 2020 he fell at his home address and sustained a right fractured neck of femur. He was admitted to the Royal Stoke University Hospital, Stoke-on-Trent and received a hemiarthroplasty. His hip dislocated once on the 5 January 2021 after he fell at a care home and once on the 17 January 2021 after he fell at the Haywood Hospital, Stoke-on-Trent. There was an opportunity to do a full falls risk assessment on his admission. This was not done. After both dislocations he required further surgery. After the final surgery he was discharged on the 27 January 2021 to Golden Gate Care Home. He contracted COVID 19 whilst resident here. He was further admitted to the Royal Stoke University Hospital on the 19 February 2021 after his health deteriorated. He was discharged to Trentham House Nursing Home for palliative care where he passed away on the 1 March 2021.</p> <p>The medical cause of death was found to be</p> <p>1a) Covid 19. II) Fractured neck of femur, Parkinson's Disease, rheumatoid arthritis, chronic obstructive pulmonary disease.</p> |
| 4 | <p>CIRCUMSTANCES OF THE DEATH</p> <p>Harold Blackshaw, who passed away on the 1 March 2021, at Trentham House Nursing Home, Chivelstone Grove, Trentham, Stoke-on-Trent, from COVID-19 had a past medical history of falls and Parkinson's disease. On the 12 December 2020 he fell at his home address and sustained a right fractured neck of femur. He was admitted to the Royal Stoke University Hospital, Stoke-on-Trent and received a hemiarthroplasty. His hip dislocated once on the 5 January 2021 after he fell at a care home and once on the 17 January 2021 after he fell at the Haywood Hospital, Stoke-on-Trent. There was an opportunity to do a full falls risk assessment on his admission. This was not done. After both dislocations he required further surgery. After the final surgery he was discharged on the 27 January 2021 to Golden Gate Care Home. He contracted COVID 19 whilst resident here. He was further admitted to the Royal Stoke University Hospital on the 19 February 2021 after his health deteriorated. He was discharged to Trentham House Nursing Home for palliative care where he passed away on the 1 March 2021.</p> |
| 5 | <p>CORONER'S CONCERNS</p> |

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| | <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>During the course of the inquest evidence was given regarding the admission process for patients admitted to the Haywood Hospital. Specifically the rehabilitation ward which Mr Blackshaw was admitted to (“Grange Ward”). It was heard that this ward was primarily for the rehabilitation of elderly patients that were recovering from injuries; some after falls. Some patients were high risk of falls. The evidence given suggested that there was no admission process which assessed the needs of each patient and what measures should be put in place to meet their needs, before they came to the ward, or when they were on the ward. This gives me concern that a future death could result.</p> |
| 6 | <p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you the Haywood Hospital and NHS England and/or your organisation have the power to take such action.</p> |
| 7 | <p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 29th October 2021. I, the coroner, may extend the period.</p> <p>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.</p> |
| 8 | <p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <ol style="list-style-type: none"> 1. The family of Mr Blackshaw 2. Trentham House Care Home; 3. Golden Hill Nursing Home; 4. University Hospital of North Midlands 5. NG Healthcare. <p>I am also under a duty to send the Chief Coroner a copy of your response and all interested persons who in my opinion should receive it.</p> <p>I may also send a copy of your response to any other person who I believe may find it useful or of interest.</p> <p>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.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p> |
| 9 | <p>02/09/2021</p> <p>Signature: </p> <p>Emma Serrano Area Coroner Stoke-on-Trent & North Staffordshire Coroner's Court</p> |