REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive, Stepping Hill Hospital**
1	**CORONER** I am Joanne Kearsley, Area 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 the 9th October 2013 I commenced an investigation into the death of Laura Hill date of birth 13.09.1936. The investigation was concluded at the end of the Inquest on the 5th February 2014. The conclusion of the Inquest was that the deceased had died as a result of 1a) Pneumonia 2) Chronic Obstructive Pulmonary Disease, Ascending Cholangititis, dislocated left hip replacement requiring manipulation, Vascular Dementia, Rheumatoid Arthritis and immunosuppression treatment. I returned a conclusion that she had died as a result of natural causes.
4	**CIRCUMSTANCES OF THE DEATH:** On the 28th September 2013 the deceased presented to Stepping Hill Hospital with acute abdominal pain and sepsis due to cholangitis. She had an extensive complex medical history. She was admitted for treatment initially to the Surgical Assessment Unit. She was initially treated with antibiotics and was not considered fit enough to undergo MRCP procedure. On the 1st October the deceased was transferred to ward B6. At 03.50am on the 2nd October the deceased was seen to fall from her bed, as a result she sustained a fracture to her left hip. This required manipulation and needed several attempts before this was successful. The deceased continued to deteriorate and died on the 8th October 2013. The death was initially reported to the Coroner's Office with a cause of death offered as 1a) Pneumonia and 1b) Manipulation under anaesthesia for displacement of left total hip replacement. At the inquest I heard evidence that the pneumonia was on balance due to her admitting condition and a number of co-morbidities. However I also heard evidence that on her admission to hospital no Falls Risk Assessment was carried out, that she was transferred between wards at 01.30am and that on arrival on Ward B6 where she had her fall there was again no Falls Risk Assessment carried out. It was noted that the deceased would in all likelihood have been assessed as requiring cot sides (albeit that does not prevent someone falling) and identified as at high risk of falls.

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. Despite training being in existence in relation to the carrying out of Falls Risk Assessments there was a missed opportunity throughout the time Mrs Hill was in hospital for this to be carried out. There was no assessment on her admission to Ward C3 nor when she was transferred to Ward B6.
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 14th April 2014. 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 [redacted] son of the deceased, and to the Coroners' Society Website. 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	**17th January 2014** **Joanne Kearsley, HM Area Coroner**