ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Owen Williams, Chief Executive, Calderdale and Huddersfield NHS Foundation Trust** **2.** [redacted] **3.**
1	**CORONER** I am MARY BURKE, Assistant Coroner for the coroner area of WestYorkshire (Western)
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 30 July 2013 I commenced an investigation into the death of Jeanne Elsie Summers, aged 78 years. The investigation concluded at the end of the inquest on 3rd and 4th March 2015. At the conclusion of the inquest the medical cause of death was established as 1(a) Bronchopneumonia and 11. Immobility due to fracture of right ankle (operated) and Chronic Obstructive Pulmonary Disease and the narrative conclusion was*: "On 14 July 2013, whilst a patient at Huddersfield Royal Infirmary, Jeanne Elsie Summers suffered an unwitnessed fall which it is likely could have been prevented. As a result she suffered a fracture to her right ankle which required surgery, following which she had a period of worsening immobility which is likely to have contributed to the development of bronchopneumonia which led to her death on 24 July 2013."*
4	**CIRCUMSTANCES OF THE DEATH** On the 29th June 2013 Mrs. Summers was admitted to Huddersfield Royal Infirmary with an exacerbation of her Chronic Obstructive Pulmonary Disease, together with infection. Mrs Summers was commenced on intravenous antibiotic medication and began to show signs of improvement. By the 6th July 2013 she was thought well enough to be discharged home, although there appears to have been no assessment of Mrs. Summers' mobility levels at the time of discharge. The following day, the 7th July 2013, Mrs. Summers was readmitted as she was unable to mobilise at home and was unable to get out of bed. Following further admission on the 7th July she was queried to be suffering from pneumonia and/or a urinary tract infection and she once again commenced intravenous antibiotics. She subsequently showed signs of slow but gradual improvement. Shortly after midnight on the 14th July 2013 she was using a zimmer frame to mobilise to the toilet, supervised by members of staff. Following arrival at the toilet she suffered an unwitnessed fall in the toilet cubicle. As result she suffered an open fracture to her right

	ankle, which required surgical intervention. Mrs. Summers subsequently developed pneumonia, which was treated with antibiotic medication. Unfortunately Mrs. Summers did not respond. Her condition continued to deteriorate and her death was confirmed at 0250 hours on the 24th July 2013 on Ward 5 at Huddersfield Royal Infirmary.
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. – **(1)** The assessment review of Mrs. Summers' ability prior to her discharge on the 6th July 2013. There is no clear indication that an assessment had been undertaken prior to Mrs. Summers' discharge on the 6th July 2013. Her condition was such that she required further readmission on the 7th July 2013. **(2)** During the further readmission on the 7th July 2013 Mrs. Summers was reviewed on a number of occasions by a physiotherapist. At the inquest [redacted] Clinical Lead Physiotherapist, provided evidence and indicated that the physiotherapy written records did not provide a full record of all relevant details. These notes are reviewed by nursing staff in order to ensure the patient's safe mobilisation and the preparation of appropriate care plans. I would ask you to consider that additional training and/or direction should be given to the Physiotherapy Department in order to ensure that a full record of all relevant details are made within patients' records. **(3)** From the evidence presented at the inquest it appears that at the time when Mrs. Summers was mobilising in the early hours of the 14th July 2013 she was wearing her own "fluffy socks". These were not slipper socks. She was clearly not wearing slippers at the time. In addition the health care assistant who was supervising Mrs Summers did not ensure that Mrs. Summers was seated on the toilet within the toilet cubicle before he left her. I would request you to consider training and guidance to nursing staff to ensure that, firstly, patients are wearing appropriate footwear prior to mobilisation and, secondly, to provide training guidance to staff of safe systems of transfer to ensure that patients are not left whilst in the process of transfer. **(4)** At the inquest Matron [redacted] gave evidence in respect of an investigation which she undertook in respect of the circumstances surrounding Mrs. Summers' fall. Matron [redacted] indicated in her evidence that she had not received full training with regard to undertaking an investigation and preparing an investigative report. Although in her report she stated that one of the objectives was to consider if the fall could have been prevented, that question was not addressed in her report. When questioned by me she confirmed in evidence that the socks which Mrs. Summers was wearing at the time of her fall and the fact that she was left before she had effectively safely transferred on to the toilet are likely to have been factors which would have caused, or significantly contributed to Mrs. Summers' fall. Neither of these points were identified in the report. I would request that in future all investigators receive the appropriate training to enable them to undertake a full and appropriate investigation.
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. 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: [redacted] who may find it useful or of interest. 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	**16th April 2015** **M. T. Burke, Assistant Coroner**