	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mrs Ann Barnes, Chief Executive Officer, Stepping Hill Hospital, Poplar Grove, Stockport SK2 7JE**
1	**CORONER** Andrew Bridgman, Assistant Coroner for **Manchester South**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 18/05/2016 I commenced an investigation into the death of Maureen Patricia FLYNN. The investigation concluded at the end of the inquest 23rd August 2016. Medical Cause of Death Ia **Pneumonia** b **Left neck of femur fracture (operated)** II **Merkels cell carcinoma, Dementia** How, when and where ..... Mrs Flynn was admitted to Stepping Hill Hospital on 30th March 2016 with a UTI and an INR of 18.8, for which she received appropriate treatment, and from which she was expected to recover. On the morning of 3rd April 2016 Mrs Flynn suffered a fall from her bedside chair causing a fracture to her left hip which was operated on 5th April 2016. Very soon after surgery Mrs Flynn deteriorated and developed a chest infection which did not respond to antibiotics and she died on 7th May 2016. Conclusion Accidental death
4	**CIRCUMSTANCES OF THE DEATH** Following admission to the AMU, through A&E, Mrs Flynn was transferred to Ward E2 at 05.00hrs on 01.04.16. A falls risk assessment was started but not completed as Mrs Flynn was not alert and in effect bed bound. There was no assessment of Mrs Flynn's ability to mobilise herself in and out of her bed or her bedside chair, nor an assessment of her steadiness. Mrs Flynn remained in bed throughout 01.04 and 02.04. No further assessment was carried out. Over her bed there were signs signifying that she was a dementia patient and a high falls risk. On the morning of 03.04 Mrs Flynn was assisted with her breakfast by an HCA while she remained in bed. Mrs Flynn then asked the HCA to sit her on the bedside chair. This the HCA did but without knowing that the falls risk assessment had not been completed, in particular with regard to this transfer and Mrs Flynn's capabilities and safety while seated in a chair. Mrs Flynn was left alone and discovered soon after on the floor, but sadly she had fractured her hip resulting in her death.
5	**CORONER'S CONCERNS**

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	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 evidence at the Inquest suggested that if, from the falls risk assessment, there were concerns as to Mrs Flynn's mobilising in and out bed and/or in and out of her chair and her stability then these would have been highlighted in the nursing notes/care plan and discussed at any handover. However, as the assessment had not been completed out no-one knew, least of all the HCA. It is of concern to me that those caring for a patient were ignorant of the fact that Mrs Flynn's falls risk assessment had not been completed. It is clear that the HCA was unaware. It is reasonable for staff, in my view, to assume that all assessments have been appropriately carried out and completed. Why would the HCA have thought otherwise given the high falls risk sign above Mrs Flynn's bed? It would seem eminently sensible to adopt a system whereby staff are alerted to the fact that a falls risk assessment has not been completed. My concern extends to any other assessment required for a patient's safety and well-being. I am further concerned that the Patient Safety Investigation did not identify that fact that the falls risk assessment had not been completed.

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 28.10.16. 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] the deceased's daughter 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	26/08/2016 Signature________________________ Andrew Bridgman Assistant Coroner **Manchester South**