REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Louise Robson, Chief Executive, Stockport NHS Foundation Trust**
1	**CORONER** I am Jason Wells, Assistant Coroner for the Coroner Area of Greater 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 29th April 2019 an investigation was commenced into the death of DAVID CRAIG KERR (dob 06.12.33). The investigation concluded at the end of the inquest on 16th October 2019. **The conclusion of the inquest was accidental death.** The medical cause of death was: **1 a) Respiratory failure** **1 b) Extensive idiopathic pulmonary fibrosis** **II) Fractured neck of femur (operated), Ischaemic heart disease, Chronic obstructive pulmonary disease.**
4	**CIRCUMSTANCES OF THE DEATH** (1) David Kerr (DK) had an extensive past medical history, including COPD and pulmonary fibrosis for which he received home oxygen. (2) On 15th April 2019 DK was admitted to Stepping Hill Hospital following a fall at home. No cause was found for the falls. (3) DK fell on the ward on 17th and 18th April after removing his oxygen; on the second occasion he sustained a fractured neck of femur, for which he underwent successful operative fixation. Postoperatively he was transferred to Ward D2 (orthopaedic). (4) DK became increasingly unwell and died on 27th April 2019.
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 could 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) DK's medical care on ward D2 was poor and probably contributed to his death. (2) Between 24th and 26th April DK was allowed to become increasingly dehydrated; on 24th April he received a total of 300mls of fluid and the input/output chart was not filled in on 25th/26th April, despite the fact that he was seriously unwell. (3) There were few clinical observations on this sick patient. On 26th April, clinical observations were performed at 11.12 (MEWS 1) and 21.06 (MEWS 0). There were no clinical observations thereafter. No protocol was produced regarding the frequency of observations in sick patients on Ward D2.
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 17th June 2020. 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] (son). I have also sent it to the Care Quality Commission, 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	 **Jason Wells** **HM Assistant Coroner** **22.04.2020**