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. Springfield Health Care Services** **2. The Care Quality Commission**
1	**CORONER** I am Carly Elizabeth Henley, Assistant Coroner, for the coroner areas of Newcastle upon Tyne and North Tyneside.
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 24th February 2021 the Senior Coroner opened an inquest into the death of David Michael O'Brien. On 15th December 2021 I resumed the inquest, hearing oral evidence over the course of two days.
4	**CIRCUMSTANCES OF THE DEATH** David Michael O'Brien (born 3.5.1948) died at North Tyneside General Hospital on 23.1.2020 aged 71 years old. He had a significant previous medical history including: Bilateral Above Knee Amputations Underlying Peripheral Vascular Disease Stroke Splenectomy Partial Blindness He lived independently in his own home but was dependent on carers four times a day. His care was provided by Springfield Health Care Services. He was dependent on a wheelchair to mobilise and transfer by hoist.

	On 1.1.2020 he was admitted to hospital following an unwitnessed fall from his wheelchair, resulting in a long lie prior to him being discovered (2-4 hours) by his carers. He had sustained a fractured hip, which was operated on at NSECH on 3.1.2020. He died of 1a) Bronchopneumonia due to 1b) his fall with hip fracture (operated on 3.1.2020). Contributory conditions were: Bilateral lower limb amputations due to severe peripheral artery disease. Old cerebral infarcts and swallowing difficulties. Emphysema.
5	**CORONER'S CONCERNS** During 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. I heard evidence from Springfield Health Care Services that Mr O'Brien was using his wheelchair throughout the day and was either in bed or transferred to his wheelchair with nowhere else for him to safely sit. This excessive use was contrary to advice from Wheelchair Services, who had advised that the wheelchair was only to be used as a mobility aid. 2. Carers from Springfield Health Care gave evidence that Mr O'Brien's use of the wheelchair was "an accident waiting to happen" as he was partially sighted, "top heavy and could topple over out of his chair". 3. Whilst Springfield Health Care contacted Occupational Therapy to report concerns that the wheelchair appeared too big and his seatbelt too loose, Occupational Therapy was not the correct service to address these issues. 4. The evidence from Occupational Therapy contained a clear and contemporaneous note dated 7.11.09 that they informed Springfield Health Care that they were not the correct service and provided contact details for Wheelchair Services. Advice is clearly documented within the evidence from Occupational Therapy that "we cannot assess a wheelchair no matter how urgent and they must contact Wheelchair Services." The note goes on to state, "[Springfield Health Care] advised client is at severe risk of falling or choking and duty OT advised that client should be maintained in bed if he cannot safely

	access his wheelchair." Springfield Health Care "does not recall" that advice. Mr O'Brien continued to use the wheelchair every day following this advice, being transferred by hoist into it by his carers. 5. Evidence from Wheelchair Services was that an assessment of the wheelchair took place in Mr O'Brien's home on 20.12.19. Mr O'Brien and one of his regular carers from Springfield Health Care were present. His seatbelt was tightened and advice was given by Wheelchair Services that the wheelchair was only for use to mobilise and not for general seating. Notwithstanding this advice, Mr O'Brien continued to use the wheelchair throughout the day as his only seating option and was assisted into it by hoist by his carers. 6. Springfield Health Care state that they were not aware of the assessment on 20.12.19 by Wheelchair Services or the advice given, despite one of their carers being present during the assessment. On 1.1.2020 Mr O'Brien fell from his wheelchair sustaining injuries which ultimately led to his death. 7. The evidence that I heard suggests that Springfield Health Care have poor record keeping and poor communication between staff. It also suggests that as an agency, it is not aware of which agencies are responsible for providing assistance to its clients. Advice given by other agencies appears not to have been documented or followed. 8. Springfield Healthcare accepts that it had not undertaken a risk assessment of Mr O'Brien's use of the wheelchair, nor had it requested such an assessment be carried out by another agency.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 10th February 2022. 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: Mr O'Brien's family 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	**16.12.2021** **C E HENLEY**