REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) Sir [redacted] CBE, Chief Executive, Manchester University Hospitals NHS Foundation Trust; 2) Rt. Hon Matt Hancock MP, Secretary of State for Health and Social Care; 3) Sir Simon Stevens, Chief Executive, NHS England, and 4) Mr [redacted], Chief Executive, Care Quality Commission.
1	CORONER I am Chris Morris, Area Coroner for 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 30th August 2018, an inquest was opened into the death of Mr William Ivan McKibbin who died at Trafford General Hospital, Trafford on 20th August 2018, aged 86 years. The investigation concluded at the end of the inquest, which I heard between 25th – 27th August, and 4th September 2020. The court heard evidence that **Mr McKibbin died as a consequence of:-** **1a) Aspiration pneumonia** **1b) Traumatic brain injury** **1c) Fall** **II) Rheumatoid arthritis, Chronic lymphocytic leukaemia** The inquest concluded that **Mr McKibbin died as a consequence of Accidental Death contributed to by Neglect.**
4	CIRCUMSTANCES OF THE DEATH Mr McKibbin died at Trafford General Hospital, Trafford on 20th August 2018 as a consequence of complications of a traumatic brain injury sustained in a fall in hospital on 18th August 2018.

Mr McKibbin had been admitted to the hospital for treatment and rehabilitation having sustained a broken wrist in a fall at home.

Whilst in hospital, Mr McKibbin developed problems with his eyes which were initially attributed to bacterial conjunctivitis. On 6th August 2018, Mr McKibbin was correctly diagnosed with peripheral ulcerative keratitis, a rare complication of rheumatoid arthritis, at Manchester Eye Hospital and aggressive treatment with immunosuppressive agents started.

Had ophthalmological advice obtained on 30th July 2018 been followed, it is more likely than not that Mr McKibbin would have been diagnosed with, and begun receiving treatment for, peripheral ulcerative keratitis 4 or 5 days sooner than was in fact the case. Had this occurred, it is probable that Mr McKibbin would have been discharged from hospital well before 18th August 2018 and his death would therefore have been averted.

On 18th August 2018, Mr McKibbin sustained the traumatic brain injury which ultimately led to his death in an unwitnessed fall which probably occurred when he attempted to get out of bed. The fall was contributed to by the fact that nursing staff had left at least one of the bed rails down, and not reapplied the bed brakes having released them.

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. –

To the Chief Executive of Manchester University Hospitals NHS Foundation Trust 'the Trust', the Secretary of State for Health and Social Care, and the Chief Executive of NHS England

1. The evidence heard at this inquest left me with residual concerns as to the prevailing culture at the Trust, and by extension, within the NHS.

   It was clear from the evidence that by the time of Mr McKibbin's death, Managers from the Trust were aware at the very least that the brakes simply cannot have been applied to his bed at the time he sustained the fall which led to his death.

Despite this, no confirmation of this fact was made to Mr McKibbin's family, or in the report of his death to the Coroner. Similarly, this conclusion was not drawn by a number of internal investigations undertaken by the Trust, or indeed in evidence given to the court by Professor [redacted], Chief Nurse and a member of the Trust's board.

For a duty of candour to have meaning, it is essential the prevailing culture of an organisation is one where staff have freedom to speak out. For the reasons set out by Sir [redacted] QC in his Report into events at Mid Staffordshire NHS Foundation Trust, unless staff of all levels feel able to speak up about their own errors, and to speak out to highlight poor practice of others, a significant risk of future deaths will remain.

2. It is a matter of concern that NHS nursing documentation, such as Intentional Rounding Checklists, in use at the Trust and in other hospitals, currently do not include 'tick-box' checks to confirm bed-rails are in the appropriate position, and the bed brakes are on.

To the Chief Executive of the Trust

3. Given the operating model of the Trust, whereby different specialists provide services at different hospitals, it is a matter of concern that no proforma documentation / communication paradigm exists which sets out the minimum standard of information expected to be conveyed when a clinician seeks advice from a specialist based at another hospital.

   The risk of death in this regard is currently compounded by the fact that medical records from one hospital are not necessarily accessible from another site within the Trust group.

4. In view of the importance of robust and reliable investigations into clinical incidents to reducing the risk of future deaths, it is a matter of concern that no guidance currently exists for on-call managers and investigators as to quickly identifying, securing and gathering relevant evidence.

   Improvements in gathering evidence would assist the Trust in reliably identifying the underlying cause or causes of incidents, which in turn would better inform actions to be taken with a view to reducing the risk of future deaths.

To the Chief Executive of the Care Quality Commission

	5. In order to enhance learning from deaths, consideration should be given to modifying the Statutory Notification process following death of a service-user so as to require Registered Providers to lodge specified relevant evidence as to how the death occurred within a defined period.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 23rd November 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 Miss [redacted] on behalf of the family, in addition to Ms [redacted] of Hill Dickinson LLP who appeared at the inquest on behalf of the Trust. I have also sent a copy of my report to the Care Quality Commission, Healthcare Safety Investigation Branch, Trafford CCG, Trafford Metropolitan Borough Council, and the Regional Medical Examiner for North West England, 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	**Christopher Morris** **HM Area Coroner, Greater Manchester South** **28.09.2020**