ANNEX B

Regulation 28: Prevention of Future Deaths report

Brendan Sean Murphy (died 5/10/19)

	THIS REPORT IS BEING SENT TO: Janet Goldman Chief Executive East Melchester Foundation NHS Trust St. Mary's Hospital Wheatsheaf Lane Melchester M1 2WS
1	**CORONER** I am: Senior Coroner Doe Senior Coroner for Melchester Melchester Coroner's Court James Street Melchester M1 5AD
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 11/10/2018 I commenced an investigation into the death of Brendan Sean Murphy. The investigation concluded at the end of the inquest 15th April 2019. The conclusion of the inquest was a narrative conclusion; *"Mr Murphy's cause of death was starvation ketoacidosis, following an unwitnessed fall at home. The deceased could not move or raise an alarm following the fall. Mr Murphy had suffered a similar fall and long lie in*

	August 2018, following that incident the need for a panic alarm was identified. No alarm had been put in place at the time of his death."
4	**CIRCUMSTANCES OF THE DEATH** Mr Murphy was admitted to hospital on 28th August 2018 having fallen at his home address, where he lay undiscovered for 4 to 5 days. Following treatment, he was discharged from St. Mary's on 19th September 2018. During pre-discharge planning a Trust occupational therapist identified the urgent need for a pendant alarm on 6 September 2018. After discharge there was a delay in arranging a home visit to fit the alarm. The visit took place on 24th September 2018. The vist was not effective. Mr Murphy did not have a telephone landline so an alternative type of alarm was recommended. Advice was provided to the occupational therapist on how to request this, on the 29 September 2018. The occupation therapist did not lodge the request until 7 October 2018. Sadly, Mr Murphy was found deceased by a district nurse on the 5 October 2018. It is likely that he had suffered a fall and was unable to get back up or to seek assistance. He died from starvation ketoacidosis.
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. Evidence was heard regarding the training provided to occupational therapists in relation to the emergency equipment available from the supplier. It is requested that the training for occupational therapists is reviewed to consider: a. The emergency alarm equipment available. b. The order process required for such equipment, and c. The compatibility between the alarm system and the telephone systems within the home setting.

6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 June 2019 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 following. ● The Murphy Family, ● Melchester Borough Council, ● The Care Quality Commission. 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 orof 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	**DATE** **SIGNED BY SENIOR CORONER DOE**

Regulation 28: Prevention of Future Deaths report

Rodney Eric Hadley (died 20th March 2019)

	THIS REPORT IS BEING SENT TO: Emily Franklin Chief Executive Blenheim Care Ltd Angel Lane Melchester M1 5HB And, The Nursing and Midwifery Council
1	**CORONER** I am: Senior Coroner Doe Senior Coroner for Melchester Melchester Coroner's Court James Street Melchester M1 5AD
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 30/03/2019 I commenced an investigation into the death of Rodney Eric Hadley. The investigation concluded at the end of the inquest on 15th November 2019. The conclusion of the inquest was a narrative conclusion; *"Mr Hadley was a resident in a care home, he was assessed at a high risk of bone fracture, due to osteoporosis. On an unknown date he sustained a traumatic, fragility fracture to his left hip. Mr Hadley died in hospital on 27th March 2019 as a result of a natural illness, pneumonia. The immobility*

	caused by the traumatic fracture was a key contributor to his death. The circumstances that led to the fracture in the care home cannot be determined."
4	**CIRCUMSTANCES OF THE DEATH** Mr Hadley was a 92 year old suffering from dementia and osteoporosis. He had a history of falls resulting in fractures at his care home. Care home records show that; ● He injured his right hand and elbow on 20th March 2019, ● He developed a large bruise on his thigh on 21st March 2019 which led to an increase in his prescribed analgesia, ● On 22nd March 2019 Mr Hadley had a swelling on his left thigh. He was examined by a nurse but not referred to hospital. ● On 23rd March 2019 a massive bruising was discovered on his left thigh and groin. An ambulance was called and he was taken to hospital. At hospital, imaging diagnosed a traumatic, fragility fracture of the left hip. Despite surgery on 24th March 2019 and rehabilitation he died peacefully at 21.34 on 30th March from a chest infection and dementia.
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. Evidence was heard regarding the quality of nursing notes at the care home. a. Observation charts and progress notes were incomplete, making it difficult to determine who had cared for Mr Hadley in the hours and days prior to his death. b. Incident report forms were not completed as appropriate when Mr Hadley sustained injuries. c. There was no evidence available to the Court to confirm that these issues had been remediated by the care home.

	2. The Nurse in charge on 22nd March 2019 examined Mr Hadley; a. She found one leg more swollen than the other and of a different temperature but took no action, b. She failed to establish the care assistant's concerns prior to assessing the patient. c. She failed to take observations. d. She failed to escalate to medical care to enable a diagnosis of fractured hip to be made.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 January 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 following. ● The Hadley Family. ● Melchester Borough Council, ● The Care Quality Commission 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	**DATE**	**SIGNED BY SENIOR CORONER DOE**

Regulation 28: Prevention of Future Deaths report

DARREN SHARP (died 11/2/19)

	THIS REPORT IS BEING SENT TO: **1. Sarah Ahmed - Chief Medical Officer East Melchester NHS Foundation Trust Trust**
1	**CORONER** I am: Senior Coroner Doe Senior Coroner for Melchester Melchester Coroner's Court James Street Melchester M1 5AD
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 15 February 2019, I commenced an investigation into the death of Darren Sharp, The investigation concluded at the end of the inquest on 16th August 2019. I made a determination of suicide. The medical cause of death was: 1a multiple traumatic injuries
4	**CIRCUMSTANCES OF THE DEATH** Mr Sharp was diagnosed with a schizophrenic illness with a history of self-harm and suicidal ideation. On 8th February 2019, Mr Sharp was assessed by a psychiatric liaison nurse at Melchester Hospital A&E. Mr Sharp had been brought to hospital by police having been found walking into busy traffic. Mr Sharp declined informal admission and was not deemed to be detainable under the Mental Health Act.

	Mr Sharp was discharged with advice to contact the Melchester Mental Health Crisis Line ("MMHCL") if he felt unsafe. Records show that Mr Sharp called the MMHCL an hour after discharge, the call ended when Mr Sharp hung up. Mr Sharp was never asked if he felt suicidal. On 10th February 2019 Mr Sharp jumped from a 12th Floor balcony to his death.
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. When Mr Sharp rang the MMHCL the call handler had access to Mr Sharp's notes, knew his history and yet did not ask questions regarding suicidal ideation, without asking that question a robust risk assessment could not be meaningfully completed.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 11th October 2019 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 following.

	● The Sharp family. ● The Care Quality Commission for England 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	**DATE** **SIGNED BY SENIOR CORONER** **DOE**

Regulation 28: Prevention of Future Deaths report

AMY THATCHER (died 20/08/19)

	THIS REPORT IS BEING SENT TO: **1. Tran Nyugen - Manager** **Burnmill's Nightclub** **Lancaster Road** **Melchester M1 6TG**
1	**CORONER** I am: Senior Coroner Doe Senior Coroner for Melchester Melchester Coroner's Court James Street Melchester M1 5AD
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 5 September 2019, I commenced an investigation into the death of Amy Thatcher, the inquest concluded on Monday 2nd December 2019. I made a determination that death was drug related. The medical cause of death was: 1.a. methylenedioxymethylamphetamine (MDMA) toxicity
4	**CIRCUMSTANCES OF THE DEATH**

	In evidence at the inquest it was heard that Ms Thatcher ingested two tablets containing MDMA whilst attending Burnmill's nightclub on the evening of 20th August 2019. In the early hours of 21st August 2019 she became unwell, her friends sought emergency assistance from staff in the club. Staff attended upon Ms Thatcher. An ambulance was not called for a further 15 minutes. Ms Thatcher was taken by Melchester Ambulance to hospital, her life was pronounced extinct at 02.45 at the emergency department of Melchester General Hospital.
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. The Manager of the nightclub gave evidence that Burnmill's policy to be complied with before calling an ambulance was; 1. To call the duty manager, 2. To take two separate sets of observations from the customer (regardless of the results of the first).
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 27th January 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 following. ● The Thatcher 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	**DATE** **SIGNED BY SENIOR CORONER DOE**

Regulation 28: Prevention of Future Deaths report

Miriam Anne Charles (died 20th May 2019)

	THIS REPORT IS BEING SENT TO: Ministerial Correspondence and Public Enquiries Unit Department of Health and Social Care 39 Victoria Street London SW1H 0EU United Kingdom And, Legal Department North Melchester University Hospital, Moss Way, Melchester M1 8RR
1	**CORONER** I am: Senior Coroner Doe Senior Coroner for Melchester Melchester Coroner's Court James Street Melchester M1 5AD
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On the 25th May 2019 I opened an investigation touching the death of Miriam Anne Charles , aged 85 years old. I opened and inquest

	on the 30th May 2019. The inquest concluded on the 6th August 2019. The conclusion of the inquest was Accidental Death with a short narrative, “Consequences of surgery following a fall at home”. The medical cause of death was; ● 1a Pulmonary thrombo-embolism, ● 1b Deep vein thrombosis ● 1c Recent surgery (right elbow) ● 2 Ischaemic heart disease, type 2 diabetes mellitus, chronic obstructive pulmonary disease.
4	**CIRCUMSTANCES OF THE DEATH** On the 10th May 2019 Miriam Anne Charles fell at her home and was taken to hospital where she had surgery to her right elbow on 13th May 2019. Mrs Charles was discharged home on16th May 2019 without prophylaxis to prevent DVT. Mrs Charles was found unresponsive in bed by family on 20th May 2019. Had Mrs Charles had surgery to a lower limb she would have fallen within the National guidelines for the prevention of DVT and pulmonary embolus but there are no such recommendations for upper limb surgery.
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. That although there are clear National guidelines for the prevention of DVT and pulmonary embolus but there are no such recommendations or guidance for upper limb surgery.

6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 1st October 2019 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 following. ● The Charles 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	**DATE** **SIGNED BY SENIOR CORONER DOE**

Regulation 28: Prevention of Future Deaths report

ELSIE SMITH (died 1/2/19)

	THIS REPORT IS BEING SENT TO: **1. John Brown Chief Executive, Highways England**
1	**CORONER** I am: Senior Coroner Doe Senior Coroner for Melchester Melchester Coroner's Court James Street Melchester M1 5AD
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 28th February 2019 an investigation was commenced into the death of Mrs Elsie Smith who died at the age of 80 years old. The investigation concluded at the end of the inquest on 20 August 2019. The conclusion of the inquest was accidental death.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Smith was a retired Post-mistress in Melchester, she had lived in the town all her life and was well known in the local community. On 1st February 2019, Mrs Smith had visited her friend who lives at the other side of Town. She left at 6.00pm and it was dark. She used a pedestrian crossing that crossed the A555. The crossing contains fenced central traffic island which is located in the middle of the north and southbound carriageways of the A555. Mrs Smith crossed the southbound carriageway and made it on to central traffic island. She crossed the island toward the northbound carriageway. The breadth of the northbound carriageway at this point was 3.8m.

	Mrs Smith allowed a Taxi to pass by and then commenced her crossing of the carriageway. She walked into the path of a black Ford Focus that was travelling at 50mph. She suffered catastrophic injuries and died at the scene. The inquest heard from Melchester Constabulary Collision Investigator who confirmed; ● The Ford Focus was 16 to 25m away when Mrs Smith attempted to cross. ● The vehicle was travelling at 50mph (22.35 metres/sec) ● There were 0.8 seconds between Mrs Smith stepping out and being struck ● The driver of the vehicle had no opportunity to react in such a period. ● It is estimated that Mrs Smith would require 3.04 seconds to have crossed the north bound carriageway. ● The driver required a distance of 67.94m to react when travelling at 50mph. ● It was highly likely that Mrs Smith had failed to see the Focus, which was obscured by the Taxi. ● The absence of street lighting on the A555 meant that Mrs Smith would have been wholly reliant on judging distance by gauging the speed of approaching headlights. ● The section of the A555 is a long, straight, single lane stretch between 2 sections of dual carriageway. Average vehicle speeds are high in this area. ● The road is tree lined & located in a valley reducing the level of natural light.
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 speed of traffic on this particular stretch of the A555. 2. The position of this pedestrian crossing. 3. The poor lighting on this stretch of the A555. 4. Low levels of signage related to the pedestrian underpass 300ms away from the crossing.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 15th October 2019 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 following. ● The Smith family. ● Chief Constable, Melchester Constabulary. ● Chief Executive, Melshire County Council. 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	**DATE** **SIGNED BY SENIOR CORONER** **DOE**

Regulation 28: Prevention of Future Deaths report

Nosheen Begum (died 1st October 2019)

	THIS REPORT IS BEING SENT TO: Jim O'Sullivan, Chief Executive of Highways England
1	**CORONER** I am: Senior Coroner Doe Senior Coroner for Melchester Melchester Coroner's Court James Street Melchester M1 5AD
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 3rd October 2019 I commenced an investigation into the death of Nosheen Begum aged 50 years. The investigation concluded at the end of the inquest on 6th May 2019. The conclusion of the inquest was that Ms Begum died from multiple injuries and the narrative conclusion was that: "*Ms Begum died following a road traffic collision after aqua-planing into an oncoming vehicle. Standing water had accumulated due to blocked gullies on the side of the road that had not previously been identified on routine inspection*"

4	**CIRCUMSTANCES OF THE DEATH** Nosheen Begum died on the A555, Melchester when Mrs Begum's car aqua-planed across the road into the path of an oncoming vehicle. Mrs Begum died at the scene as a result of her injuries.
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. During the course of the evidence I heard how the roads are examined and monitored on a regular basis but that such inspections are conducted at speed and that the process failed to identify the problem with this particular drain on the A555. I believe that the process for inspection should be reviewed.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 1st July 2019 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 following. ● Mrs Begum's family

	● The Chief Constable, Melchester Police 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	**DATE** **SIGNED BY SENIOR CORONER DOE**