A R W Forrest LLM, FRCP, FRCPath
GMC Number: 1333523
Her Majesty's Senior Coroner for South Lincolnshire

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. Stephen Graves, Chief Executive, Peterborough and Stamford NHS Trust**
1	**CORONER** I am ARW Forrest, Senior Coroner for the Coroner's area of South Lincolnshire.
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 29th May 2014 I commenced an investigation into the death of Elaine Marilyn GILES, age 66. The investigation concluded at the end of the inquest on 4th December 2014. The conclusion of the inquest was ACCIDENT.
4	**CIRCUMSTANCES OF THE DEATH** Elaine was a generally fit 66 year old woman who fractured her left neck of femur in a minimal trauma fall at work. She had an uneventful operation with the insertion of a prosthetic hip. She required 10 days of post-operative care in hospital before discharge. Her care was complicated by recurrent nausea, difficulty in pain control, dizziness, feeling faint, and swollen feet. This all interfered with her rehabilitation. Evidence was presented at the inquest that she had been pronounced "safe" in walking with an aid and "safe" on stairs. Once at home it became clear that Elaine was not "safe" on her stairs at home. The problems she had included foot swelling to the extent that her slippers did not fit securely. 5 days after her return home she fell whilst descending the stairs. There were no obvious signs of injury but she took more than a minute or two to recover. She

Unit 1, Gilbert Drive, Endeavour Park, Boston PE21 7TQ
Tel: 01522 553374 Fax: 01522 516717
Email: HMCoroner_Southlincolnshire@lincolnshire.gov.uk

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	had a telephone conversation at 5pm that evening, but was found dead at 1pm the following day. Whilst it is difficult to estimate the time of death with any precision it is likely that she died about 12 hours or so before she was found. The cause of death at post mortem was fat embolism. The likely cause of the fat embolism was jarring of her hip joint prosthesis in the fall. Forcing fatty material from her bone marrow into the systemic circulation.
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 Whilst assessed as "safe" on stairs prior to discharge from Peterborough City Hospital, it is very clear that Elaine could not negotiate stairs safely when she got home. This tragic case draws attention to the need for detailed assessments of a patient's likely functional performance in their home circumstances after discharge and the importance of ensuring adequate support is available in the home environment.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 **29th January 2015**. 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

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	Persons: 1. [redacted] - Mother 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	**5th December 2014** **ARW Forrest**..... **H M Senior Coroner for South Lincolnshire**

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