REGULATION 28: REPORT TO PREVENT FUTURE DEATHS .

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Professor Matthew Makin, Executive Medical Director, North Manchester General Hospital – Pennine Acute Hospitals NHS Trust Copied for interest to: • The family of the deceased
1	**CORONER** I am Nigel Meadows, H.M. Senior Coroner for the area of Manchester City.
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	**INQUEST** On 3 March 2015 I commenced an investigation into the death of Milly ZEMMEL, aged 89. The investigation concluded at the end of the inquest on 29 March 2016. The cause of death was found to be: 1a Right upper lobe pneumonia II Fractured neck of femur, chronic kidney failure Recurrent confusional state The conclusion of the inquest was Accidental Death contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** The deceased, who was aged 89, and registered blind, lived in sheltered accommodation. She had the benefit of carers who visited her regularly as well as family members. However, on 7 February 2015 she was feeling particularly unwell and an ambulance was called. She was admitted into North Manchester General Hospital (NMGH). She was initially seen and assessed in the Accident and Emergency Department. Following this she was admitted to Ward H3 where, despite being blind, she was assessed as not being at risk of falls. This was later acknowledged by NMGH to be totally incorrect and her care plan was not

appropriately completed nor was her risk of falls correctly assessed.

She suffered from chronic conditions, ischaemic heart disease, kidney disease, anaemia, gout and diverticular disease. Her presenting symptomology suggested that she may have suffered an injury to her elbow in a fall but she did not report having had a fall.

She was treated with supportive therapy but over the next few days suffered episodes of acute confusion and disorientation. She was transferred to Ward E5 on 9 February and her risk of falls was reassessed. She suffered further episodes of confusion and disorientation and it was suspected that she was suffering from a urinary tract infection. On 21 February 2015 the deceased suffered an apparently witnessed fall at her bedside. Initial nursing assessment detected no obvious injuries and she was assisted back to sit in her chair. A request for medical review was made and initial neurological observations were commenced. No clinician attended to review her until she was seen on 25 February and this was not escalated appropriately by the nurse in charge of the ward on 21 February and nor was it noted or recognised when her care was handed over to a number of shifts thereafter.

Between 21 February and 1 March 2015 it is recorded that the deceased was repeatedly confused and agitated. At about 5am on 1 March 2015 it is recorded that she was suffering an acute confusional episode and requires one to one supervision. She appeared to be hallucinating and had been in and out of bed constantly. Despite this no one to one supervision was initiated and there was no evidence that her deteriorating condition was handed over to the next shift starting at approximately 07.30am. She had previously been subject to a regime of two hourly checks, however, that morning she was not checked and was not subject to one to one supervision for several hours. At around 11.30am she was found on the floor by her bed after having had an un-witnessed fall.

Subsequent investigations established that she had suffered a fracture of her left femur. Clinically it was decided that she was not fit enough for surgery and despite treatment her condition deteriorated and she died on 3 March 2015.

Following the death of the deceased NMGH initiated an investigation into her fall on 1 March 2015 and produced a template report. It concluded: "The patient has a poor standing balance, requiring assistance of one, and was suffering from acute delerium with history of impaired vision. Whilst the care plans and risk assessments were all in place there was a failure to consider a low rise bed, tab alarm or patient watch".

The deceased was in fact totally blind and did not have impaired vision. It was recognised that after having a fall at her bedside on 21 February 2015 she had not been clinically reviewed until 25 February and this had not been escalated or recognised by anyone. A number of action

	recommendations were made. The internal hospital investigation did not fully and properly identify the gross failure to provide the deceased with the basic medical care which her condition obviously required on the morning of 1 March 2015. The full particulars only became apparent when evidence was heard at the inquest and the records were checked. The gravity of the failings in care had not been properly identified. Following the death of the deceased the Hospital Trust introduced a new risk falls policy and initiated training for staff.
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 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 Trust's own internal investigative procedures were demonstrably inadequate because the internal hospital investigation did not fully and properly identify the gross failure to provide the deceased with the basic medical care which her condition obviously required on the morning of 1 March 2015. The full particulars only became apparent when evidence was heard at the inquest and the records were checked. The gravity of the failings in care had not been properly identified. 2. There have been failures to assess and correctly apply the then existing falls risk policy. 3. There was a failure to escalate the requirement for a clinical review following her fall on 21 February 2015 and nor was this identified at handovers on several occasions. 4. There was a gross failure to initiate appropriate one to one supervision and observations for the deceased from the early hours of the morning on 1 March 2015. In addition there was a failure to ensure that important clinical information about the deceased's condition was handed over to the next shift. Nor did the next shift nurse in charge ensure that the deceased's records were checked to find out what the up to date information on the situation was. Consequently the deceased, who was suffering an

	acute confusional state, and who was blind was left unsupervised for several hours leading her to have a fall and suffer a serious injury which caused or contributed to her death.
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. In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. 1. The Trust should consider reviewing their own internal investigation systems and ensure that they are transparent, thorough, appropriately candid and up to date. Those involved in the deceased's care and management or who have line management responsibility should not form part of any investigative team. 2. Whilst the introduction of a new falls policy is commendable and to be applauded, there was failure in nursing and clinical hand-over, escalation and management which should not have been allowed to occur. This was part of basic nursing and clinical management. The Trust should consider reviewing the hand-over and escalation policies and protocols so as to ensure a fail safe system.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 June 2016. 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 Interested Persons. I have also sent it to organisations 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	**6 April 2016** **Nigel Meadows HM Senior Coroner – Manchester City Area**