REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: East Lancashire Hospitals NHS Trust**
1	**CORONER** I am Rachel Galloway, assistant coroner for the area of Blackburn, Hyndburn and Ribble Valley.
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 the 28th September 2016 an inquest was opened into the death of Patrick Clifford. Evidence was heard at inquest on the 22nd March 2017. The inquest was adjourned part heard on the 22nd March 2017 and completed on the 11th October 2017. A narrative conclusion was left: *Mr Clifford fell backwards following a faint in the toilet on Ward B4 at the Royal Blackburn Hospital on the 19th March 2016. He suffered a fractured acetabulum as a result. This was treated conservatively. His condition deteriorated over time. He developed pneumonia due to immobility and heart failure and passed away on the 18th September 2016 at Springhill care home in Accrington.*
4	**CIRCUMSTANCES OF THE DEATH** **Mr Clifford suffered a fall in the toilet at Royal Blackburn Hospital where he was a patient on the 19th March 2016. No risk assessment had been carried out but I found that the fall would not have been prevented had a risk assessment taken place, as there was no requirement for Mr Clifford to be supervised in the toilet due to his level of his mobility. The Trust accepted that a risk assessment should have been carried out and this has now been addressed on Ward B4. During the course of the evidence, it appeared to be suggested that supervision in the toilet would not be required unless there had been a fall on the ward (even if there had been a relevant fall at the patient's home or other risk factors were present).** **Following the fall in March 2016, Mr Clifford sustained a fractured acetabulum. This was treated conservatively, as surgery was not recommended. He was referred to Orthopaedics at Royal Blackburn Hospital and then referred to Wrightington Hospital for advice to be obtained on the fracture. The referral to Wrightington was mainly to obtain advice on the fracture and to obtain their expert opinion on when weight bearing or partial weight bearing could commence. There were delays in obtaining advice from Wrightington, which led to extended bed-rest in Mr Clifford's case. These delays were due to problems with accessing the images from different PACS systems at the hospitals and misunderstandings as to whether Wrightington could access the images. There were also delays caused by the Radiology department at the Royal Blackburn Hospital refusing to undertake the Judet views that were specifically requested by Wrightington.** **Whilst there were delays in commencing partial weight bearing and**

	communications issues later at Burnley General Hospital regarding daily hoisting, I concluded that these matters did not contribute to Mr Clifford's death in September 2016 on the balance of probabilities. However, these were missed opportunities to improve his condition.
5	**<u>CORONER'S CONCERNS</u>** 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 evidence from the nursing staff that a patient would not be supervised within the toilet unless there had been a fall on the ward. It was not clear whether this was a general understanding by nursing staff or a specific policy. I am concerned that future falls (and therefore deaths) will occur unless action is taken to address this policy/understanding. 2. The evidence from the clinicians was that there were sometimes difficulties in transferring images to other hospitals. In this case there appeared to be misunderstandings as to whether or not Wrightington could access radiology images/reports through the Royal Blackburn Hospital PACS system and vice-versa. In the present case this caused delays in the commencement of necessary physiotherapy treatment and I am concerned that future delays could similarly delay treatment and risk future deaths as a result. 3. During the course of evidence it became apparent that the Radiology department at the Royal Blackburn Hospital had refused to carry out Judet X-rays as specifically requested by the orthopaedic specialists at Wrightington. This caused delays in commencing partial weight bearing physiotherapy in Mr Clifford's case. I am concerned that future delays could similarly delay treatment and risk future deaths as a result.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 7th December 2017. I, the assistant 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 namely the family of Mr Clifford , 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	