**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**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Patrick Crowley, Chief Executive York Teaching Hospital NHS Foundation Trust.** [redacted]<br>**2. HHJ Lucraft QC, Chief Coroner 11TH Floor Thomas More Building, RCJ, London WC2A 2LL.** [redacted]<br>**3.** [redacted]**, Legal Services Manager, York Teaching Hospital NHS Foundation Trust.** [redacted] |
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| 1 | **CORONER**<br><br>I am JOHN NIGEL BROADBRIDGE, Assistant Coroner, for the Coroner Area of YORK |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 28 April 2017 the Senior Coroner commenced an investigation into the death of KENNETH JOHN SWIFT aged 80 years. The investigation concluded at the end of the inquest on 12 July 2017. The conclusion of the inquest was that "KENNETH JOHN SWIFT died at York Hospital, York on 28 April 2017 of community acquired pneumonia with other significant conditions contributing to the death but not related to the disease or condition causing it being fractured neck of femur (operated) and frailty of old age." The narrative Conclusion was that, in addition, "Whilst general frailty of health was likely to be a co-factor the surgically treated injury received in his fall/collapse at the Hospital on 21st April 2017 was one of the significant contributory factors in the development of his existing illness which led to his death." |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Kenneth John Swift ("Mr Swift") was admitted to York Hospital, York on 19 April 2017 with symptoms diagnosed as community acquired pneumonia. He was assessed as being at risk of falls. He was being treated for that condition when on 21 April 2017 he fell in his room when unaccompanied, fracturing his neck of femur which was surgically treated uneventfully. His condition deteriorated however and he died in Hospital on 28 April 2017. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br>(1) Although assessed as being at risk of falls and despite being positioned in a bay that was close to the Nurses' Station in the Ward for better observation, Mr Swift was also recommended to have a falls sensor as he was observed by occupational therapist and physiotherapist trying to mobilise without supervision despite advice not to do so. |

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| | (2) It was said in evidence that:<br>No falls sensor was immediately available- Mr Swift was put on a 'waiting list' of 34 existing patients needing such equipment.<br>The cost of a chair sensor was said to be £60; of a bed sensor £90. The Hospital was said to be in a tendering process to acquire such equipment.<br>In the relevant Ward (AMU/AMB) 95% of the usual 30 patients (when full) at any one time would have been assessed at risk of falls.<br>Four sensors have been acquired since Mr Swift's death for use at the present time in that Ward.<br>(3) Such a mechanism may have made staff aware that Mr Swift, an elderly man known to be capable of confusion and already suffering from infection that could be aggravated by immobility if injured, was mobilising unsupervised.<br>(4) That in this Ward at least there is the potential for future deaths resulting from, or the aggravation of, conditions by the consequences of falls in other patients. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday 20 September 2017. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons, namely [redacted]<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **26 July 2017** **Signed** JN Broadbridge |