	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Healthcare Governance Manager Patient Safety, Royal Stoke University Hospital [redacted] Corporate Governance Manager, Staffordshire & Stoke-on-Trent Partnership NHS Trust.
1	**CORONER** I am Margaret J Jones HM Assistant Coroner for **Stoke-on-Trent & North Staffordshire**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 23rd March 2018 I commenced an investigation into the death of Kenneth William Horne. The investigation concluded at the end of the inquest on 2nd May 2018. The conclusion of the inquest was that the deceased had a history of lung cancer in 2015 which had been operated on. In December 2016 he was admitted to the Royal Stoke University Hospital, Stoke on Trent with a chest infection. He was investigated for cancer of the colon but was unfit for further tests due to his comorbidities and general frailty. He transferred to ward 80 where infections settled. He suffered two falls on the ward whilst mobilising from the toilet without requesting assistance. One of the falls was on the morning of the 27th January 2017 which was also his planned discharge to Leek Moorlands Hospital where he was admitted at 7.50pm. Details of his previous falls were not included on the discharge letter and there was no verbal nurse to nurse handover. His falls documentation and risk assessments were sent with him to Leek Hospital but the transfer of care form had not been updated. At 2.00am on the 28th January 2017 he was found on the floor at the side of his bed. Observations indicated a deteriorating condition and he was readmitted to the Royal Stoke University Hospital. A CT scan found a very large haematoma of the left thoracic wall and possible infection. His nutritional intake remained poor. He was not suitable for intervention and was treated as palliative. He transferred to Bradwell Hall Nursing Home, Newcastle-under-Lyme on the 22nd February 2017 where he died on the 24th February 2017. The cause of death was. 1a Sepsis. 1b Bronchopneumonia. 1c Chest wall injury. II Old age.
4	**CIRCUMSTANCES OF THE DEATH** The conclusion of the inquest was Accidental 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:- (1) The deceased had 2 falls whilst at the Royal Stoke University Hospital, one on the morning of his transfer to Leek Moorlands Hospital. The falls were not included in the discharge letter. (2) There was no nurse to nurse discharge call between the hospitals. (3) The Transfer of Care form was not up to date. If these matters had been properly dealt with Leek Moorlands Hospital might not have accepted the transfer. He had a fall with serious injury approximately 6 hours after admission to Leek Moorlands Hospital.

	As a side issue and a matter of concern, communication with the relatives appeared to be poor. No Datix form was completed for the second fall in the Royal Stoke University Hospital until December.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe the Royal Stoke University Hospital and Leek Moorlands Hospital 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 **Friday 29th June** 2018, 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 Persons: [redacted] son of the deceased. 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	03/05/2018 Signature: Margaret J Jones HM Assistant Coroner **Stoke-on-Trent & North Staffordshire**