REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Ms Helen Thompson, Interim Chief Executive, Stockport NHS Foundation Trust, Stepping Hill Hospital, Poplar Grove, Hazel Grove, Stockport, SK2 7JE

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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

INVESTIGATION and INQUEST

On 8th March 2018, I opened an inquest into the death of Mr Malcolm Marshall Shaw, who died at Stepping Hill Hospital, Stockport on 20th February 2018 aged 82 years. The investigation concluded at the end of the inquest which I heard on 20th August 2018 and 2nd January 2019.

At the end of the inquest, I recorded a narrative conclusion that Mr Shaw died as a consequence of injuries sustained in a fall which occurred whilst he was unobserved. His death was contributed to by underlying lung disease.

CIRCUMASTANCES OF THE DEATH

Mr Shaw was admitted to Stepping Hill Hospital on 10th February 2018 as a consequence of a general decline in his condition and hyponatraemia, for which he received treatment on the Acute Medical Unit. Investigations undertaken whilst on the Acute Medical Unit included a CT scan which showed evidence of Chronic Obstructive Airway Disease.

In view of Mr Shaw's medical history together with a raised Troponin level and new changes on an ECG undertaken on the Acute Medical Unit, a decision was made to admit Mr Shaw to ward A3, a cardiology ward. Mr Shaw was transferred to ward A3 late on the evening of 13th February 2018.

On transfer to ward A3, Mr Shaw was noted to be confused and agitated, something which continued throughout the night. At some point between 06:00 and 06:35 on 14th February 2018, Mr Shaw sustained a fall on ward A3 which was not observed by any of the staff on duty.

Whilst it was not initially thought Mr Shaw had sustained serious injury in the fall, on 15th February 2018, his right leg was noted to be shortened and rotated by the cardiology Senior House Officer. An X-Ray was then taken which confirmed that Mr Shaw had suffered a fracture to his right femur, in all probability as a result of the fall on the ward the previous day.

Mr Shaw was referred to the Orthopaedic Surgeons, who listed him for surgery which was planned to take place on 17th February 2018 subject to optimisation of his condition. He was reviewed by a Consultant Anaesthetist on 16th February 2018 who considered he was fit for surgery,

notwithstanding an operation would be high risk. When reviewed again on the day of surgery, it became apparent Mr Shaw's condition had deteriorated dramatically, and surgery was deferred. He was diagnosed with bronchopneumonia and died on 20th February 2018.

A post mortem examination was performed following Mr Shaw's death which confirmed he died as a consequence of:-

1a	Bronchopneumonia
b	Chronic Obstructive Airways Disease and Immobilisation following fractured right femur

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. –

In view of the fundamental importance of rigorous patient safety investigations whose conclusions are capable of withstanding logical analysis to improving care, it is a matter of concern that the Trust's original investigation into the circumstances of Mr Shaw's fall (which had presumably passed through the Trust's own quality assurance mechanisms) was manifestly and fundamentally flawed.

Whilst the court heard evidence of significant improvements the Trust has made to the way it undertakes investigations, it is a matter of residual concern that the organisation has yet to launch a revised programme of investigation training for those who undertake patient safety investigations.

Specifically in relation to cases involving falls, it remains of concern that frontline staff do not appear to have been provided with any guidance as to how to capture the best available evidence as to the circumstances of the fall as soon as reasonably possible after the incident. This is a matter of particular concern bearing in mind the potential benefits such an approach would bring to the Trust's ongoing efforts to understand the causes of falls on wards with a view to trying to prevent as many of them as possible.

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.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 7th March 2019. 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

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to [redacted] on behalf of Mr Shaw's family. I have also sent a copy to [redacted] of Hill Dickinson LLP, solicitors to the Trust.

I have sent a copy of my report to the Care Quality Commission, and the Healthcare Safety Investigation Branch 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.

Dated: 10th January 2019.

Signature:

Chris Morris HM Area Coroner, Manchester South.