	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive, Barnsley Hospital NHS Foundation Trust**
1	**CORONER** I am Stephen Eccleston, Assistant Coroner, for the coroner area of South Yorkshire (West)
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. (1) Where – (a) A senior coroner has been conducting an investigation under this Part into a person's death (b) Anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and (c) In the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action. (2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it. (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner
	INVESTIGATION and INQUEST On 25th January 2019, I commenced an investigation into the death of Carolyne Senior (dob 20.01.55). The investigation concluded at the end of the inquest on 10th November 2020. The Medical cause of death was 1a. Lower respiratory tract infection 1b. Chronic obstructive pulmonary disorder 2. Frailty, falls in hospital and fractured necks of femur The conclusion of the inquest was: Carolyne Senior died on 20.01.19 at Barnsley Hospital from the consequences of three falls and fractured left and fractured right neck of femur incurred while in the care of Barnsley Hospital. The falls and Carolyne's death were contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Carolyne Senior was admitted to admitted to Barnsley Hospital on 29.12.18 and discharged on 13.01,19. She was then admitted on 14.01.19 and remained there until her death on 20.01.19.

	The evidence was that Carolyne fell on 30.12.18, 11.01.18 and 17.01.19. It was admitted in the serious incident report (SI) that the fall on 17.01.19 was avoidable. I found that Carolyne suffered a fractured right neck of femur as a consequence of the fall on 30.12.18 and fractured left neck of femur as a consequence of the fall on 17.01.19. Carolyne suffered from a number of mental health issues including schizophrenia.
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. – Evidence was given that Carolyne's mental health issues could have inhibited her insight and ability to follow advice around falls prevention. The SI report author accepted in evidence that the question of whether hospital staff had sufficient access to advice to support them in caring for patients with mental health needs had not been addressed in that review. Nursing evidence was to the effect that advice and guidance was limited. In particular that mental health staff could take a very long time to attend a ward when asked but, more generally, that mental health input was insufficient to support hospital staff in caring for such patients and was known to be provided to a better standard in other hospitals. I was concerned that staff in Barnsley hospital did not take sufficient account of Carolyne's mental health needs in formulating falls risk assessments and mitigations. I was concerned that there may be inadequate specialist provision to support staff in caring for patients with mental health needs such that these patients, some of whom may be challenging to care for, would therefore be placed at greater risk of falls than would be the case if risk assessments were formulated with their specific needs in mind.
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 January 2021 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 solicitors to the family who might be interested in it 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	**11.11.20**	***Stephen Eccleston***