REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: 1) [redacted], Chief Executive, Tameside and Glossop Integrated Care NHS Foundation Trust.

CORONER

I am Chris Morris, Area Coroner for Greater 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 16th December 2021, I opened an inquest into the death of Derek Holmes who died on 2nd December 2021 at Tameside General Hospital, Ashton-under-Lyne, at the age of 79 years. The investigation concluded with an inquest which I heard on 20th June 2022, and which concluded that Mr Holmes had died as the consequence of an accident.

CIRCUMSTANCES OF THE DEATH

Mr Holmes had a complex medical history which included advanced metastatic prostate cancer and congestive cardiac failure.

On 23rd October 2021, Mr Holmes was admitted to Tameside General Hospital whereupon investigations showed him to have developed an acute kidney injury, infected pressure ulcer, and worsening congestive cardiac failure.

In the early hours of 25th October 2021, Mr Holmes fell whilst attempting to get up from his bed on the Acute Medical Unit. As a consequence of the fall, Mr Holmes sustained a periprosthetic fracture to his left hip.

The Trauma and Orthopaedic Surgeons assumed oversight of Mr Holmes's care, and a referral was made to the specialist orthopaedic service at Wrightington Hospital. Following receipt of specialist advice, an operation to treat the fracture surgically was ultimately performed at Tameside on 8th November 2021.

Mr Holmes did not make progress as hoped for after surgery and on 29th November 2021, he vomited and began to show signs of a chest infection. Despite treatment with IV antibiotics and fluids, Mr Holmes died on 2nd December 2021.

The inquest concluded that Mr Holmes died as a consequence of complications of a serious injury sustained in a fall which required surgery against a background of multiple complex medical problems.

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. Notwithstanding the fact that the document had passed through the Trust's quality assurance process, it is a matter of concern that the Root Cause Analysis investigation into the circumstances of Mr Holmes's fall contained a number of basic and obvious errors. Prompt, rigorous and effective investigations of clinical incidents are essential to deriving learning and improving patient safety, thereby reducing the risk of future deaths;

2. The formal learning derived from the Trust's investigation (in the form of an Action Plan to the Root Cause Analysis) does not appear to take into account the breadth of issues raised by the case and which were apparent to the Trust from complaints correspondence and statements obtained from staff in advance of the inquest. As such, the Trust does not appear to have taken the opportunity to formally examine and critically analyse key issues such as:

    - the adequacy of existing processes designed to ensure patient call-bells are working at all times; and
    - why a delay has occurred in obtaining advice from a specialist hospital in the present case and whether the processes by which such advice is obtained are fit for purpose.

3. Connected with the above, the Trust does not appear to have revisited the grading of "moderate" harm originally assigned to Mr Holmes's fall on the Acute Medical Unit notwithstanding his death being reported to the Coroner on the basis there was reason to suspect it contributed to his death. The court heard evidence to the effect that this grading informs the nature and extent of investigation which arises from a patient safety incident (thus impacting upon the learning which can be derived from such an incident).

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 **17th August 2022.** 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 the family.

I have sent a copy of my report to the Care Quality Commission, Tameside Metropolitan Borough Council and NHS Tameside and Glossop CCG 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: 22nd June 2022

Signature: Chris Morris HM Area Coroner, Manchester South.