REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Stockport NHS Foundation Trust**
1	**CORONER** I am Lauren Costello, Assistant Coroner, for the Coroner Area of Manchester South
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.
3	**INVESTIGATION and INQUEST** On 14th June 2022 I commenced an investigation into the death of Kenneth Goodwin then aged 86 years. The investigation concluded at the end of the inquest on 9th October 2022. At the end of the Inquest, I recorded a narrative conclusion that Mr Goodwin died as a result of an acute subdural haematoma following a fall. The medical cause of death being 1a Traumatic Subdural Haematoma II Cholecystitis

4	**CIRCUMSTANCES OF THE DEATH** Kenneth Goodwin was admitted to hospital on 1st June 2022 with severe abdominal pain and was treated for sepsis from gall stones and cholecystitis. The infection for which he was admitted was gradually improving during his admission following conservative treatment. Mr Goodwin's family confirmed to the hospital that he was a falls risk. On 3rd June 2022 he had a fall in hospital and banged his head, likely on his hospital bed. The fall occurred after being transferred from one ward to another during the night. He was transferred at 21:09 and the fall occurred at 01:40 before a falls risk assessment had been completed on the new ward. After transfer he displayed signs of confusion and wished to get out of bed to use the bathroom despite being catheterized. The Inquest heard that it was unclear if the bed rails were used. As a result of the fall, he developed an acute subdural haematoma. This was treated conservatively but despite treatment he deteriorated and died on 9th June 2022 whilst still at Stepping Hill Hospital. Stepping Hill Hospital have taken steps to reduce nighttime transfers for patients experiencing confusion or who are at risk of falls.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTER OF CONCERN** is as follows. – (1) The Inquest heard that the transfer process between wards for patients at risk of falls does not require a specific written confirmation that a handover in relation to that risk has taken place. (2) The falls risk assessment on the new ward was not completed for just over 4.5 hours. The Inquest heard that the target time for this assessment is within 6 hours, a length of time which is of concern for patients transferred at night, displaying signs of confusion, and already identified as a fall risk. (3) The Inquest heard that the use of signs on beds to visually identify falls risk to the staff is not consistently used.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 6th December 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.

8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] [redacted] of Hempsons, solicitors to the Trust I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. 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.
9	**DATE** **SIGNED BY CORONER** L. Costello **14th October 2022**