	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: University Hospitals Birmingham NHS Foundation Trust**
1	**CORONER** I am Vanessa McKinlay, Assistant Coroner for Birmingham and Solihull
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 3 November 2022 I commenced an investigation into the death of Norma Winifred BRUTON. The investigation concluded at the end of the inquest . The conclusion of the inquest was; Natural causes contributed to by injuries sustained in a fall.
4	**CIRCUMSTANCES OF THE DEATH** **The deceased was admitted to Birmingham Heartlands Hospital on 13 October 2022 for treatment of a pneumothorax with a background of pulmonary mycobacterium infection and chronic obstructive lung disease. An assessment of her risk of falling did not take into account the presence of a chest drain and an intravenous drip and Mrs Bruton was assessed as being able to mobilise independently. She had an unwitnessed fall on the morning of 15 October 2022 when trying to walk the short distance to her bathroom and sustained a right fractured neck of femur for which she underwent surgery on 20 October 2022. Mrs Bruton's condition deteriorated after the surgery and she died in hospital on 22 October 2022.** Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Sepsis** **1b Hospital acquired pneumonia** **1c** **II Chronic Obstructive Lung Disease, Frailty, Neck of femur fracture (operated), Pneumothorax**
5	**<u>CORONER'S CONCERNS</u>** 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 Birmingham Heartlands Hospital falls risk assessment document does not prompt staff to consider or document the presence of attachments such as chest drains or intravenous infusions. 2. The document does not prompt staff to comment on the relevance or otherwise of such attachments when assessing the risk of falls. 3. Where attachments are documented on other forms (for example, the manual handling

	assessment form), this does not prompt the staff to reconsider the falls risk assessment.
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 14 July 2023. 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 Family of Mrs Bruton I have also sent it to NHS England, 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.
9	**19 May 2023** Signature:  **Vanessa McKinlay** **Assistant Coroner for Birmingham and Solihull**