REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) NHS England and; 2) Care Quality Commission
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater 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 20th February 2023 I commenced an investigation into the death of Marion Nickson. The investigation concluded on the 6th July 2023 and the conclusion was one of **Narrative: Died from the complications of an accidental fall sustained when not observed in hospital exacerbated by necessary anticoagulation therapy and when an inpatient following a pneumothorax a complication of a necessary medical procedure**. The medical cause of death was **1a) Traumatic acute subdural bleed on the background of anticoagulation therapy; 1b) Fall; II) Iatrogenic pneumothorax during pacemaker insertion, complete heart block, ischaemic heart disease, acute coronary syndrome**
4	CIRCUMSTANCES OF THE DEATH Marion Nickson was admitted to Macclesfield Hospital on 26th January 2023 after a fall at her home address. It was identified she had had a heart attack and needed a pacemaker. Whilst at Macclesfield she had a fall on 27th January whilst unobserved in a bay where she should have been observed but she sustained no significant injury. She was transferred to Stepping Hill Hospital as a day patient on 2nd February 2023 for a pacemaker to be fitted. During the fitting she sustained a pneumothorax a recognised complication of the pacemaker fitting. A chest drain was fitted and she was admitted to Stepping Hill Hospital

	whilst the chest drain was required. On the 12th February 2023 she had an unwitnessed fall but sustained no significant injury, She was identified as having acute coronary syndrome and treated with anticoagulants. On 13th February the chest drain was removed and on 14th February she was deemed to be medically optimised for discharged. She was in a bay where a member of staff should have remained at all times. That did not happen. Whilst unobserved she had an accidental fall when she tried to mobilise independently from her chair. She was sent for a CT scan and a bleed to the brain was identified. She deteriorated rapidly and died at Stepping Hill Hospital on 14th February 2023 as a consequence of her head injury.
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. – The inquest heard evidence that to deal with the risk of falls in patients deemed to be high risk the concept of observable bay nursing had been introduced at both Trusts. At both Trusts Mrs Nickson fell whilst unobserved due to the challenges of maintaining the bays as observed bays. The challenge for both trusts had arisen where staff were required to deal with issues out of the bay and left the bay area. The cause of that was multifactorial and included a lack of understanding of the risk presented by leaving the bay and a need for the staff to complete other urgent tasks due to the demand on ward staff. The inquest heard that preventing in patient falls to reduce avoidable deaths was recognised as being important and that across the NHS bays of this nature were seen as a way to reduce the risk. However they would only work if staff had the time and there were cultural changes amongst staff where it was recognised that observing patients had to be seen as a priority and not something that could be left to fit around other demands. The evidence was clear that if observable bays could not function as intended then across the NHS there would continue to be avoidable falls and consequential deaths. If bay nursing could not effectively delivered due to resourcing then other options to keep patients safe needed to be explored by Acute Trusts.

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 15th September 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 namely [redacted] on behalf of the Family, 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	**Alison Mutch** **HM Senior Coroner**  **21.07.2023**