MR G IRVINE
SENIOR CORONER
EAST LONDON
East London Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], **Chief Executive Officer, Barts Health NHS Foundation Trust** [redacted] 2. **Rt Hon Steve Barclay MP, Secretary of State for Health & Social Care** [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 2nd January 2023 this Court commenced an investigation into the death of Iris Elaine Fordham aged 95 years. The investigation concluded at the end of the inquest on 5th October 2023. The court returned a narrative conclusion; *Iris Elaine Fordham died in a step-down care centre on 1st January 2023, she was recovering from a surgical repair of injuries sustained in a fall. Her death was caused by worsening symptoms of Alzheimer's disease.* Mrs Fordham's medical cause of death was determined as;

	1.a. Alzheimer's disease 2. COVID-19, fractured neck of femur, suspected colorectal cancer
4	**CIRCUMSTANCES OF THE DEATH** Iris Fordham was admitted to hospital on 22nd November 2022 having sustained an unwitnessed fall in the community, her admission was not to treat any traumatic injury, but rather that concerns existed about her ability to ensure her own safety due to Alzheimer's disease. Mrs Fordham was placed on 1:1 nursing care in order to, amongst other things, mitigate the risk of further falls. Those caring for Mrs Fordham failed to conduct a falls risk assessment, introduce a falls care plan, or conduct an enhanced care assessment when indicated, these successive failings resulted in removal of 1:1 care and then an unwitnessed fall on 25th November 2022. Mrs Fordham sustained a broken neck of femur and underwent a surgical repair. Post surgically, she was transferred to a step-down care centre where she died on 1st January 2023.
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 **MATTERS OF CONCERN** are as follows. – 1. The poor quality of recording clinical records impeded the Trust's governance processes, in that the author of a serious incident investigation was unable to rely on clear evidence to understand why essential actions were not carried out in Ms Fordham's care. 2. The Trust failed to complete a falls risk assessment of Ms Fordham. 3. The consequence of (2) was that no falls care plan was completed. 4. The fact that the failures at (2) & (3) were not detected and remediated by successive clinical staff members suggests that they did not read essential parts of the clinical record when providing care. The cumulative failings, on the part of multiple healthcare professionals suggests a culture of indifference inimical to the provision of safe and effective practice. 5. The Trust has not considered any step to resolve individual failings in care through disciplinary or regulatory channels.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 **8th December 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 the family of Mrs Fordham I have also sent it to the local Director of Public Health who may find it useful or of interest. 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. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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] 05/10/2023 [SIGNED BY CORONER]**