Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Inquests - Frimley Health Foundation Trust (FPH Frimley Park Hospital)** **2** [redacted] **3**
1	**CORONER** I am Krestina HAYES, HM Assistant Coroner for Surrey for the coroner area of Surrey
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 03 July 2023 I commenced an investigation into the death of Isabella MCCREADIE aged 90. The investigation concluded at the end of the inquest on 03 June 2024. The conclusion of the inquest was that: On 24th April 2023 Mrs McCreadie at the age of 90 years old suffered a mechanical fall at home resulting in a comminuted fracture of the distal femur and fracture of her humerus. She was admitted to hospital and had an operation to repair the fracture to her distal femur. Mrs McCreadie suffered known complications following the major operation including low haemoglobin and delirium. She also developed a hospital acquired stage 4 pressure sore on her sacrum. Mrs McCreadie did not have the physiological reserves and died on 6th June 2023 at 18:30 at home in a residential address in Camberly of pneumonia.
4	**CIRCUMSTANCES OF THE DEATH** On 24th April 2023 Mrs McCreadie at the age of 90 years old suffered a mechanical fall at home resulting in a comminuted fracture of the distal femur and fracture of her humerus. She was admitted to hospital and had an operation to repair the fracture to her distal femur. Mrs McCreadie suffered known complications following the major operation including low haemoglobin and delirium. She also developed a hospital acquired stage 4 pressure sore on her sacrum. Mrs McCreadie did not have the physiological reserves and died on 6th June 2023 at 18:30 at home in a residential address in Camberly of pneumonia.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) 1. In evidence I was advised during Mrs McCreadie's stay in hospital her dietetic needs were not addressed as there was insufficient staffing in the dietician department. I asked the hospital when giving evidence if these issues had been addressed and was advised that there were still ongoing. I am concerned that if appropriate staffing levels are not put in

	place, patient's needs will not be met. 2. During evidence I was advised that a training need had been identified for staff regarding pressure sores following the passing of Mrs McCreadie. I have been advised in submissions by the hospital that they intend to address this training need by identifying e-learning staff can complete. Given in evidence it was identified that a) some staff do not know how to support and or handle patients who are in pain and refuse to be repositioned; and b) the staff are unaware of the techniques needed to be used to reposition patients who have multiple injuries, I do not consider that these can be adequately addressed by e-learning. 3. During the doctor's evidence, at inquest, an issue was highlighted regarding ordering of fortsips on the hospital computer system, a dietary supplement. An order had been made to be started on 10th May to 3rd June twice daily. This was not processed. I was advised in evidence by the hospital that the doctor could be shown how to release it. However, there is no evidence as to how this error could be identified if it should reoccur and a clinician was not aware that the order for fortsips was not released on the system. 4. At the time of the inquest, I was informed during Mrs McCreadie's stay a number of staff were agency staff. I note that the hospital now have more permanent staff in place on the ward than when Mrs McCreadie was on the ward. I remain concerned that agency staff who may still need to be called to assist on the ward may not have sufficient training on the computer system used for recording medical care provided before they are required to do so whilst working on the ward. At the inquest there was evidence that insufficient training had been given and therefore there were inconsistencies in recording of treatment given or needed. I understand permanent staff receive 9 hours of training, whereas agency staff may receive only up to 1 hour of training.
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 July 29, 2024. 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 I have also sent it to 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 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 by the Chief Coroner.

9	**Dated: 03/06/2024**  **Krestina HAYES** **HM Assistant Coroner for Surrey for Surrey**