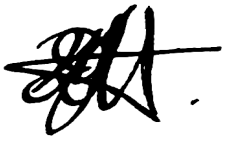
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted] – Chief Executive of East Suffolk and North Essex NHS Foundation Trust**
1	**CORONER** I am Darren STEWART OBE, HM Area Coroner for the coroner area of Suffolk
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 15 February 2023 I commenced an investigation into the death of Michael John BURKE aged 75. The investigation concluded at the end of the inquest on 15 February 2024. The conclusion of the inquest was that: Narrative Conclusion - Michael John BURKE died due to advanced lung disease with a fractured neck of femur sustained due to a fall on 30th January 2023 having made a material contribution. The medical cause of death was confirmed as: 1a Hospital Acquired Pneumonia,, Acute Pulmonary Oedema 1b Acute Heart Failure, Cardiomegaly 1c Ischaemic Heart Disease, Chronic Obstructive Pulmonary Disease
4	**CIRCUMSTANCES OF THE DEATH** Michael John BURKE was described by his family as a kind, loving, strong minded, dignified, intelligent man whose personality filled a room and who was a dedicated father and husband. Mr. Burke was diagnosed with asthma in 1969 for which he received treatment including steroid medication. This condition progressively worsened and he was diagnosed with Chronic Obstructive Pulmonary Disease (COPD) in 2008. Despite the significant impact this condition had on Mr. Burke's wellbeing, particularly in his later years, he sought to maintain an active life to the fullest extent possible and was otherwise healthy. Mr. Burke's COPD had worsened significantly towards the end of his life with an assessment in 2016 determining that he was suffering from advanced lung disease with only 16% use of his lungs. On the 30th December 2022 Mr. Burke was admitted to hospital with a suspected chest infection. Subsequent assessment determined that he was suffering from Community Acquired Pneumonia and an osteoporotic fracture of his vertebrae. He received treatment for his infection and conservative treatment for the fracture. His recovery was slow, however by 25th January 2023, Mr. Burke was medically fit for discharge; he had recovered from his pneumonia and was suitable to be stepped down for assessment as to care and rehabilitation needs in the community. He was discharged to a care home on 25th January 2023 for further assessment. The following evening, 26th January 2023, Mr. Burke was found collapsed on the lavatory floor

	by staff. Although not suffering a traumatic injury, Mr. Burke's oxygen saturation levels were dangerously low and ambulance were called who transported Mr. Burke to hospital. On admission Mr. Burke was diagnosed with suffering from a chest infection and delirium caused by both his infection and the effect of the pain medication he was receiving. On 30th January 2023 Mr Burke suffered a fall on the ward whilst trying to get up out of his bed. Limited and inadequate measures had been put in place to mitigate his falls risk and no falls assessment had been undertaken. Mr. Burke was assessed and diagnosed as having suffered a fractured neck of femur. Surgery to address the fracture was delayed due to Mr. Burke's general condition and very high risk of mortality from surgery. Mr. Burke's condition continued to deteriorate and by the morning of 2nd February 2023 he was assessed as being at the end of life. Michael John BURKE died on the 2nd February 2023.
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) The Court heard evidence that risk assessments were to be carried out regularly on patients in relation to their falls risk. This is particularly important in circumstances where a patient was being transferred between wards/units within the hospital and where the risk to the patient may change due to the change in environment. Mr. BURKE was such a risk from falling whilst on the ward and therefore arrangements were required to be put in place to manage this risk, informed by a risk assessment. He had been admitted to Ipswich Hospital on 26th January 2023 following an unwitnessed fall at rehabilitation centre where he had been discharged to from Ipswich Hospital the previous day; 25th January 2023. Mr. BURKE was moved to a new ward on the 30th January 2023 following his admission, assessment and initial treatment. He was not risk assessed when transferred to the ward and the outstanding task to carry out the risk assessment had not been completed by the end of the shift during which he had been transferred onto the ward. This requirement was not handed over to the on-coming shift and a falls risk assessment had not been completed at the time Mr. BURKE sustained a fall on the ward. I am concerned that Ipswich Hospital has inadequate arrangements in place to both highlight circumstances where the requirement for risk assessments have not been completed and in the arrangements for the handover of tasks (particularly falls assessments) between shifts. I am further concerned that the failure to have adequate arrangements in place to address this raises a risk of future deaths which I am under a duty to bring to your attention.
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 May 31, 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 [redacted] 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	**Dated: 05/04/2024**  **Darren STEWART OBE** **HM Area Coroner for** **Suffolk**