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 Medequip UK**
1	**CORONER** I am David LEWIS, Assistant Coroner for the coroner area of Liverpool and Wirral
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 17 January 2024 I commenced an investigation into the death of Douglas ARMSTRONG aged 88. The investigation concluded at the end of the inquest on 12 August 2024. The conclusion of the inquest was that: On 16 December 2023 the Deceased had an unwitnessed fall at his home address. He sustained a fractured neck of femur, but this was not identified either by two responders from an agency or by the district nurse who attended. As a result his arrival at Arrowe Park Hospital, Arrowe Park Road, Wirral hospital was delayed by around 18 hours, and it is likely that his subsequent surgery was similarly delayed, adding slightly to the mortality risk. He died at the hospital on 5 January due to aspiration pneumonia, which resulted from the accidental injury sustained in the fall. It is unlikely that the delay in hospital admission either caused or materially affected the timing of his death.
4	**CIRCUMSTANCES OF THE DEATH** On 16 December 2023 the Deceased had an unwitnessed fall at his home address. He sustained a fractured neck of femur, but this was not identified either by two responders from an agency or by the district nurse who attended. As a result his arrival at Arrowe Park Hospital, Arrowe Park Road, Wirral hospital was delayed by around 18 hours, and it is likely that his subsequent surgery was similarly delayed, adding slightly to the mortality risk. He died at the hospital on 5 January due to aspiration pneumonia, which resulted from the accidental injury sustained in the fall. It is unlikely that the delay in hospital admission either caused or materially affected the timing of his death.
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) Following his fall at home the Deceased was visited by two representatives of the care agency. They did not appreciate that he had suffered a fractured neck of femur. They placed more reliance than was justified upon his assertion that he had not hurt himself and was not in pain. The information supplied during their verbal communication with the

	ambulance service did not result in the latter appreciating the need for a personal attendance or visual assessment. Fractured neck of femur is a common consequence of falls in the elderly and requires prompt attention. Those providing a response system should have the skills, knowledge and training necessary to identify the problem or to appreciate that they cannot do so, and to communicate the limits of their diagnostic ability to the ambulance service. I was told that the responders acted in accordance with their existing training and have had no additional training since these events, nor was I told that any is planned. I am concerned that responders attending a similar call might be unable to assist effectively and would appreciate their employers addressing this by considering whether opportunities exist to improve the situation.
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 October 07, 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 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: 12/08/2024** David Lewis **David LEWIS** **Assistant Coroner for** **Liverpool and Wirral**