Prevention of Future Deaths Report

Ian Gilmore HEGARTY (date of death: 17 June 2024)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Group Chief Executive** **Barts Health NHS Trust** **Executive Offices** **Ground Floor** **Pathology and Pharmacy Building** **The Royal London Hospital** **80 Newark Street** **London** **E1 2ES**
1	**CORONER** I am Ian Potter, assistant coroner, for the coroner area of Inner North 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.
3	**INVESTIGATION and INQUEST** On 17 June 2024, an investigation was commenced into the death of Ian Gilmore Hegarty, then aged 89 years. The investigation concluded at the end of an inquest heard by me on 23 October 2024 at Poplar Coroner's Court. The inquest concluded with a short-form conclusion of 'accidental death'. The medical cause of death was: 1a hypovolaemic shock 1b traumatic fracture of right femur 1c frailty syndrome, vascular dementia II HIV encephalitis
4	**CIRCUMSTANCES OF DEATH** Mr Ian Hegarty was admitted to hospital on 5 June 2024, following a fall at home and increased confusion. He did not sustain any traumatic injury as a result of the fall at home.

	On 14 June 2024, Mr Hegarty was transferred to the Royal London Hospital for management of his underlying health conditions. He underwent a falls risk assessment following admission, which assessed him as being at moderate risk of falls. The ward put mitigation measures in place to address the falls risk, which included being placed in a bay where all four patients were constantly within the sight of an allocated member of staff who was expected to remain in the bay at all times. On 16 June 2024, the allocated member of staff left bay. In doing so, they did not follow the protocol that had been put in place to reduce the risk of falls for all patients in that bay. During the period of time in which the allocated member of staff was not within the bay, Mr Hegarty had an unwitnessed fall, causing him to sustain a fracture to his right neck of femur. Shortly after the fall, Mr Hegarty's blood pressure dropped. Despite treatment, his clinical condition deteriorated and he died in the Royal London Hospital in the early morning of 17 June 2024.
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 **MATTER OF CONCERN** is as follows: 1) That the plan of care put in place specifically to reduce the risk of falls for multiple patients was not followed. I heard evidence that an internal investigation into the matter has been commenced but is not yet concluded. As such, there was insufficient reassurance, at the time of the inquest, that the risk is being addressed.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 the report, namely 9 December 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 the following: 1. [redacted] and [redacted] – members of Mr Hegarty's family ([redacted]) 2. Care Quality Commission 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. She may send a copy of this report to any person who she 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	**Ian Potter** **HM Assistant Coroner, Inner North London** **28 October 2024**