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 CEO - Frimley Health NHS Foundation Trust**
1	**CORONER** I am Robert SIMPSON, Assistant Coroner for the coroner area of Berkshire
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 01 October 2024 I commenced an investigation into the death of Patrick Anthony COFFEY aged 85. The investigation concluded at the end of the inquest on 06 June 2025. The conclusion of the inquest was that: On the 29th September 2024 Patrick Anthony Coffey died at Wexham Park Hospital, Slough. He fell at home on the 12th September fracturing multiple ribs and remained on the floor until the following day contracting a chest infection. He was admitted to hospital for treatment but continued to deteriorate.
4	**CIRCUMSTANCES OF THE DEATH** As a result of falling at home Mr Coffey fractured multiple ribs and remained on the floor for about 17 hours. On arrival at hospital he was found to have contracted a chest infection. He suffered from COPD which did not usually affect his life and he was mobile prior to the fall. He was assessed in hospital and it was decided to treat the fractures conservatively. This required effective pain control which was not always offered or achieved. He did undergo 2 periods of local anaethesia infusions which were more effective in controlling the pain. He was treated with anitbiotics for the chest infection throughout his stay.
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) I heard evidence that it was important that Mr Coffey spent most of his time in a seated position rather than lying down. This was to assist with his ability to breathe more deeply and cough more effectively; both of which are of importance when treating chest infections especially in the context of a patient with rib fractures. The nursing witness for the trust confirmed that Mr Coffey should have been repositioned every 2-4 hours. It had been identified by the hospital during random monthly audits that this was either nor being done or not being properly recorded for some patients.

	Frimley Trust, after the inquest concluded, provided confirmation of when Mr Coffey's position was recorded during his stay. These reveal that on certain days almost no information is recorded and on other days it is possible to know his position on a 2-4 hourly basis. Of particular note is the following: 1. There is no record of his position from 16.39 on the 15/9/2024 to 06.51 on the 16/09/24, 2. The only record between 19.11 on the 16/9/24 and 04.18 on the 18/9/24 is one entry at 06.23 on the 17/9/24 3. The only record between 22.26 on the 18/9/24 and 01.51 on the 20/9/24 is one entry at 10.34 on the 19/9/24 4. There are only 2 entries for the 22/9/24 at 06.06 & 22.11 5. The entries for the 24/9/24 cease at 14.08 and they do not restart until 12.24 on the 25/9/24 6. The last entry on the 25/9/24 is at 14.35 and the next entry is not until 17.59 on the 26/9/24 7. The final entry on the 26/9/24 is at 20.54 and the first entry on the 27/9/24 is at 10.03. These records therefore have gaps of up to 27 hours. In addition the vast majority of records that do exist do not reveal whether Mr Coffey was actually repositioned as only one position is recorded. It is only on about 7 or 8 occasions that a repositioning has been recorded. The medical records from the hospital do not show repositioning every 2-4 hours and I found that Mr Coffey was probably not repositioned as required. In the particular circumstances of Mr Coffey this did not contribute to his death lack of repositioning does give rise to a risk of future deaths of those suffering from chest infections or, indeed, those particularly at risk of pressure damage.
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 September 01, 2025. 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 Mr Coffey** 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. 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	**Dated: 07/07/2025**  **Robert SIMPSON** **Assistant Coroner for** **Berkshire**