

16 September 2026

Mr Christopher Morris
Area Coroner, Manchester South
HM Coroner's Office
1 Mount Tabor
Stockport
SK1 3AG

Wythenshawe Hospital
Southmoor Road
Wythenshawe
Manchester
M23 9LT

Chief Executive's Office
Hospital HQ

Dear Mr Morris

Re: Inquest into the death of Mr William Brian Keary
Response to Prevention of Future Deaths Report dated 30 July 2026

I write on behalf of Manchester University NHS Foundation Trust (the Trust) in response to the Prevention of Future Deaths Report (PFD Report) issued following the conclusion of the Inquest into the death of Mr William Brian Keary. The Trust offers its sincere condolences to Mr Keary's family and would like to assure HM Coroner and Mr Keary's family that the concerns raised within the PFD Report have been taken very seriously by the Trust.

The Trust has reviewed HM Coroner's matters of concern through a multidisciplinary process involving Healthcare Legal Services, Corporate Nursing, Clinical Governance, Digital/Informatics and the Senior leadership team at Wythenshawe, Trafford, Withington and Altrincham (WTWA) Hospitals Clinical Group. The response below addresses each concern in turn and sets out the action taken, the evidence available and the arrangements for ongoing oversight.

Summary of HM Coroner's matters of concern

MATTER OF CONCERN 1: CAPTURE AND AVAILABILITY OF CONTEMPORANEOUS FALLS EVIDENCE

Concern that the First Responder document referred to in the Trust's 23 November 2020 response in the William McKibbin case appeared to have fallen out of use. HM Coroner identified the importance of gathering the best available evidence about the causes and precise circumstances of inpatient falls and considered that this created an ongoing risk of future deaths.

The Trust recognises the importance of obtaining, preserving and making available the best contemporaneous evidence following an inpatient fall. We also recognise that evidence must be readily identifiable for clinical review, incident investigation, complaint handling and coronial proceedings.

What the Trust's review established

Following Mr Keary's fall on 21 August 2025, the paper First Responder falls document was completed and scanned into the 'media' section of the Hive Electronic Patient Record (EPR), in line with the process in place at that time. This document formed the contemporaneous post-fall record. The Trust acknowledges, however, that the terminology used during the Inquest may have caused confusion, particularly because post-falls documentation is now completed differently across Trust hospitals using Hive EPR. Since December 2025, those hospitals have no longer used the paper First Responder falls document. Instead, staff complete the electronic post-falls action record in Hive EPR, which provides the contemporaneous record of post-fall management, including the assessment undertaken, actions completed, investigations requested and any further interventions implemented to reduce the risk of a further fall. This record is readily available and visible to relevant staff within the patient's Hive record. A small number of community intermediate care units across the Trust do not currently use Hive EPR and continue to use the paper First Responder falls documentation until they transition to Hive. The Trust has therefore reviewed and disseminated the Falls Prevention and Management Policy to ensure that the required post-falls documentation is described clearly and consistently across all settings. The principal learning is not that a post-fall record was absent in Mr Keary's case, but that the Trust must ensure such documentation is consistently identifiable, retrievable, reviewed and disclosed when required for clinical review, governance processes, incident investigation, complaint handling and coronial proceedings.

Whilst the correct post-fall document was completed for Mr Keary, this did not accurately capture that Mr Keary had been escorted to the toilet, which in turn did not support the inclusion of accurate and comprehensive information within the initial evidence provided to the court. The section below outlines the post-falls procedures that should be followed in accordance with the Trust's Falls Prevention and Management Policy.

Following the fall, an incident report was submitted and Mr Keary's falls risk assessment and falls care plan were reviewed and updated, in line with Policy.

Actions and assurance

- The Trust's Falls Prevention and Management Policy includes a clear flow chart setting out the actions to be taken following any patient fall. This includes immediate clinical actions, escalation requirements and the necessary documentation. All inpatient falls are reviewed, regardless of whether harm is identified.
- All acute hospitals within the Trust use Hive EPR. In these areas, the electronic post-falls action record in Hive EPR is the required record and has replaced the former paper First Responder falls document. This documentation captures the immediate post-fall assessment, circumstances of the fall, observations, actions taken, escalation and ongoing safety measures.
- WTWA Hospitals completed an audit of inpatient falls between February 2026 and July 2026. This demonstrated full compliance with completion of falls risk assessments before and after a patient fall, and strong compliance with completion of the post-falls action record. Findings will be reviewed through the WTWA Hospitals Fundamentals of Care Group, chaired by the Director of Nursing, incorporated into the falls action plan, and re-audited in October 2026 to confirm sustained improvement and provide ongoing assurance.

- The Trust provides falls awareness training to all clinical staff. This covers the frequency of falls risk assessments, identification of falls risk factors, including medicines that may increase risk, bed rails guidance and risk assessment, care planning, and post-fall reporting requirements. Current training compliance is 93% across the Trust and 91% across WTWA Hospitals. Compliance is monitored through hospital quality and safety meetings, with Trust-wide oversight provided by the Trust Falls Steering Group. A trajectory is in place to achieve training compliance above 95% for all clinical staff by the end of November 2026.

Ongoing monitoring

Falls resulting in harm are monitored at Trust level through the Integrated Performance Report, using the measure of falls with harm per 1,000 bed days. At hospital level, all falls, including those where no harm is identified, are reviewed through the Quality and Safety Group, chaired jointly by the Medical Director and Director of Nursing, with exceptions escalated to the Trust Quality and Safety Management Committee as required. Trust-wide learning and improvement in falls prevention and post-falls management will continue to be overseen by the MFT Trust Falls Steering Group, which meets bi-monthly and focuses on shared learning, data review and improvement activity to reduce falls and strengthen patient safety across the Trust.

MATTER OF CONCERN 2: CANDOUR, OPENNESS, TRANSPARENCY AND ACCURACY OF EVIDENCE

Concern that evidence at the part-heard inquest on 30 December 2025 from the co-ward manager of the OPAL Assessment Unit was not candid as to her understanding of the circumstances in which Mr Keary fell. HM Coroner emphasised the importance of openness and transparency in enabling adverse incidents to be quickly and fully understood, particularly by those in management or leadership roles.

The Trust recognises and supports that coronial proceedings require evidence that is candid, accurate and comprehensive. This includes an organisational responsibility to ensure that witnesses, particularly those in management or leadership roles, are supported to access the relevant clinical records, staff accounts, incident documentation and complaint correspondence before giving evidence.

What the Trust's review established

At the initial hearing on 30 December 2025, evidence was given based on what at the time was understood to be circumstances surrounding the fall, namely that Mr Keary had mobilised to the toilet unaccompanied before the fall. The Trust's review identified that the Ward Manager had been informed by Mr Keary after the fall that he had walked to the toilet unaided and that she relied on his account when forming her understanding of the circumstances. However, the Trust acknowledges that this account should have been tested against the wider available evidence, including staff accounts and clinical documentation. The reliance placed on Mr Keary's account contributed to the investigation and evidence review not being sufficiently thorough, as it was later clarified that Mr Keary had walked to the bathroom assisted by a member of staff. The corrected factual position was subsequently reflected in staff evidence and in the Trust's further complaint response, which included an apology to the family and was disclosed to HM Coroner.

The Ward Manager has reflected significantly on this matter and on the importance of ensuring that any statement or evidence is supported by a complete review of all available records and relevant accounts. The Trust does not have concerns regarding the Ward Manager's candour or professional integrity, and appropriate communications have taken place with the relevant regulatory body. The learning identified is organisational and relates to ensuring that investigation processes, evidence reconciliation and witness preparation are sufficiently robust before evidence is provided. The WTWA Falls Review Standard Operating Procedure, updated in March 2026, now supports this by requiring an immediate hot debrief to capture accurate and relevant information from staff, senior nurse review of each fall, identification of learning, appropriate escalation and oversight, regardless of whether harm is sustained.

The Trust recognises HM Coroner's concern that openness and transparency are essential to enabling adverse incidents to be quickly and fully understood. Those in management or leadership roles have a particular responsibility to ensure that relevant evidence is reviewed together, that any uncertainty or inconsistency is actively identified and explored, and that evidence provided to HM Coroner is clear, complete and appropriately qualified where facts remain uncertain.

Actions and assurance

- The Trust's coronial case preparation includes evidence reconciliation. Clinical records, incident documentation, complaint responses, family concerns and witness statements are reviewed together, with any discrepancies or areas of uncertainty explicitly recorded and appropriately brought to the court's attention.
- There is a robust process in place for witness preparation. This includes access to the complete relevant evidence bundle, clear explanation of the duty to identify and explain any uncertainty or discrepancy, and a structured debrief and reflective learning process following a hearing.
- Hospital Senior Leadership Team oversight is now in place for cases that raise significant patient safety, regulatory, reputational or professional issues. This provides senior review of the evidence base and confirms that relevant records and accounts have been considered before evidence is provided to assist the court.

Learning from the 2020 Prevention of Future Deaths Report

The Trust acknowledges HM Coroner's reference to the 2020 Mr McKibbin PFD response and the importance of demonstrating that coronial learning is implemented and sustained. The actions described in this response build on that earlier learning by strengthening the capture, visibility, review and disclosure of contemporaneous post-fall evidence, and by ensuring that post-falls documentation requirements are clearly reflected in current policy, training, audit and governance arrangements.

Governance and executive oversight

Executive oversight of the response and associated improvement actions will be provided by the Deputy Trust Chief Executive and Chief Nursing Officer as executive sponsor. Operational delivery will be led through the relevant senior leads, including the Director of Nursing, Medical Director, Deputy Chief Nursing Officer, Chief Nursing Information Officer/Digital Lead and Head of Healthcare Legal Services. This will ensure that actions relating to post-falls documentation,

evidence reconciliation, witness preparation, coronial learning and escalation are progressed collectively, with appropriate clinical, governance, digital and legal input. Primary oversight will be through the Quality and Safety Management Committee, with assurance and escalation to the Quality, Safety and Performance Board Committee as required, so that implementation, impact and any residual risks are subject to executive scrutiny.

Conclusion

The Trust is grateful for the opportunity to respond and has taken both matters of concern seriously. The actions described above are intended to ensure that contemporaneous post-fall evidence is consistently captured, clearly located, retrievable and reviewed; that learning from previous PFD reports is demonstrably implemented and sustained; and that evidence provided during coronial proceedings is supported by robust investigation, evidence reconciliation, openness, accuracy, witness support and senior oversight.

We will provide any further information that HM Coroner may require.

Yours sincerely



Chief Executive
Wythenshawe, Trafford, Withington and Altrincham Hospitals