

REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

1.	CORONER I am Chris Morris, Area Coroner, for the coroner area of Greater Manchester (South)
2.	DATE OF REPORT 30 July 2026
3.	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.	THIS REPORT IS BEING SENT TO 1) The Chief Executive, Manchester University NHS Foundation Trust. You are under a duty to respond to this report within 56 days of the date of this report, namely by 24 September 2026. I, the coroner, may extend the period if an appropriate application is made.

4.	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
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5.	SUMMARY OF CORONER'S CONCERNS This report is made in respect of concerns surrounding the processes in place at the Trust to capture evidence following a patient falling whilst in hospital, and about candour in response to adverse incidents by those in management and / or leadership roles.
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6.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
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7.	INVESTIGATION AND INQUEST On 8 October 2025, an inquest was opened into the death of William Brian Keary who died at St Ann's Hospice, Stockport on 17 September 2025. At the inquest, it was determined Mr Keary had died as a consequence of Metastatic Prostate Cancer. The inquest concluded on 23 July 2026. At the end of the inquest, I recorded a Narrative Conclusion, finding that Mr Keary died as a consequence of dedifferentiated metastatic prostate cancer.
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8.	CIRCUMSTANCES OF DEATH Mr Keary died at St Ann's Hospice, Stockport on 17 September 2025 as a consequence of metastatic prostate cancer having ben discharged there from Wythenshawe Hospital, where he had been admitted with signs of right-sided pain, confusion, general decline and low haemoglobin.
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9.	CORONER'S CONCERNS During the course of the inquest, I heard evidence 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: 1. The court heard evidence about Mr Keary falling over in a bathroom whilst a patient on the OPAL Assessment Unit. On 28 September 2020, I issued a Prevention of Future Deaths Report to your predecessor following my investigation into the death of Mr William McKibbin who died at Trafford General Hospital on 20 August 2018 as a consequence of complications of a traumatic brain injury sustained in a fall there. In the Trust's letter of response dated 23 November 2020 (pp. 7-8) the following is stated: <i>'In addition, in response to the learning arising out of the review of Mr McKibbin's care, a First Responder document has been developed and brought into use Trust-wide from September 2020, included as part of the updated Falls Investigation template. This document has been designed to support staff in investigating the immediate scene following an inpatient fall. Key considerations for completion of the First Responder document have been disseminated to staff using the "Feedback Friday" campaign.</i>
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*This has included communicating that the First Responder document **must be completed for all falls, even where patient harm is not suspected*** (emphasis added).

In the light of evidence given by Wythenshawe's current Director of Nursing, I am concerned that the First Responder document referred to above appears to have fallen out of use at the Trust. In view of the importance to patient safety of gathering the best available evidence as to the causes of falls and the precise circumstances in which they occur, I am concerned this creates an ongoing risk of future deaths.

2. I am concerned that when giving her evidence on 30 December 2025 before the inquest was adjourned to obtain further evidence, the co-ward manager of the OPAL Assessment Unit was not candid as to her understanding of the circumstances in which Mr Keary came to fall. Given the importance to the prevention of future deaths inherent in fostering a culture of openness and transparency in complex NHS organisations with a view to adverse incidents being quickly and fully understood, a lack of candour from those in management and / or leadership positions is a matter of particular concern.

10.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: <i>[please do not use individual's names, but instead roles/titles]</i> 1) Mr Keary's family; 2) The Trust's legal department; 3) The Nursing and Midwifery Council; and 4) The Care Quality Commission. I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
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