REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Sir Michael Deegan CBE, Chief Executive, Manchester University NHS Foundation Trust, Cobbett House, Manchester Royal Infirmary, Oxford Road, Manchester M13 9WL

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 14th November 2018, Rachel Galloway, Assistant Coroner for Manchester South opened an inquest into the death of Mr Geoffrey Jackson, who died at Trafford General Hospital on 6th November 2018 aged 87 years. The investigation concluded at the end of the inquest which I heard on 19th February 2019.

At the end of the inquest, I recorded a narrative conclusion that Mr Jackson died as a consequence of natural causes contributed to by recognised complications of recent surgery.

CIRCUMSTANCES OF THE DEATH

Mr Jackson's medical history included ischaemic heart disease and coronary artery disease. He had previously suffered two myocardial infarctions, but was considered stable by the cardiologists who kept him under regular review as an outpatient.

Mr Jackson's mobility had declined in recent years, as a consequence of osteoarthritis of both knees and the left hip joint.

On 28th September 2018, Mr Jackson was admitted to Manchester Royal Infirmary for an elective (acknowledged to be high-risk) hip replacement procedure under the care of [redacted] The surgery proceeded without incident, however Mr Jackson became unwell in its aftermath, having experienced a cardiac event and developed hospital acquired pneumonia.

On 25th October 2018, Mr Jackson was transferred to Trafford General Hospital for rehabilitation, via the Acute Medical Unit. On 1st November 2018, Mr Jackson was moved to Ward 6.

A Risk of Falls assessment undertaken on the Acute Medical Unit had identified Mr Jackson as being at risk of falls. Upon transfer to Ward 6, there was a delay in completing a further Risk of Falls Assessment within the timescales prescribed by Manchester University Hospitals NHS Foundation Trust.

On 3rd November 2018, Mr Jackson removed his NG feeding tube, and according to his daughter was exhibiting signs of agitation. Despite this and the fact he was moved to a side room, no repeat Risk of Falls Assessment was undertaken.

Later that day, Mr Jackson was found on the floor near his bed, having sustained an unwitnessed fall. In view of the fact Mr Jackson appeared to have sustained a head injury, a junior doctor sought to obtain a CT scan. This was, however, never undertaken.

Mr Jackson died on 6th November 2018 as a consequence of:

1a) Congestive Cardiac Failure;

b) Ischaemic Heart Disease

2) Left Hip Replacement and Hospital Acquired Pneumonia.

There was no evidence before the court to suggest that the fall on 3rd November 2018 contributed to, or materially hastened, Mr Jackson's death.

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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

1. Notwithstanding the actions which have been taken following the Trust's investigation into the circumstances of Mr Jackson's fall, a spot-check recently undertaken by the Matron on Ward 6 found 2 out of 32 patients had not had Risks of Falls Assessments completed in accordance with Trust requirements;

2. A further matter of concern arose from the manner in which nursing records are made at Trafford General Hospital, with an emphasis on proforma care plans which simply require signing and dating by nurses, observation charts, and sheets upon which variances from the care plans can be recorded. It is a matter of concern that the absence of any requirement upon the nurse looking after a patient for a given shift to make a structured narrative record of what transpires over that period represents a missed opportunity to capture nuanced changes in a patient's condition, and communicate these to others.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 23rd April 2019. 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

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to [redacted] on behalf of Mr Jackson's family.

I have sent a copy of my report to the Care Quality Commission, who may find it useful or of interest.

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. 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.

Dated: 26th February 2019

Signature:

Chris Morris HM Area Coroner, Manchester South.