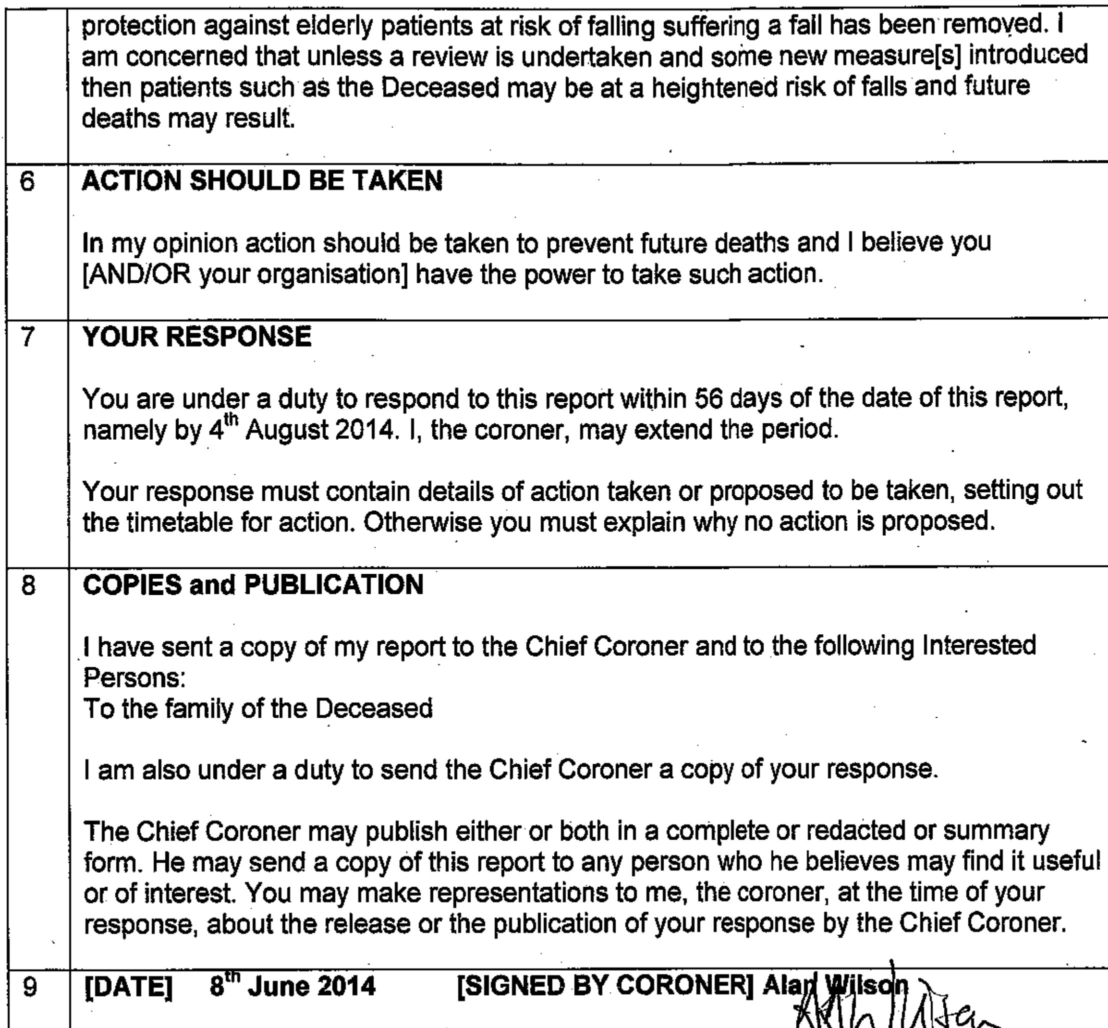
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Arrow Park Hospital NHS Trust**
1	**CORONER** I am Alan Wilson assistant coroner, for the coroner area of Merseyside [Wirral]
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 11th December 2013 I commenced an investigation into the death of James McArdle, born 22/05/24.The investigation concluded at the end of the inquest on 25th April 2014. The medical cause of death was 1 a Large left sided Subdural Haematoma 11 Aortic stenosis The conclusion of the inquest was one of Accidental death.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased was an elderly but independent man who suffered from a number of co-morbidities. Having been admitted to hospital on 24th November 2013, he suffered two falls on 5th December 2013, just under 20 hours apart. After the first fall he was assessed by medical staff, and the observations did not indicate a CT scan was needed. After the second fall his condition was not survivable. Evidence was heard from a senior member of the nursing staff who explained that as a patient at risk of falls, the Deceased was given a call bell to alert staff if he wanted to leave his bed and he could be escorted, but that should he leave his bed staff on the ward would realise he was at risk of falls due to a system that involved patients wearing coloured wrist bands to signify their level of risk. This witness explained that since this incident the use of the wrist band system had been withdrawn and not replaced.
5	**<u>CORONER'S CONCERNS</u>** 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. – That whatever the thinking was as regards the merits of the coloured wrist band system, the system has been withdrawn and not replaced, and in the process a level of



	protection against elderly patients at risk of falling suffering a fall has been removed. I am concerned that unless a review is undertaken and some new measure[s] introduced then patients such as the Deceased may be at a heightened risk of falls and future deaths may result.
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 4th August 2014. 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: To the family of the Deceased 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.
9	**[DATE] 8th June 2014 [SIGNED BY CORONER] Alan Wilson**