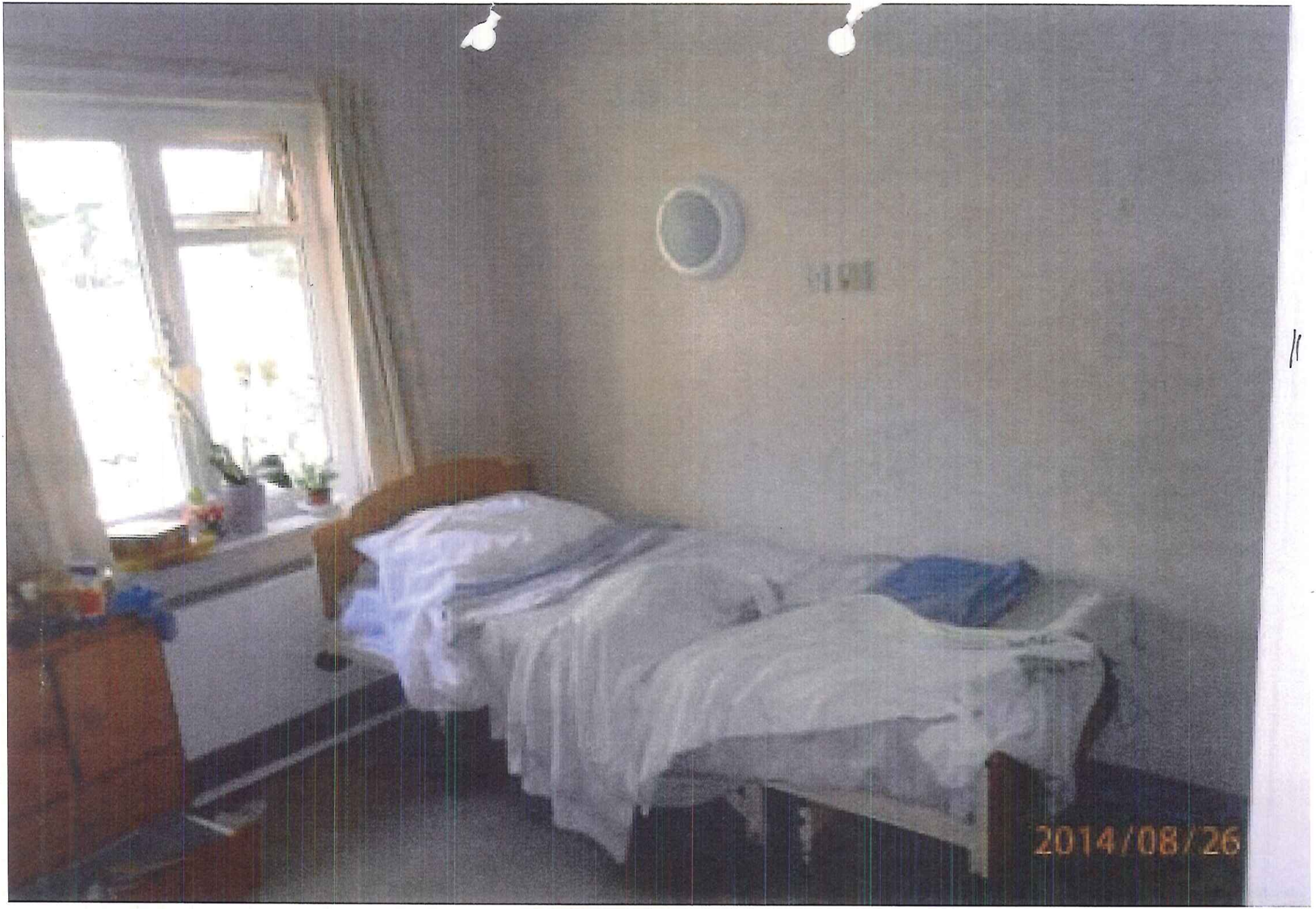
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive** **Norfolk & Suffolk NHS Foundation Trust** **Trust Headquarters** **Hellesdon Hospital** **Drayton High Road** **Norwich** **NR6 5BE**
1	**CORONER** I am JACQUELINE LAKE, senior coroner, for the coroner area of NORFOLK
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 30 December 2013 I commenced an investigation into the death of ANN MARY WELLS, AGE 77 YEARS. The investigation concluded at the end of the inquest on 2 September 2014. The conclusion of the inquest was medical cause of death: 1a) Traumatic intracerebral haemorrhage b) fall with head injury; and short-form conclusion: Accidental Death.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Wells was resident on Sandringham Ward, Julian Hospital, Norwich (providing care and treatment for those with complexities in later life) and was mobile with the aid of a 3 wheeled frame. Mrs Wells was assessed as being at risk of falls. A Falls Care Plan was in place. On 21 November 2013 Mrs Wells was found on the floor of her room. She told staff she had crossed her room to switch on her light. There is a light switch and a call bell on the wall beside her bed where she was sleeping. Mrs Wells was taken to hospital, returned to Julian Hospital and then readmitted to hospital. She had another fall. Her condition deteriorated and Mrs Wells died on 28 December 2013.
5	**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. – (1) A light switch was positioned on the wall beside Mrs Wells' bed (see attached photograph). Mrs Wells was 77 years of age, frail with scoliosis, osteoarthritis and a tremor and walked with the aid of a 3 wheeled frame. Evidence was given that this could have been reached by Mrs Wells when in a sitting position in bed. Photographs taken of the bedroom do not support this. Further the emergency call switch is situated next to the light switch. (2) No risk assessment had been carried out with regard to Mrs Wells being placed in

	this particular room.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 10 November. 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: [redacted] (daughter) 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: 11 September 2014** ..... **Jacqueline Lake** **Senior Coroner for Norfolk**


2014/08/26