	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. County Durham and Darlington NHS Trust
1	**CORONER** I am Andrew Tweddle Senior Coroner for the coroner area of County Durham and Darlington.
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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 2nd March 2015 I commenced an investigation into the death of Thomas Luke-Taylor. The investigation concluded at the end of the inquest on 2nd March 2015. The conclusion of the inquest was that "The deceased who had had a stroke fell out of bed and sustained an injury whilst in Bishop Auckland General Hospital. A conclusion of Accidental Death was returned and a cause of death of 1a, Sub-Dural Haematoma. 1b, Head Injury secondary to a Fall and 2, Cerebro-Vascular Disease, Bronchopneumonia and Fractured Left Femur, was found.
4	**CIRCUMSTANCES OF THE DEATH** The deceased who had had a stroke was in the Stroke Rehabilitation Ward at Bishop Auckland General Hospital where he fell out of bed, suffered a head injury and subsequently died. On admission to the University Hospital of North Durham a staff nurse assessed him as not being at risk of falls. He was admitted following transfer from the Royal Victoria Hospital in Newcastle where he had been assessed at risk of falls following his stroke but the staff nurse was not aware of this. On transfer to Bishop Auckland Hospital a student nurse completed a falls risk assessment and wrongly categorised the deceased as not being at risk of falls. Her involvement in the deceased's care was not properly supervised by a staff nurse. In evidence it was said that the staff nurse who made the initial assessment at UHND made the assessment in good faith based on her professional assessment but that she was relatively inexperienced. Two other staff nurses, who were both more experienced, believed that the fact that the deceased had had a previous stroke would have made him more likely to have been at risk of falls and in the absence of any contraindication would have assessed him as being at risk of falls. The matron who produced the RCS concurred that stroke patients were often at increased risk of falls.
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. – In evidence the Matron was asked whether it might be preferable for the falls risk assessment form to give a presumption that certain classes of patients (for example stroke patients) were at increased risk of falls and should be considered as such unless there were good reasons to the contrary. It was her view that this would not be good practice as each and every patient should be assessed on an individual basis. Whilst that is a laudable outlook it was put to her that if there had been such a presumption then the misclassification by the original staff nurse and by the student nurse might have

	been avoided and this could lead either in this case or in other cases to a potentially different outcome. The matron's view was that freedom of assessment was nevertheless best practice. I indicated my concern over this issue as to whether there should be a presumption in certain cases of an increased risk of falls and that consideration of this issue would be useful.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 28th April, 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]. I have also sent it 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.
9	**[DATE]** 3. III - 15 **[SIGNED BY CORONER]** [redacted]