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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. Nottinghamshire Healthcare NHS Trust (hereafter referred to as “the Trust”)**
1	**CORONER** I am Miss Stephanie Haskey, Assistant Coroner, for the Coroner area of Nottinghamshire
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** The death of John Lowe was subject to an Inquest from 23rd to 25th March 2015.
4	**CIRCUMSTANCES OF THE DEATH** John Lowe was an inpatient in wards controlled by the Trust for mental health assessment and care following his suffering a stroke on 7th January 2014. He had been transferred to the Trust from medical wards controlled by Nottingham University NHS Trust, where he had been assessed as being at high risk of falls and had been provided with 1:1 nursing as a result of such assessment. Whist on mental health wards in the care of the Trust he suffered a series of falls, the final one of which, on 18th February 2014, caused him to sustain a fractured left neck of femur. This injury made a material contribution to his eventual death from bronchopneumonia on 26th February 2014.
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. That there was a belief amongst members of the Trust’s nursing staff that they were unable as a matter of policy to provide 1:1 nursing care for a patient in respect of that patient’s falls risk assessment alone, no matter what that assessment might be. 2. That there was a belief amongst members of the Trust’s nursing staff that 1:1 nursing could only be provided on the basis of a patient’s particular mental health needs, and not in respect of his or her physical care needs.
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 1st June 2015. 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], John Lowe's granddaughter and Nottingham University Hospitals NHS Trust, 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	**1st April 2015** **Stephanie Jane Haskey,** **Assistant Coroner, Nottinghamshire**