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:** **Chief Executive** **Queen Elizabeth Hospital** **Gayton Road** **King's Lynn** **Norfolk PE30 4ET**
1	**I am Yvonne Blake** Area 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 24 November 2016 I commenced an investigation into the death of James Charles MALLETT, 93yrs of age. The investigation concluded at the end of the inquest on 14 March 2017. The conclusion of the inquest was given in a narrative form (see attached). The medical cause of death was 1a) Subdural Haemorrhage, 1b) Fall and 1c) Parkinson's disease.
4	**CIRCUMSTANCES OF THE DEATH** Mr Mallett was admitted to hospital after a fall at home. Whilst an inpatient he fell again and sustained a fatal head injury. He was put back to bed and a doctor called, this doctor appears to have arrived some two hours later. There was no attempt by the nursing staff to secure his more urgent attendance. They did not ask for help from the night team. The neurological observations carried out were unclear and not of an acceptable standard or in a timely manner. In addition when the doctor did arrive he ordered a CT scan (urgent) and after seeing the results showing a massive intracranial bleed, then ordered neurological observations to done two hourly which is not as per hospital guidelines.
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) It became clear during evidence that the nursing staff on duty on 13 November 2016 were not able to understand and carry out proper neurological observations. This became evident when on one set of observations the nurse assessed Mr Mallett's Glasgow Coma scale (GCS) as 3 (lowest score possible) and yet still had equal power in all four limbs which would not have been possible to assess. Some of the observations contradicted each other with one nurse assessing the patient as 6 on the GCS. (2) There was no apparent urgency to secure the prompt attendance of a doctor to assess the patient. The nursing staff, who were described by Sr Snowden as a "junior

	workforce" did not seem to understand the seriousness of the injury and did not seek senior help from the night team. The nursing staff did not carry out regular and/or timely neurological observations. (3) The nursing staff made no contemporaneous notes for a period of five hours on the system so there was little information about the timings of their actions. The doctor did not arrive until over two hours later but did order an urgent CT scan, however when he had the results he then ordered neurological observations be done every two hours which is not as per hospital protocol. 4) The nursing staff on duty do not appear to have the requisite knowledge **or experience** to nurse patients such as Mr Mallett. There was no falls planning or prevention, there was no care plan in place on this ward. There was no use of items such as sensor crash pads, or equipment which can be attached to patients to warn of movement. The nurse who was stationed in that 6 bed bay because Mr Mallett and others in there were at particular risk, left her post and then Mr Mallett was found on the floor. 5) There do not appear to be systems in place at the hospital which are sufficient to recognise when nurses are so inexperienced and/or lacking in training that they cannot undertake basic observations on a patient following an injury of this kind.
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 11 May 2017. 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] (Niece) I have also sent it to: • Department of Health • Healthwatch Norfolk 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	**Dated: 16 March 2017** ..... **Yvonne Blake, Area Coroner**