## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Black Country Partnership, NHS Foundation Trust**<br>**Chief Executive, New Cross Hospital.** |
| 1 | **CORONER**<br><br>I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 17 January 2017, I commenced an investigation into the death of the late Mr Reginald Frank Lewis. The investigation concluded at the end of the inquest on 27 April 2017. The conclusion of the inquest was a short narrative conclusion of accident.<br><br>The cause of death was:<br><br>1a Intracerebral Haemorrhage<br>b Fall<br>c<br>II Bronchopneumonia, Chronic Kidney Disease, Ischaemic Heart Disease, Hypertension |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>i) Mr Lewis was admitted to New Cross hospital after a fall at home on the 13 January 2017.<br><br>ii) He had a medical history including chronic kidney disease, previous myocardial infarction, poor memory, peripheral vascular disease, COPD and worsening confusion. A chest x-ray showed consolidation of the right upper lobe suggestive of pneumonia and he was started on antibiotics.<br><br>iii) A CT head scan on admission did not show any intracranial haemorrhage, subdural collection or fractures. He was then transferred from the Acute Medical Unit (AMU) ward to ward C19 which deals with respiratory illness when a bed became available.<br><br>iv) He was transferred on the basis that he had mild confusion but it wasn't made clear to staff on ward C19 the extent of his confusion and risk of falls and that he was also registered blind.<br><br>v) On the afternoon of the 14 January 2017, Mr Lewis became increasingly agitated and after family had left visiting him he had a fall and sustained a significant head injury. The family maintain they had notified staff they were |

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| | leaving at the time.<br><br>vi) A repeat CT head scan demonstrated a left parietal intraparenchymal bleed. This was discussed with neurosurgeons who deemed he wasn't suitable for surgical intervention. He was also reviewed by the stroke team.<br><br>vii) He gradually deteriorated following this with GCS dropping to 3 and sadly passed away on the 17 January 2017 due to the head injury and bleed on the brain. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>1. Evidence emerged during the inquest that the patient was left alone unsupervised when family visitors left the ward. It transpired that staff didn't know relatives had left the ward.<br><br>2. On ward c19, there were already six patients on the ward required to be observed 24 hours a day in two bays. Two bays were subsequently closed to diarrhoea and vomiting.<br><br>3. Evidence emerged from nursing staff on Ward C19 that they were unable to take any more patients that are confused, wandering or aggressive. This was based on the enhanced scoring tool and the number of patients that required one to one observation.<br><br>4. Despite initial reservations, junior nursing staff did eventually accept Mr Lewis into Ward C19 on the basis he had mild confusion and claimed they felt "under some pressure" from senior nursing staff to accept him. This was in contrast to the opinion of the senior Charge Nurse on ward C19 who gave evidence that he still would not have accepted the patient in the circumstances. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.<br><br>1. You may wish to consider setting up a review of the management policy of transfers of patients between wards and the sharing of information including medical history so that a clear picture of the risk assessment is considered. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 June 2017. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons; Family. |

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| | 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 | **4 May 2017**<br><br>**Mr Zafar Siddique**<br>**Senior Coroner**<br>**Black Country Area** |