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.** Ms Trish Armstrong-Child, Director of Nursing, Royal Bolton Hospital, Minerva Road, Farnworth, Bolton BL4 0JR **2.** Mr Anthony Ennis, Chief Operating Officer, Royal Bolton Hospital, Minerva Road, Farnworth, Bolton BL4 0JR **3.** Rambleguard Ltd., Elmfield House, Rathenraw Industrial Estate, Greystone Road, Antrim BT41 2SJ **4.** The Right Honourable Jeremy Hunt, Department of Health, Richmond House, 29 Whitehall, London SW1A 2NS
1	**CORONER** I am Timothy William Brennand, HM Assistant Coroner for the Coroner Area of Manchester West.
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 the 30th May 2017 I commenced an Investigation into the death of Pauline Hayston, aged 81. The Investigation concluded at the end of the Inquest on the 22nd September 2017. The medical cause of death was determined to be:- Ia Bronchopneumonia Ib Immobility following Fracture of Neck of Right Femur II Coronary Artery Atherosclerosis, Hypertension and Diabetes Mellitus There was a narrative conclusion that Pauline Hayston died as a consequence of injuries sustained in an accidental fall and resulting immobility on a background of naturally occurring disease.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a history of Pulmonary Hypertension, Atrial Fibrillation, Ischaemic Heart Disease, Congestive Heart Failure and Type II Diabetes. The deceased was admitted as an inpatient at the Royal Bolton Hospital, Minerva Road, Farnworth on the 14th April 2017, presenting with declining health, increased frailty and recent episodes of falls. She was managed conservatively and on the 20th May 2017, sustained a fractured neck of femur in an unwitnessed fall on ward while attempting to mobilise from her bed. A falls mat

	in place to alert staff of such un-assisted movement did not activate. By reason of her frailty and co-morbidities, the deceased was assessed as unfit for surgery and her fracture was therefore managed conservatively. Her condition was to deteriorate until she died on the 25th May 2017.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: 1. The deceased had correctly been assessed as presenting a high risk of falls as an inpatient on ward and nursing staff accordingly were to deploy the use of a Rambleguard falls mat. The evidence established that it was correctly positioned. 2. The Rambleguard falls mat failed to activate upon the un-assisted mobilising of this patient. Evidence from the Ward Manager and Nursing Staff established that: a. The wireless "WiFi" activated system would frequently cause a significant delay as between a patient activating the signal and the transmission to nursing staff. b. There had been at least 4 occasions within the experience of the Ward Manager that the Rambleguard fall mats were not activating at all – in circumstances that suggested to the Ward Manager that the mats were not fit for purpose. c. The mats had been returned to the manufacturer who were unable to establish why the fall mats had not been activated. d. The issue of the time delay between activation and the triggering of the nursing alarm was considered by the manufacturer, potentially, to be because of an interference of the signal arising from the number of mats in use in one Ward, but there was no evidence that nursing staff had been given instruction or guidance as to how resolve this potential technical operational issue. The evidence raises the following concerns:- 1. The reliability of the Rambleguard fall mats and its fitness for purpose. 2. The suitability of a wireless "WiFi" activated on a ward where several fall mats are in place in close proximity to each other. 3. Interim instructions to nursing staff where the operational integrity of an essential item of equipment to alleviate falls risks has been identified.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that you 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 November 18th 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] The Clinical Director, Royal Bolton Hospital, Minerva Road, Farnworth, Bolton BL4 0JR 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** **28th September 2017**	**Signed** **Timothy W Brennand,** **HM Assistant Coroner**