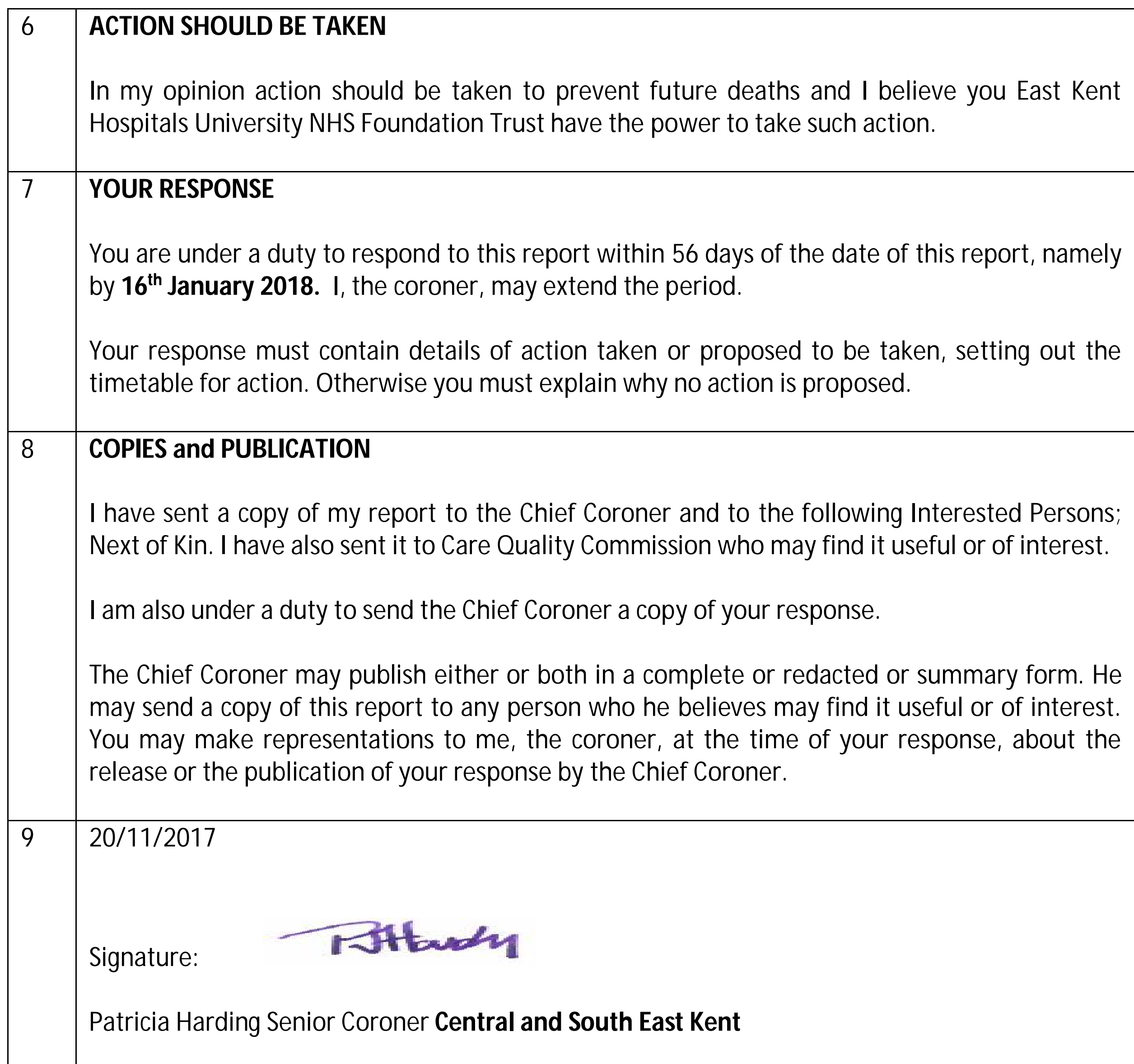
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: East Kent Hospitals University NHS Foundation Trust
1	**CORONER** I am Patricia Harding Senior Coroner for **Central and South East Kent**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 30/03/2017 I commenced an investigation into the death of Peter Blakeney KING. The investigation concluded at the end of the inquest 20th September 2017. The conclusion of the inquest was Peter King died on 19th March 2017 from head injuries sustained when he fell from his bed on 18th March 2017 whilst an inpatient at William Harvey Hospital where he had been admitted with confusion and fever. This, together with his age and mobility issues meant that Mr. King was a high risk of falls: at the time the fall occurred no precautions had been put in place to minimise the risk of falling 1a **Head Injuries** b c II
4	**CIRCUMSTANCES OF THE DEATH** Mr King presented to the Accident and Emergency department at William Harvey Hospital on 16th March 2017 with acute onset of confusion, headache, fever and limb weakness. He was treated with antibiotics for sepsis and a CT head was performed which was diagnostically of no use because Mr King was agitated at the time of the scan. Mr King was moved from the clinical decision unit to Cambridge M1 ward at 01.40 on 18th March 2017 and underwent a further CT scan at 09.08. He was sedated in order for the CT scan to be carried out. The scan showed no evidence of gross intra or extra axial collection or gross acute large infarction. At 18.50 on 18th March 2017 Mr. King was found sitting on the floor having fallen from his bed. The fall was unwitnessed by staff but another patient reported that he had seen Mr. King climbing through the gap between his bed rails and the end of the bed. Mr. King had not lost consciousness as a result of the fall but had suffered a bleeding laceration to his forehead which was dressed. It is not clear from the evidence how this injury was sustained. A CT scan performed at 21.41 revealed a large acute extra axial collection along the entire right hemisphere measuring a maximum depth of 33mm, a midline shift of 25mm and mass effect with compression and total effacement of the ipsilateral ventricular, third and fourth and frontal horn of the left lateral ventricle. There was a loss of grey-white matter differentiation and sulci/gyral pattern of the entire brain parenchyma. Acute haemorrhage appeared to be filling the fourth ventricle. Advice was sought from the neurosurgical team at King's College Hospital who determined that Mr. King was not a candidate for any surgical intervention and should be conservatively managed as the prognosis was poor. Mr. King subsequently died on 19th March 2017.
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) Between January 2017 and April 2017 five deaths occurred on Cambridge Wards at William Harvey Hospital. Common to each was the fact that the death was caused as a result of a fall on the ward in circumstances where falls risk assessments were either inadequate, incomplete, not reviewed or not enforced. Inquests in respect of each the deaths have been held, the last in November 2017. The Trust was given an opportunity following the earlier inquests to provide evidence of changes to practice following the deaths. It is recognised that at the time of hearing the inquests much work has already been done to address these issues but that work is ongoing and parts of that work have not yet been implemented/were in the process of being implemented. It is for this reason that Regulation 28 reports arise from three of the deaths.
(2) In respect of Mr King a falls risk assessment and precautions to minimise the risk of falls was not properly documented; interventions were not recorded and no referrals were made to either the falls team or physiotherapy. A bed rails risk assessment was completed which recorded that bed rails were not recommended but were in use at the time of the fall.
(3) When Mr King was transferred to Cambridge ward from the clinical decision unit the receiving nurse recognised that Mr King should have been nursed in an observable bed with a crash mat and as neither were available on the ward, escalated the matter to the site co-ordinator. There was no evidence that these concerns were ever addressed by the site co-ordinator or followed up by nursing staff
(4) A review of the falls risk assessment and bed rails assessment was recorded, however the fact that interventions were required to prevent the risk of falls was either not recognised or not implemented.
(5) Falls risk was not addressed at handover



6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you East Kent Hospitals University NHS Foundation Trust 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 **16th January 2018.** 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; Next of Kin. I have also sent it to 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	20/11/2017 Signature: Patricia Harding Senior Coroner **Central and South East Kent**