REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, The Dudley Group NHS Foundation Trust**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 29 November 2017, I commenced an investigation into the death of Mr Ronald Compson. The investigation concluded at the end of the inquest on 18 January 2018. The conclusion of the inquest was a short narrative conclusion of accident. The cause of death was: 1a Subdural Haematoma b Fall c II Parkinsons Disease
4	**CIRCUMSTANCES OF THE DEATH** i) Mr Compson had a medical history including Parkinsons disease and was admitted to Russells Hall Hospital on the 16 November 2017 after a period of confusion and drowsiness. ii) He was initially treated for sepsis and then later his medication for Parkinson's revised. iii) On the 18 November 2017 at 9.40pm he had an unwitnessed fall from a chair near his bed and sustained a head injury. Initially his neurological observations were within normal range. iv) There was a failure to notify a Doctor and no examination took place by a Doctor until the following morning at around 3.30am. At this stage he had vomited on two occasions and a CT scan was requested. v) His condition declined and he became unresponsive at around 7am and a CT scan revealed a subdural haematoma. vi) He wasn't deemed suitable for neurosurgery and placed on an end of life care pathway and sadly died on the 25 November 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. Evidence emerged during the inquest that there was a failure to contact a Doctor and it isn't clear if this was a system failure through the "nerve centre" system designed to inform the on call Doctor. 2. There were two separate incidents of vomiting and poor record keeping of when these occurred. 3. There was poor communication to the family about the initial fall.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. 1. Given the examples of poor record keeping, poor communication with the family and notification/escalation issues to a Doctor for examination. You may wish to consider reviewing your policy and/or additional training given to those involved.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 21 March 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; Family. 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	**24 January 2017** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**