Mrs Sarah Louise Slater
Assistant Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive, Doncaster and Bassetlaw NHS Foundation Trust, Doncaster Royal Infirmary, Armthorpe Road, Doncaster DN2 5LT
1	**CORONER** I am Mrs Sarah Louise Slater, Assistant Coroner for South Yorkshire (East District)
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 27th September 2017 I commenced an investigation into the death of Alfred William Meek. The investigation concluded at the end of the inquest on 14th June 2018. The conclusion of the inquest was that Mr Meek died from: 1(a) Pneumonia 1(b) Subdural Haemorrhage A short form conclusion of Accidental Death was recorded in Box Four and Box three completed in the following term: Mr Meek had an unwitnessed fall on or around the 30th August 2017 but he did not receive any medical attention following this. However, Mr Meek was admitted to Doncaster Royal Infirmary on the 2nd September 2017 after sustaining head and facial injuries in a fall at his home. On the 12th September 2017, whilst in the hospital, Mr Meek suffered a further fall on Ward S12. Mr Meek died on the 13th September 2017 as a consequence of traumatic head injury. However, it is not possible to attribute this injury to a specific fall.
4	**CIRCUMSTANCES OF THE DEATH** Mr Meek was an 87 year old gentleman who suffered with some cognitive impairment due to dementia. He lived independently but his family had increasing concerns because he had on occasions let himself out of the house and been found wandering at inappropriate times. Mr Meek suffered an unwitnessed fall by a lake on or around the 30th August 2017. An ambulance was called by a member of the public and Mr Meek was taken to the Emergency Department of Doncaster Royal Infirmary. He was later joined by his son who described his father as wanting to go home and was becoming increasing frustrated at the long wait. There were no visible injuries and therefore Mr Meek took his father home. On the 2nd September 2017, Mr Meek was admitted to Doncaster Royal Infirmary having fallen at home and suffered obvious head and facial injuries. Mr Meek was underwent an Enhanced Care Supervision assessment and was initially assessed at Amber which requires intermittent observations and to be nursed near the Nurses Station. The Policy States that the assessment should be reviewed daily. However, four days lapsed before a further review took place.

	A review of the Enhanced Care Supervision on the 8th September 2017 assessed Mr Meek as Red requiring continual cohort supervision because he was not compliant with the use of his call bell due to his dementia and his risk of falls was high. On the 9th September 2017, the nurse in charge of Ward S12 determined that there was insufficient resources available to provide this level of supervision to Mr Meek and escalated this to the site manager accordingly. There was no evidence before the Court that this escalation of concern from the nurse lead to any further action by the Trust. On the 10th September 2017, Mr Meek was still considered a Red risk, but the Trust is unable to identify what level of supervision Mr Meek received. On the 11th September 2017 no review of the Enhanced Care Supervision Plan occurred and the Trust is unable to identify what level of supervision was in place. However, it was evident that when Mr Meek suffered a fall during the early hours of the 12th September 2017, the required cohort nursing was not being provided. Mr Meek's Enhanced Care Supervision plan was updated following his fall to Purple which requires one to one supervision. Mr Meek died on the 13th September 2017 as a consequence of Pneumonia secondary to Subdural Haemorrhage.
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) There was clear evidence of poor compliance with the Enhanced Care Supervision engagement policy and daily assessments. There was evidence before the Court of numerous days being missed and when the assessment was made the care was not provided in accordance with the policy or the level of risk identified leaving patient's vulnerable to falls. 2) There was no evidence to suggest that any action was taken by the Trust following escalation by ward staff regarding concerns about the lack of resources to provide appropriate supervision in accordance with the level of risk identified. The Secretary of State for Health is asked to consider whether it is appropriate for Trust to review its systems and procedures in place in relation to Enhanced care Supervision and its implications, as [redacted] is concerned that this situation could occur again.

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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **Thursday 9th August 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: [redacted] and The Rt Hon Jeremy Hunt, The Secretary of State for Health and Social Care, Department of Health. 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 14 June 2018 Signature_____ Assistant Coroner for South Yorkshire (East District)

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