East London Coroners
MISS N PERSAUD
SENIOR CORONER
Walthamstow Coroner's Court Queens Road Walthamstow E17 8QP
Telephone 020 8496 5000 Email coroners@walthamforest.gov.uk

REF:7813

25th February 2019

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [redacted] The Royal London Hospital, Whitechapel Road, Whitechapel, London E1 1BB**
1	**CORONER** I am Miss N Persaud Senior Coroner for **East London**
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 05/01/2018 I commenced an investigation into the death of Brenda Kathleen GOWAN. The investigation concluded at the end of the inquest 21st February 2019. The conclusion of the inquest was a narrative conclusion: *Brenda Gowan suffered a stroke on the 1 December 2017. She was discharged home for a trial period on 18 December 2017. At the time of discharge she was assessed as requiring 24 hour supervision and was assessed as being at risk of falls. There was no professional care support provided during the night. Her family were not provided with advice as to how to manage the risk of falls at night. When her family reported a concern that Mrs Gowan was getting up a lot during the night, there was no documented reconsideration of the risk assessment or care plan. Mrs Gowan suffered a fall in her home address in the early hours of the morning, on the 23 December 2017. She sustained a catastrophic injury in this fall, from which she passed away.*
4	**CIRCUMSTANCES OF THE DEATH** Brenda Gowan suffered a moderately severe stroke on the 1 December 2017. She was initially cared for on the Hyper Acute Stroke Unit at the Royal London Hospital. Her family describe the care at the Royal London Hospital as excellent. She was transferred to Whipps Cross Hospital on the 5 December 2017 for further medical care and rehabilitation. Her medical condition was relatively stable and her NIHSS score improved from 17 to 9. Her general condition however was far removed from her pre-stroke functioning. She was unable to communicate her needs; she was doubly incontinent; she had problems with balance and was at risk of falls. The possibility of an adverse outcome from falls was raised due to her lack of understanding of how

to protect herself (e.g it is likely she would not have known to put her hands out to cushion her fall) and due to the prescription of clopidogrel. In hospital she had a full care plan in place to address the risk of falls.

On 12 December 2017 a home visit was made with OT staff. It was identified that Brenda would need 24 hour supervision and that all of her care needs would need to be anticipated. Equipment was identified as being required, to include a falls detector.

On 13 December 2017 a family meeting was held at the hospital. The family were provided with information from the medical, nursing, SALT and OT teams. The family were informed of the plan. There is no documentation about the family's view relating to discharge. The family gave evidence that they made it clear at the meeting that they did not consider that Brenda was ready for discharge. They also did not consider that adequate arrangements were in place to allow a safe discharge.

Brenda was discharged on 18 December 2017, for a "trial period". Despite identifying that Brenda required 24 hour supervision, only 4 hours of care (broken into 4 visits) was provided. There were no care visits between 8pm to 8am.

Brenda was noted to be at risk of falls during the night. No specific advice was provided to the family on how to address this risk.

On the 19th December 2017 Brenda's daughter called the hospital to report her concern that Brenda was getting up a lot during the night. The discharge plan had been based on Brenda being settled at night. There is no evidence that her risk assessment and care plan was reviewed in light of this concern raised by Brenda's daughter.

The recommended falls pendant had not been provided to the family.

In the early hours of the 23 December 2017, Brenda had a fall near to her bed. From the position in which she was found, it is unlikely that Brenda cushioned her fall. Her face and head suffered a significant impact.

A CT scan revealed a catastrophic intracranial bleed with significant mass effect and extensive facial fractures. Brenda passed away as a result of these injuries on the 23 December 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) Brenda was discharged home, less than 3 weeks after a moderately severe stroke, for a "trial period". She required 24 hour supervision, but only 4 hours of social care was provided. Her family were expected to provide 20 hours of care. Her family did not consider that adequate steps had been taken to ensure that systems were in place to allow Brenda's safe return home. The family were concerned about the amount of care support in place; the equipment required and the access to community services. There is no evidence that the family's views were taken into account by the discharging team.

(2)Brenda was at risk of falling at night. There is no evidence that the risk was fully assessed on discharge from hospital and no evidence of the family being provided with advice on how to manage the risk.

(3)The discharge plan was based upon Brenda being settled at night time. When the family reported that this had changed and that Brenda was "up a lot" – the care plan for Brenda should have been re-considered.

(4) There were no community support arrangements in place for the family to access, as the OT services had no contractual arrangement in place with Brenda's registered GP.

(5) The equipment required for managing the risk of falls had not been provided prior to Brenda's fall (5 days after discharge from hospital).

(6) There was no comprehensive plan in place address key aspects such as how care would be provided during the trial period. Such a plan could include the risks identified and how they were to be managed; the equipment required and ensuring that it was provided, installed and those providing the care trained in its use and ensuring that community support is available. Such a plan should be discussed with the community carers (family in this case) and key aspects agreed with them before discharge.

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 **23rd April 2019**. 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] (representing the family) and to the CQC. I have also sent it to Mr Matthew Cole (Director of Public Health) 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	25/02/2019 Signature Miss N Persaud Senior Coroner **East London**