	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Stephen Conroy, Chief Executive, Bedford Hospital NHS Trust, Bedford Hospital, South Wing, Kempston Road, Bedford MK42 9DJ
1	**CORONER** I am **Amy Street**, Assistant Coroner for Bedfordshire & Luton
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/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 8 November 2018 the Senior Coroner for Bedfordshire & Luton commenced an investigation was into the death of Pamela Evans, aged 87. The investigation concluded at the end of the Inquest held by me, on 25 July 2019, when my determinations and conclusion were delivered. The medical cause of death was found to be: "1a Large right-sided acute on chronic subdural haematoma". The Conclusion of the Inquest was a Narrative Conclusion: "Pamela Evans died as a result of becoming dizzy and falling in hospital, hitting her head. At the time of the fall she had been appropriately attended by nursing staff and the fall was not preventable. The cause of the fall was medical, rather than mechanical, although the precise cause is unknown. She was under cardiac investigation for dizziness, fainting and falls which had so far proved inconclusive."
4	**CIRCUMSTANCES OF THE DEATH** Pamela Evans was admitted to Bedford Hospital on 18th October 2018 after she fell and hit her head at home (having experienced recurrent falls following dizziness/fainting). She was admitted to the coronary care unit. On 26th October 2018 an implantable loop recorder was inserted in order to record heart rhythm and she was due to be discharged on 29th October 2018. On 29th October 2018 at 0345 she was on her way to the toilet with her frame and one nurse, in accordance with the mobility care plan. Before entering the toilet she was stationary with her frame in front of her and the nurse behind her, and she became dizzy and fell, twisting forwards, between the wall and toilet, hitting her head. Greater assistance from nursing staff was not warranted and would have risked compromising her mobility and independence, and the fall could not have been prevented. She subsequently, albeit not immediately, deteriorated. Despite the increasing concern of nursing staff, she was not seen by a doctor until 0600; the relevant medical team was attending a cardiac arrest and the critical care outreach team was not called. However earlier medical review would have made no difference to the outcome. A CT scan around 0625 showed a large right-sided acute on chronic subdural haematoma. This had been caused by the fall earlier that morning. Following consultation with family members, palliative care only was provided. Pamela Evans died at Bedford Hospital on 4th November 2018.
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 could occur unless action is taken. In the circumstances, it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows.

The evidence at the Inquest revealed:

(i) A mismatch between:

(a) on the one hand, the expressed intention of senior nursing staff as to when nurses should call the critical care outreach team if the relevant medical team is unable to attend, namely that nurses should call when they have concerns about a patient, irrespective of the patient's NEWS score

and

(b) on the other hand, the understanding of at least some nurses that they cannot or will not call the outreach team, despite having concerns, unless the NEWS score exceeds a specific number (5 or above, according to the cardiac nurse practitioner who cared for the deceased; 7 or above, according to a doctor setting out her experience of some nurses' practice).

(ii) The absence of a means (eg audit) of assessing the understanding held by those who need to know (eg nurses), of when the critical care outreach team could/should be called; and therefore a lack of knowledge within the Trust of whether training on this point has been effective and comprehensive to all relevant people or whether further/different training needs to take place.

(iii) Even if the critical care outreach team had been called, a doctor would not initially attend, but rather a critical care nurse with limited power to take action – eg could not request a CT scan. I am therefore concerned that, if the relevant medical team is busy dealing with another emergency, a patient (eg with a head injury needing a CT scan) may still face delay receiving potentially life-saving measures, even if the critical care outreach team is called.

(iv) Incorrect recording of this patient's NEWS and associated score after her fall which could in other circumstances influence whether/when potentially life-saving measures for future patients take place. Significantly, the deceased's confusion at some point after 0500 should have been recorded as 3 under D ("consciousness") but was never noted at all. It was not clear why; the cardiac nurse practitioner was aware of it and thought the clinical support worker completing the chart had been made aware. Further: first, vomiting after 0500 should have given a nausea score of 2 but was only scored 1; secondly, while a heart rate of 160 after 0500 was noted in the nursing records, only 93 was recorded in the NEWS observation chart at 0515.

(v) That points (i)-(iv) had not been detected by the Trust despite its carrying out of a serious incident investigation. I am therefore concerned that significant and potentially life-saving learning may be missed by the Trust in the future even if serious incident investigations are carried out.

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 **29 November 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 Pamela Evans' family as interested persons. I have also sent it to [redacted], Chair of the National Outreach Forum, 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	**4 October 2019 SIGNED BY ASSISTANT CORONER:**