REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **CQC** **Chief Executive, Royal United Hospital Bath**
1	**CORONER** I am Dr Sean Cummings Assistant Coroner for the Coroner Area of West 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.
3	**INVESTIGATION and INQUEST** Inquest into the death of Dennis Peter Alfred Warner
4	**CIRCUMSTANCES OF THE DEATH** Mr Warner died at the West Middlesex University Hospital (WMUH) on the 6th December 2016. He had fallen at his home address in Trowbridge on the 18th November 2016 injuring his chest. He attended his local Accident and Emergency Department at the Royal United Hospital Bath on the 19th November 2016 and was discharged the next day with analgesia. He then went to stay with his son in London. He was admitted to the WMUH on the 30th November 2016 with increasing thoracic pain and died from multiple organ failure arising from complications of his chest injury. The recorded Conclusion was of Accidental Death.
5	**<u>CORONER'S CONCERNS</u>** (1) Mr Warner suffered from advanced dementia and was the main carer for his elderly wife who also suffered with dementia. He was given information about managing his injury on discharge which he was demonstrably unable to comprehend or remember. Specifically, it was recorded by the examining clinicians that he was unable to answer any orientation questions or to remember the reason for his being in hospital. (2) The Emergency department was full beyond capacity and he was examined in a meeting room as no cubicles were available (3) chest xray was performed. I heard in written evidence from a [redacted] Consultant in Emergency Medicine that chest xray is a suboptimal modality for imaging the chest after injury often underestimating both the number of rib fractures and the extent of any intrathoracic injury(4) there was a delay in senior clinician review of the chest xrays after reporting and a passive approach to contacting Mr Warner was taken by the reviewing clinician. An incorrect number was held for Mr Warner but even if contact had been made then he would have had difficulty comprehending and retaining the information; attempts to contact to contact the GP by phone were abandoned because the phone was not answered. A letter was sent which [redacted] described as misleading. Consequently the efforts made to contact and recall the patient were inadequate.

6	**ACTION SHOULD BE TAKEN** To address the particular concerns and to review how elderly patients with dementia are communicated with and to review appropriateness of imaging techniques in the Emergency Dept.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 25th March 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 Person: [redacted] 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	**28th January 2019 Dr Séan Cummings**