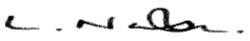
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, The Dudley Group Trust Foundation Trust** **2. Care Quality Commission**
1	**CORONER** I am Laura Nash, Assistant 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 21st March 2018, I commenced an investigation into the death Hubert Kelly. The investigation concluded at the end of the inquest on 12 September 2018. The conclusion of the inquest was a short narrative conclusion of natural causes death. The cause of death was: 1a Old Age 2 Hypertension, Aortic Stenosis, Bullous Pemphigoid
4	**CIRCUMSTANCES OF THE DEATH** i) On the evening of 13th November 2017 Hubert Kelly was taken to hospital in an ambulance following a deterioration in his health; ii) He was triaged by a nurse at the Accident and Emergency Department at Russells Hall Hospital; iii) He was directed to the waiting area of the emergency department where he spent four hours in a wheelchair sat with his family; iv) There was no meaningful interaction with Mr Kelly during those hours with nursing staff until it was noticed that he was not disrupted by noise in the waiting room. Nursing staff conducted a check at 4am and discovered that Mr Kelly had passed away.
5	**<u>CORONER'S CONCERNS</u>** 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 following triage assessment nursing staff lacked room or resources to allow patients to remain in the ambulance triage area or in a cubicle and consequently patients were left to wait in corridors; 2. There was no meaningful interaction with patients waiting for further assessment including no permanent medically qualified staff in the waiting area; 3. Waiting times at the emergency department were frequently exceeding the four-hour waiting time set nationally, with patients waiting to be seen by clinicians for up to seven hours.
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. The Trust may wish to review the accountability and monitoring in place for patients who have been triaged in the Emergency Department and are awaiting further clinical assessment.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 14th November 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	**19th September 2018**  **Miss Laura Nash** **Assistant Coroner** **Black Country Area**