REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Chief Executive Officer, The St.George's University Hospitals NHS Foundation Trust of Blackshaw Road, Tooting, London SW17 0QT 2. The Chief Executive Officer, The Nursing and Midwifery Council of 61 Aldwych, Holborn, London, WC2B 4AE 3. The Chief Coroner of England & Wales, His Honour Judge Mark Lucraft WC, Room C09, Royal Courts of Justice, Strand, London, WC2A 2LL.
1	**CORONER** I am Russell A Caller, HM Assistant Coroner, for the Coroner Area of Inner London West
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 Wednesday 4th December 2019 Russell Caller, Assistant Coroner, heard the inquest of John David Long who died at St .George's Hospital Blackshaw Tooting London on 4th May 2019. **Medical Cause of Death** 1 (a) Intracranial Haemorrhage (b) Traumatic head injury (c) Ischaemic heart disease (treated with coronary Bypass Graft and pacemaker insertion. **How, when and where and in what circumstances the deceased came by his death:** The Deceased suffered an unwitnessed fall from his bed in Benjamin Weir Ward at St. George's Hospital, Blackshaw Tooting London which led to a head injury which led to his death on 4th May 2019 **Conclusion as to the death:** Accidental Unwitnessed Fall

4	**CIRCUMSTANCES OF THE DEATH** The Deceased suffered an unwitnessed fall from his bed in Benjamin Weir Ward at St. George's Hospital, Blackshaw Tooting London which led to a head injury which led to his death on 4th May 2019
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. The bed rails affixed to patients beds allow a patient to fall easily from the patient's bed and the make and manufacture of bed rails should be reviewed to ensure they are fit for purpose and act to ensure the patient is secure in their bed and also prevent a patient accidentally falling from their bed. 2. A review is required into the use of 1:1 (one to one) care in hospital wards and in particular a review into the definition of what 1:1 (one to one) care actually means. In addition a review on how it is administered on the ward and what rules there are for those nurses and Carers to comply with when carrying out such care for a patient. Furthermore there needs to be very clear rules about how Carer or nurse carrying out such care ensures they have sufficient breaks from providing such care and how they are relieved from their duties in such circumstances but ensuring the Patient is not left alone at any time. 3.A review is required on how training of 1: 1 (one to one) care is implemented And administered on a hospital ward and also how such training is communicated to nurses and Carers.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation have the power to take such action. It is for each addressee to respond to matters relevant to them. 1. The manufacture and design of bed rails should be reviewed and changed as and when appropriate. 2. the Definition of 1:1 (one to one) care needs to be reviewed and all the rules relating to this care should be reviewed and modified where necessary. 3. The Training of 1:1 (one to one) care should be reviewed and modified where appropriate. 4. How 1:1 (one to one) care is communicated to nurses and Carers on the hospital wards needs review and where appropriate modified.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. I, the Assistant 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 : 1. The Chief Executive Officer, The St.George's University Hospitals NHS Foundation Trust of Blackshaw Road, Tooting, London SW17 0QT 2. The Chief Executive Officer, The Nursing and Midwifery Council of 61 Aldwych, Holborn, London, WC2B 4AE 3. The Chief Coroner of England & Wales, His Honour Judge Mark Lucraft WC, Room C09, Royal Courts of Justice, Strand, London, WC2A 2LL. 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 Assistant Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**14 January 2020**  **Russell Caller** **HM Assistant Coroner** **Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED**