REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **THE CHIEF EXECUTIVE** **QUEEN ELIZABETH HOSPITAL** **GAYTON ROAD** **KING'S LYNN** **NORFOLK** **PE30 4ET**
1	**CORONER** I am JACQUELINE LAKE, senior coroner, for the coroner area of NORFOLK
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 27 April 2018 I commenced an investigation into the death of RUTH PATRICIA WHITMORE, AGED 91 YEARS. The investigation concluded at the end of the inquest on 31 JANUARY 2019. The conclusion of the inquest was Medical Cause of Death: 1a) Pneumonia 2. Old Age and frailty, Pulmonary Embolism, Congestive Cardiac Failure, Traumatic Left Leg Haematoma sustained 7.1.2018 Conclusion: Natural causes contributed to by a traumatic leg injury
4	**CIRCUMSTANCES OF THE DEATH** Mrs Whitmore had multiple comorbidities and was admitted to Queen Elizabeth Hospital on 1 January 2018. During the early hours of 7 January 2018 Mrs Whitmore was receiving care when her leg became caught in the bed rail causing a large haematoma. This is not noted in the records until shortly before handover to the day shift. On 10 January the haematoma underwent surgical evacuation and continued to be dressed. Mrs Whitmore was transferred for care in the community, but her condition deteriorated, and she was readmitted to Queen Elizabeth Hospital on 21 March 2018. Sadly, Mrs Whitmore's condition continued to deteriorate, and she died on 13 April 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 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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) A substantive member of staff namely a grade 5 Nurse was deemed to be in charge of the ward and as a result responsible for ensuring an immediate investigation into events and a record being made in the Multi Disciplinary Record. Responsibility was not discussed at handover. At the inquest the Nurse remained unaware that she had been in charge on the night 6/7 January 2018 and had any such responsibilities. At the inquest it was felt this could be remedied by sending out emails to staff who are deemed

	to be in charge to tell them of this, without reference to ensuring such staff are competent to be in charge and to ensuring support is in place for such members of staff. (2) The initial investigation into the incident was not robust in that it only included an account of what happened from the patient. No attempts were made to ascertain who members of staff on duty were and interview them. There was no detailed analysis of events. It is not clear from the evidence whether the initial investigation was checked, reviewed and discussed and whether additional steps are in place to ensure all investigations are adequate and thorough.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 3 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] Son) Care Quality Commission (CQC) I have also sent it to: Department of Health HSIB Healthwatch Norfolk 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	**6 February 2019** ..... **[SIGNED BY CORONER]** **Norfolk Coroner Service** **69-75 Thorpe Road** **Norwich NR1 1UA**